COPE HEALTH SOLUTIONS

Improving Access and Quality in Post-Acute Care: Building a System-Wide Network of Skilled Nursing Facilities at One of the Nation's Largest Public Hospital Systems

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Introduction

Hospital and health systems that strive toward value-based payment as their primary payor engagement strategy become more accountable for costs and health outcomes after a patient leaves an acute care facility. Medicare has already made this accountability a fact of life for all hospitals serving Medicare members through the value-based payment and re-admissions penalties assessed on those facilities without the right systems in place to ensure better performance. Post-acute care makes up a significant share of spending for health plans, costing, for some illnesses (e.g. congestive heart failure), nearly as much as a stay in the hospital.[1] Addressing these costs has become an essential strategy for health systems looking to be successful, not only under bundled payment, ACO and capitated arrangements but even for Medicare fee for service due to the significant financial impact the VBP and re-admission penalties can represent[2]

Recognizing this, systems across the country are developing high-quality networks of select skilled nursing facilities (SNFs) in order to improve quality outcomes and patient satisfaction, reduce total cost, streamline communication and ensure system-wide adoption of best practices.[3]

Background

In recent years, one of the nation's largest public safety net hospital systems, serving over one million patients each year and operating several hospitals, outpatient clinics, SNFs, long term acute care facilities, and a variety of ancillary services across a large metropolitan area, has undertaken intensive efforts to reduce costs, increase performance, and improve care quality across the spectrum of care.

In 2016, post-acute leadership at the system began an initiative to develop a network of high-quality SNFs and other post-acute providers across their service area and to streamline the transition of patients from acute to post-acute care settings.

As one of the largest public hospital systems in the country, the development of a post-acute care network necessitated an especially robust procedure of assessment and system transformation. To achieve their goals, the enterprise embarked on a well-rounded approach, focusing on network selection, referral optimization, and IT infrastructure that resulted in targeted and sustainable SNF partnerships.

Our Approach

Post-acute leadership engaged in a three-pronged approach to building its network, using the following framework:

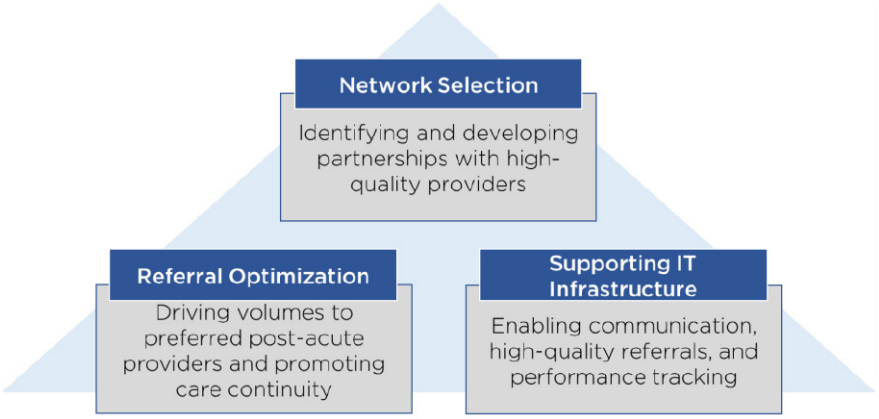

Figure 1

1. **Network Selection:** The process of selecting and forming partnerships with SNFs was the focal point of the effort to build a successful network, ensuring that the right SNFs provide the right care in the right locations to meet the unique health and social needs of the population served.

2. **Referral Optimization:** To maximize the utility of the network, post-acute leaders examined the existing hospital-to-SNF referral process, and designed protocols to enhance the choices offered to patients following discharge, minimize gaps in care quality and avoidable utilization, and increase use of preferred SNFs across the network.

3. **Enabling Technology Infrastructure:** An optimal referral process must allow discharge planners to communicate with SNFs across care settings, identify high-quality SNFs within their network, and track SNF performance for quality and utilization. Robust technology platforms facilitate these processes, allowing for better informed and faster decision-making.

The post-acute team employed a phased process to simultaneously build each of these competencies. The grid below depicts the purpose of each phase within a particular area.

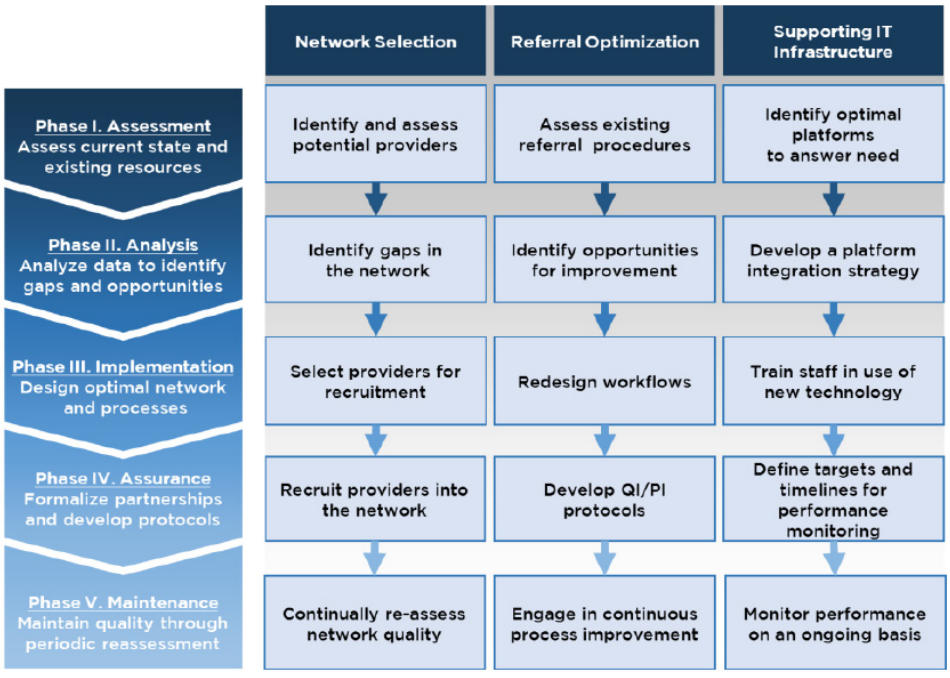

Figure 2

Key Activities and Results

Network Selection

Identifying and targeting the right SNFs for the network necessitated a careful assessment of existing providers within the service area along quality, utilization, and financial metrics. The post-acute team worked with COPE Health Solutions to develop an evaluation framework and to gather and aggregate the data, ultimately producing a fully vetted list tailored to the needs of the patient population.

Table 1

		Results and Key Successes
Work to Date	**Phase I.** Faced with the need to assess over 80 facilities across the metropolitan area, this large safety-net system partnered with COPE Health Solutions to facilitate the evaluation process. The COPE Health Solutions SNF Assessment Tool aggregated publicly available information and SNF-provided data into geography specific dashboards. Each dashboard displayed key information on individual facilities and defined criteria to support selection of target SNF partners.	Through this process, the potential network was narrowed from 80+ to 50 potential SNF partners, targeting a combination of high-quality SNFs and those who filled the identified population health needs, including behavioral health services, methadone maintenance, dialysis, and more.
	Phase II. The post-acute care team used the data gathered in Phase I to identify existing resource gaps across the service area, comparing metrics related to care access and utilization across geographic regions.	This further narrowed the list to 35 total SNFs, who would each receive a site visit from the post-acute team.
	Phase III. The team is currently developing a short-list of SNFs who met baseline quality and safety targets and who also have the ability to impact significant gaps in care.	The short list will include a total of about 30 SNFs to be recruited for inclusion in the network.
Next Steps	**Phase IV.** When a list of target SNFs has been compiled, the post-acute care team will begin reaching out to those SNFs in order to develop formal partnerships. Contracts and MOUs developed with these SNFs will contain language to ensure their accountability for performance and patient outcomes.	
	Phase V. As part of an ongoing, steady state process, the post-acute care team will continue to monitor established performance indicators, updating improvement targets on an ongoing basis and communicating targets and outcomes to SNF partners with clear expectations for improvement to ensure that patient needs are met, improving SNFs can join the network, and those with declining quality are held accountable.	

Referral Optimization

Post-acute leadership led a simultaneous effort to assess and optimize the existing acute- to post-acute referral pathways within the hospital system. The team met with frontline staff to understand existing protocols and develop more efficient strategies to quickly and easily identify SNFs that met the patients' needs.

Table 2

		Results and Key Successes
Work to Date	**Phase I:** To assess the existing referral process, the post-acute team met with discharge planners and social workers at each hospital facility, obtaining qualitative data on their current systems, workarounds and referral preferences. The team then used reports to gather utilization data, gleaning information on access to care and current referral behavior patterns across the system.	The team found the following: • The SNF referral process was driven by facility capacity and supported by qualitative notions of quality performance • Each hospital had developed its own process for referrals, typically executed by social workers
	Phase II. The post-acute team used data gathered during the assessment phase to conduct a gap analysis for the system, determining the root causes of gaps and inefficiencies and identifying key solutions and needed resources	This process identified opportunities to improve access in areas where capacity for behavioral health, dialysis, and substance use beds was limited. The team was also able to identify new SNFs that were able to fill the identified gaps.
	Phase III. The team is currently working with frontline staff to standardize workflows across the enterprise and train staff on the use of AllScripts and Care Port.	Knowledge of the existing processes and needed resources enabled the team to redesign the post-acute referral process around the following goals: • Standardization across the enterprise • Improved awareness of high-quality and in-network SNFs accepting referrals from hard-to-place populations • Data-driven, patient and caregiver centric decision making
Next Steps	**Phase IV.** Once an updated workflow had been completed, the team will develop quality assurance and process improvement protocols in order to hold acute care staff accountable for continuous and faithful implementation.	
	Phase V. The referral process will continue to be assessed on a regular basis in line with the protocols designed above. The team will adjust the workflow as needed based upon emerging issues and the needs of the patient population.	

Supporting IT Infrastructure

Recognizing the need for better access to information on post-acute providers and robust communication infrastructure, the post-acute team identified and began training staff in the use of existing technology platforms to meet their needs.

Table 3

		Results and Key Successes
Work to Date	**Phase I:** The post-acute team reviewed existing and potential platforms to determine what resources were available to enhance cross-site communication and improve the referral process for discharge planners.	• AllScripts was already in use at all hospital facilities, though use of the technology for tracking and referrals was limited due to inconsistent data input and lack of interoperability with SNF platforms. • CarePort, a referral service within the AllScripts platform, was available to provide a comprehensive list of SNFs in the area, which could be filtered by insurance accepted and in vs. out of network status, but did not have the functionality to filter by unique population needs (e.g. behavioral health or methadone).
	Phase II. The post-acute team worked with service line managers and staff to develop their fluency with the platform, address existing barriers to use, and ensure that the platforms were configured to meet patient and provider needs. Acute staff collaborated with the post-acute team to optimize the information included in the platform for their use.	The team developed a strategy to standardize and expand use of the platform, resulting in the following: • Active collaboration with discharge planners and social workers to continuously develop the system to meet emerging needs • Platforms optimized to meet the needs of discharge planners and patients
	Phase III. The post-acute team then implemented their strategy to raise system-wide awareness of the platforms and implement new protocols to ensure their use.	• Staff trained in new protocols integrating the use of AllScripts and CarePort • Widespread use of AllScripts, a discharge platform, and Care Port, a component of AllScripts that enables acute providers to access information on SNFs, across facilities
Next Steps	**Phase IV.** As part of assurance that the workflow has been adopted by the staff, the post-acute care team will run reports using AllScripts to determine how and for what it is being used. The platform will also show to which SNFs patients are discharged and key activities performed. These reports will inform Network Development Phase IV (above), as they can be used to hold SNFs accountable for MOU agreements to consistently update their information on the CarePort platform.	
	Phase V. The team will continue to monitor use of the technology on a continuous basis, following the protocols developed above and making improvements as needed.	

Conclusion

These efforts will produce a network of high-quality skilled nursing facilities that function within the system-wide provider network. Robust referral protocols and technological infrastructure will allow acute care staff to quickly and easily identify the SNFs that best meet the needs and desires of the patient, enabling seamless transitions from hospital to SNFs and lowering avoidable readmission rates. As the Post-Acute Division begins to gather data on financial, utilization, and quality performance across the enterprise, the team expects to see improvements in patient satisfaction and health outcomes with a simultaneous decrease in avoidable acute care utilization and overall cost of care for the SNF population.

Endnotes

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