

INPATIENT & BEYOND: THE POST-ACUTE CARE CONUNDRUM



WHY HEALTH SYSTEMS MUST UNDERSTAND THE IMPORTANCE OF POST-ACUTE CARE PARTNERSHIPS TO THRIVE IN TODAY'S HEALTHCARE ENVIRONMENT

WHAT'S BEEN THE STATUS QUO?

Historically, hospitals leaders and clinicians performing complex procedures on Medicare patients have had little financial incentive to pay careful attention to the cost and quality of care provided in the post-acute setting. This has driven loose or informal referral relationships with post-acute providers and limited standards to help clinicians determine the best settings for this type of care. Determining how much or what type of post-acute care (PAC) is appropriate has traditionally been challenging, due in large part to a lack of data comparing outcomes to the cost-effectiveness of care¹ as well as the lack of incentives to improve care coordination. As a consequence, hospital leaders and clinicians have simply "taken it on faith" that post-acute providers in their communities are able to deliver high-quality and cost-effective care.

Over the Next Three Years...

- 85% of C-suite leaders plan to expand their partnerships with local post-acute care providers.
- 95% of C-suite leaders report hospitals and health systems may experience challenges in creating successful, high-value post-acute partnerships.

Source: Premier Economic Outlook Survey



Skilled Nursing Facilities (2014)

- 15,000 SNFs
- 2.4 million Medicare-covered stays
- 1.7 million Medicare beneficiaries served
- \$28.6 billion spent



Home Health Care (2014)

- More than 12,400 agencies
- 3.4 million beneficiaries served
- \$17.7 billion spent



Long-term acute care hospital (2014)

- 134,000 Medicare-covered stays
- 118,000 Medicare beneficiaries served
- \$5.4 billion dollars spent



Inpatient rehabilitation facility (2014)

- 1,180 facilities
- 376,000 Medicare-covered stays
- 39,000 Medicare beneficiaries served
- \$7 billion spent

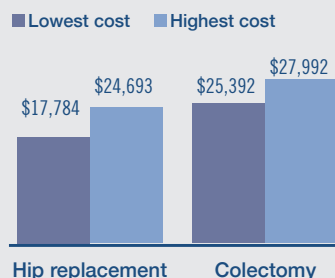
WHY CHANGE NOW?

With incentive structures shifting to measures that require hospitals to manage care across the continuum, these hospitals are now held accountable (at least in part) for the performance of their post-acute partners. Payment is now tied to readmission rates, patient satisfaction, 30-day outcomes and the cost of care for 30 days past discharge. Moreover, mandatory bundled payment programs for joint and cardiac procedures and hip and femur fractures create additional incentives to align more closely with post-acute. The transition period after a major hospital procedure represents a critical time that can mean the difference between a full recovery and an adverse event. In effect, post-acute care is now a critical extension of a hospital's care delivery model, with implications for the hospital's reputation and financial viability.

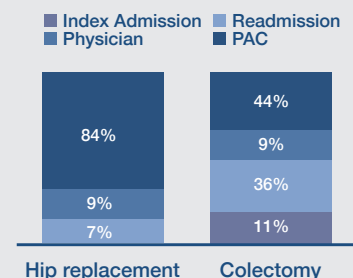
As it stands, significant disparities exist between each PAC provider—differences between providers who offer the same type of care or those that exist within the same community. What's driving this trend? The variation among PAC providers is driven by costs, quality of care and the characteristics unique to each community. Without dependable PAC providers who collaborate with hospitals to act as an extension of the health system with shared goals, the inconsistency and unpredictability in care can result in increased readmissions, unnecessary or misuse of care and unfavorable patient outcomes.

Study Finds Post-Acute Care Top Opportunity to Reduce Costs for Hip Replacements, Colectomies

Difference between top and bottom quintile in cost per episode



Percent of difference between highest and lowest cost case by service type



Source: Health Affairs - <http://content.healthaffairs.org/content/30/11/2107.full>

¹ <http://content.healthaffairs.org/content/32/5/864.full#ref-22>

Variation in Quality

Quality Measure	Mean	25th percentile	75th percentile	Ratio of 75th to 25th percentile
Discharged to the community	37.6%	29.4%	46.5%	1.6
Potentially avoidable readmissions during SNF stay	10.9%	7.8%	13.6%	1.7
Potentially avoidable readmissions within 30 days after discharge from SNF	5.6%	3.6%	7.3%	2.0
Average mobility improvement across the three mobility ADLs	43.5%	35.5%	52.1%	1.5
No decline in mobility during SNF stay	87.1%	82.7%	92.7%	1.1

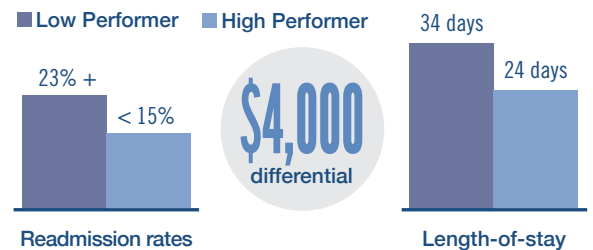
Note: SNF (skilled nursing facility), ADL (activity of daily living). Higher rates of discharge to community indicate better quality. Higher readmission rates indicate worse quality. "Mobility Improvement" is the average of the rates of improvement in bed mobility, transfer, and ambulation, weighted by the number of stays included in each measure. "No decline in mobility" is the share of stays with no decline in any of the three ADLs. Rates are the average of facility rates and calculated for all facilities with 25 or more stays, except the rates of potentially avoidable readmissions during the 30 days after discharge, which are reported for all facilities with 20 or more stays.

Source: MedPAC: [http://www.medpac.gov/documents/reports/chapter-7-skilled-nursing-facility-services-\(march-2016-report\).pdf?sfvrsn=0](http://www.medpac.gov/documents/reports/chapter-7-skilled-nursing-facility-services-(march-2016-report).pdf?sfvrsn=0)

MedPAC found wide variation across all five quality measures tracked for SNFs, including the percent of residents with new or worsened pressure sores, the percent of residents who self-report moderate to severe pain and the percent of residents who experienced falls with major injury. Similar variation was seen in the readmission rates. In analyzing these findings, MedPAC concludes that "the amount of variation across and within the groups suggests considerable room for improvement, all else being equal."²

Variation in Costs

A New England Journal of Medicine study found that lower quality post-acute providers had risk-adjusted readmission rates of 23 percent or more for five potentially avoidable conditions, while high performers had rates below 15 percent³. In addition, top performers had an average Medicare length-of-stay of less than 24 days, while lower tier performers reported more than 34 days — a quality differential that adds up to about \$4,000 per admission given prevailing Medicare rates.⁴



Variation in Practice

Placement decisions often reflect local practice patterns and the availability of different types providers, as well as patient and family preferences. As a result, there is widespread variation in PAC referral patterns, with some hospitals referring fewer than 3 percent of their patients to post-acute facilities, while others refer up to 40 percent⁵. Similarly, some hospitals recommend home health care for just 3 percent of patients, while others refer as many as 58 percent of patients⁶ to this setting.

WHAT ARE THE STEPS HEALTHCARE LEADERS SHOULD TAKE TO CREATE THESE PARTNERSHIPS?

Given this new reality, providers must better understand trends after patients are discharged from the health system and better manage how and where they engage PAC providers. As our healthcare system pushes providers more toward population health, hospital leaders must optimize their use of PAC and establish partnerships to deliver highest quality, most cost-effective patient care. With new tools, data and resources available, leaders can reshape how they engage these providers and work toward the shared goal of making care better, smarter and more efficient.

To stay ahead of the curve in a world that increasingly pushes providers toward population health, hospital leaders must begin to optimize PAC and establish partnerships to deliver the highest quality, most cost-effective patient care. While exposure to PAC providers may be limited for some, this overview serves as a roadmap to help guide healthcare leaders through the necessary steps that can lay a foundation for successful partnerships with PAC providers.

- More than one in five Medicare beneficiaries discharged to a PAC facility experienced an adverse event.
- 60 percent of the adverse events were considered preventable if better care processes had been established.

Source: MedPAC: http://www.medpac.gov/documents/contractor-reports/apr13_communitydischarge_contractor.pdf

² [http://www.medpac.gov/documents/reports/chapter-7-skilled-nursing-facility-services-\(march-2016-report\).pdf?sfvrsn=0](http://www.medpac.gov/documents/reports/chapter-7-skilled-nursing-facility-services-(march-2016-report).pdf?sfvrsn=0)

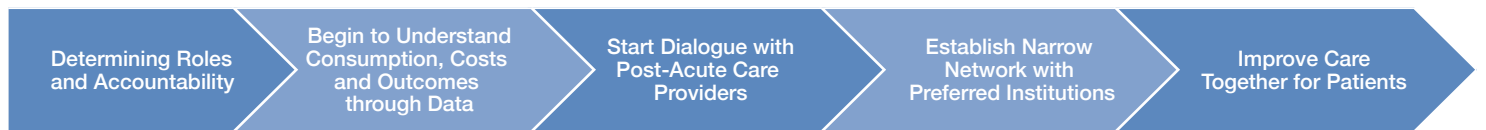
³ <http://www.nejm.org/doi/full/10.1056/NEJMp1315607>

⁴ *ibid*

⁵ <http://newsroom.ucla.edu/releases/frequent-use-of-post-acute-care-associated-with-higher-hospital-readmission-rates>

⁶ *ibid*

Best Practices for Creating an Effective Post-Acute Care Network

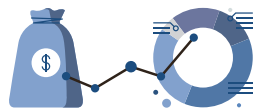


Determining Roles and Accountability

Prior to talking with potential PAC partners, there's an important need to determine roles and responsibilities internally to ensure all potential partners and stakeholders are fully aware of both the health system intent and expectations around post-acute engagement. There is a need to define who oversees leadership and management of the network, and who has ownership and accountability for implementing, monitoring and improving network operations.



This includes clarifying the roles, responsibilities, staffing, frontline communication and workflows that will be used in the collaboration between health systems and preferred PAC providers, as well as accountabilities for ongoing communication, decision-making processes and conflict resolution methods.



Begin to Understand Consumption, Costs and Outcomes through Data

Health systems must think strategically about which PAC providers to include in their networks for collaboration and performance improvement. When looking at potential partners, there is a distinct need to understand the gaps between the current landscape and desired state in order to create the infrastructure necessary to sustain a high-performing PAC network.

The data on local post-acute providers as well as internal discharge processes offers a foundation to design an effective cross-continuum care management system that can manage the linkages between the care settings and help inform who, where, what and how these processes will be carried out for each patient

Start Dialogue with Post-Acute Care Providers

After the deep dive on preliminary data and a sense of how a post-acute network will be managed and developed, the next step is to begin the discussion with PAC providers within the community to determine their level of interest in working together. Selecting strategic partners requires a rigorous approach that should include not only comprehensive reviews of cost, quality and market data, but also should evaluate post-acute provider capacity to meet expectations.



Establish Narrow Network with Preferred Institutions



After culling through baseline assessments and analysis of data, health system leaders should be equipped with the right information to identify potential partners that share or are willing to adopt accountable care measures, as well as a culture that values safety, quality and patient centeredness. A preferred post-acute partner should fit a profile that sets them apart as a top performer that can deliver the best quality and cost outcomes, successfully manage medically-complex patients and commit to ongoing performance improvements.

Hospitals in Action: Banner Health

(PHOENIX, AZ)

Banner Health examined the operations, culture and quality of care at nearly 100 skilled nursing facilities in Phoenix. After putting out an invitation to all Medicare-certified institutions to apply, Banner received more than 70 applications. Of the 70 applicants, 34 of which were chosen to be part of their narrow network. The preferred post-acute care providers agreed to work with Banner to improve recovery times for patients and prevent hospital readmissions. Preferred providers also benefitted as an affiliated provider due to the partnership. Banner reports patients sent to preferred facilities have stays that are 5-7 days shorter than those sent to non-preferred facilities, and all but one facility in the network hit their targets for readmissions. Banner's affiliated network's SNF readmission rate is less than half of the national average compared to non-affiliated SNFs.

Hospitals in Action: Kaleida Health (BUFFALO, NY)

Kaleida Health put in place a predictive modeling program for patients in total joint replacement bundles known as Ticket To Discharge. Previously, the health system had been discharging orthopedic patients to SNFs at a 90 percent rate. In contrast, in other parts of the country, 90 percent of total hip or total knee replacement patients were being discharged to home with home care. The Ticket to Discharge program featured a predictive post-discharge assessment used by any surgeon recommending that a patient undergo joint replacement surgery. At the same time, the patient would be scheduled for surgery and for a pre-operative class. Typically, these patient post-discharge assessments had a roughly 80 percent degree of accuracy. Armed with these assessments, pre-op class educators could better prepare individual patients for one of three options: going home and receiving outpatient services, receiving home healthcare or receiving care in a SNF.

Improve Care Together for the Patient

Identifying potential PAC partners and establishing a network is relatively straightforward for many organizations. The hard work lies in setting up the network for success. Health systems and post-acute providers must recognize that significant changes need to take place within both entities in order to improve internal processes and establish best practices. This means working closely toward a shared vision that makes care better and safer for patients, while also reducing clinical inefficiencies and creating new practices that foster collaboration and prevent siloes in care.



While the unique or specific needs of systems can vary greatly when it comes to improving care for patients along the acute/post-acute continuum, there are three key areas of focus for most organizations to consider, including:

- Effectively planning and improving acute to post-acute transitions
- Improving post-acute care clinical capacity and practice
- Deploying a framework for partnering and process improvement

Conclusion

As PAC emerges as the next blue ocean opportunity for reining in healthcare costs and improving outcomes, this paper shines a light on health systems already navigating a course towards post-acute integration and offers guidance on how emerging systems can chart their own journey to successful partnerships with PAC providers. For more information on Premier's expertise in post-acute care integration and our experience with health systems engaged with PAC providers, contact our team to learn about resources and solutions we've developed to guide members across their evolving continuum of care.

About Premier Inc.

Premier Inc. (NASDAQ: PINC) is a leading healthcare improvement company, uniting an alliance of approximately 3,750 U.S. hospitals and more than 130,000 other providers of care. With integrated data and analytics, collaboratives, supply chain solutions, and advisory and other services, Premier enables better care and outcomes at a lower cost. Premier, a Malcolm Baldrige National Quality Award recipient, plays a critical role in the rapidly evolving healthcare industry, collaborating with members to co-develop long-term innovations that reinvent and improve the way care is delivered to patients nationwide. Headquartered in Charlotte, N.C., Premier is passionate about transforming American healthcare. Please visit Premier's news and investor sites on www.premierinc.com.