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Hospital Boards and Post-Acute Care Partnerships: Ensuring Robust Relationships

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Whether an acute care organization is located in a market just starting the transition to fee-for-value (FFV) or in one that is well along in that transition, partnering relationships with post-acute care (PAC) entities—skilled nursing facilities (SNFs), home health agencies, long-term acute care hospitals, and acute rehabilitation providers—are vital. These relationships support the FFV emphasis on maximizing quality, reducing costs, and minimizing readmission penalties. Careful selection of PAC participant(s) and creation of a partnership structure is critical, and yet those steps are relatively easy compared with ensuring that the partnership is robust and will support the short-term success and long-term viability of both the acute care and PAC entities. The board of an acute care organization plays an important role in contributing to that success.

In a robust partnership, benefits accrue to both the acute care and PAC provider on three dimensions: strategic (differentiation and competitive position), financial (economic performance), and operational (efficiency and effectiveness of care coordination and management). This article highlights key operational elements that contribute to making a partnership robust. We focus on partnerships with SNFs, since a high proportion of acute care patients have historically been discharged to SNF care (22 percent of all patients and 42 percent of Medicare FFV patients in 2013[1]), and SNF care has had the highest impact on the escalation of PAC spending. Many of the principles addressed here will also apply to other portions of the PAC continuum.

Hospital and health system boards must understand the key operational components of robust partnerships and hold management accountable for their effective implementation. Particular attention should be paid to:

1. The formation of a preferred provider network of SNFs
2. The factors that contribute significantly to enhancing clinical quality and care coordination

Preferred Provider Networks

The emerging trend is for acute care providers to establish a PAC strategy and form a narrow preferred provider network, rather than building or acquiring organizations on the PAC continuum. The SNF portion of those networks typically includes one or more facilities, each of which meets criteria such as:

1. Location near patients served by the acute care facility
2. Available capacity
3. Willingness to adopt the acute care organization's care protocols and approach to care management
4. Strong performance on benchmarking metrics:
   a) Quality
   b) Risk-adjusted cost per patient
   c) Risk-adjusted length of stay
   d) Patient satisfaction

Ideally, when acute care organizations discharge patients who need SNF care, they should use preferred SNF network members meeting those criteria. After all, the hospital or health system has thoroughly vetted these post-acute care providers, selecting those that achieved the best outcomes, are easy for patients to access, and are providing ongoing education of PAC clinicians in medical management in SNFs. Discharging patients to these SNFs will optimize care management and achieve the best clinical outcomes while lowering the cost of care.

Discharge planners, case managers, and medical staff members typically struggle with the concept of "directing" patients to specific facilities, stating that they are legally bound to offer patients and their families a comprehensive list of all providers and let them make the final selection. After studying this

[1] Wen Tian, "An All-Payer View of Hospital Discharge to Post-Acute Care, 2013," Statistical Brief #205, Agency for Healthcare Research and Quality, May 2016.

issue, a number of hospitals and health systems in the Midwest and western U.S. have determined that they can legitimately use "soft steering" to help patients and their families to make an informed choice, using a four-step process:

1. Share a list of all SNF providers in the market with patients and their families, placing those that are members of the preferred provider network at the top.
2. Describe SNF characteristics that contribute to better care and higher patient/family satisfaction (e.g., a track record of high quality, well-coordinated transitions, proactive medication management, ongoing clinical training, etc.).
3. Indicate that the SNFs at the top of the list have been vetted by the acute care organization and are known to have those characteristics. Share data on outcomes, readmission rates, and satisfaction scores demonstrating that those at the top of the list perform well in comparison to others on the list.
4. Conclude by saying, "It's your choice."

Given the information, patients/families tend to choose those providers that are in the preferred network.

Soft steering is accepted by the Medicare Payment Advisory Committee (MedPAC) and by legal counsel for many providers once they are educated on the topic.

Preferred Provider Relationships: The Board's Role

Since soft steering of patients to preferred SNFs is beneficial, boards should be conversant with this topic and ask management to study it if the organization has not yet adopted this approach. If management experiences "push back," the board, after obtaining support from legal counsel, should actively stand by management in endorsing the approach. Both steps will contribute to making the partnership between the acute care facility and SNF more robust.

Enhancing Clinical Quality and Care Coordination through the Partnership

SNF management tends to perceive that a relationship with a hospital or health system is made robust when the two parties take a collaborative approach to patient care delivery. They want to see the acute care provider enhancing care delivery at the SNF by contributing value in one or more of the following ways:

1. Providing the SNF clinical team with access to specialty physicians, nurses, and other clinicians for care of patients at the SNF, with particular emphasis on clinical support related to infectious diseases, wound care, pressure sores, respiratory therapy, pulmonology, and infection control. SNFs favor a multi-pronged approach to clinical support that includes:
   a) Consultative arrangements for training SNF clinical staff in the care of patients with these conditions
   b) Skype/video consultations between the SNF clinical team and hospital staff
   c) On-site consultation and support at the SNF by hospital clinical staff—more frequent during the initial months of the relationship, less as time progresses
2. Having clinical team members participate in "grand rounds" at the SNF
3. Giving the SNF clinical team access to physiatrists and physical therapists
4. Establishing a health information exchange (HIE) as a "bridge" between the SNF electronic health record (EHR) and the hospital EHR, so that patient clinical data can be shared more easily
5. Offering the SNF access to hospital-developed, evidence-based protocols that extend from acute to post-acute care; guidance on the best types of equipment and supplies to purchase; and the ability to use group purchasing discounts
6. Providing the SNF with a medical director candidate who has training and expertise in geriatric care and familiarity with state SNF regulations
7. Offering an avenue for the SNF to gain patient volume, access to managed care contracts, and improved payer mix, as well as access to patients with conditions that result in improved resource utilization group (RUG) types and reimbursement
8. Enhancing the patient transition from the acute to the post-acute setting through:
   a) Medication reconciliation and management
   b) Effective transfer of patient clinical information
   c) Assistance in integrating selected SNF quality indicators with those of the acute care organization
9. Supporting enhancement of SNF performance on patient and life safety codes
10. Offering business process personnel to assist the SNF in enhancing operational efficiency and patient flow

Enhancing Clinical Care and Coordination: The Board's Role

In hospitals/systems that are developing SNF partnerships, the board should ensure that the acute care management team understands the types of clinical and operational improvements that SNF leaders seek, and request that management create a plan for addressing those. Where SNF partnerships are already established, the board should monitor the performance of the management team to ensure SNF partners obtain the value they seek.

Conclusion

Board members can play a significant role in helping their healthcare organizations achieve and maintain a robust partnership with PAC entities, by familiarizing themselves with the development of a preferred provider network for PAC, and with the specific type of value that SNFs and other PAC organizations are looking to achieve from the partnership. The board may want to consider seeking outside assistance if management is not comfortable with these concepts or needs expert assistance to put them in place.

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