

A Strategy for Post-Acute Care

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Hospitals and health systems have not historically focused on post-acute care. However, several factors are now motivating them to develop or strengthen their ties with post-acute care providers and establish an explicit post-acute care strategy.

Acute care providers need to develop strong collaborative relationships with post-acute providers to ensure access to the post-acute care capacity they need for their patients; to protect themselves from financial risks associated with value-based payment

models and Medicare readmission penalties; and to keep post-acute care patients who do need readmission, within their system.

Specifically:

- Strengthening relationships with post-acute care facilities is one of the key ways to reduce readmissions from post-acute settings.
- ACOs and those participating in bundled payments need to control total costs of care and episode costs in order to succeed. A large percentage of these costs are generated within post-acute settings, particularly in skilled nursing homes and rehabilitation services.
- Improved care coordination is vital to keeping patients that do require readmission within the health system or where relevant, within the ACO so that the ACO can maintain a cohesive care model for the patient. This also includes smoothing patient transitions from the acute to the proper post-acute environment.



Achieving these requires strong relationships with post-acute care providers.

Post-acute providers want increased integration with acute care services to ensure that they have sufficient admissions for financial viability.

The following three components of a post-acute care strategy for acute care providers will help to address these needs:

DEVELOP PREFERRED PARTNERSHIPS

While some acute care providers own their own post-acute care units, most have no or only limited capacity. Few want to invest scarce capital in building or purchasing post-acute facilities (although they may acquire them incidentally during an acute care merger).

Instead, many acute care providers have developed a network of partnerships with preferred post-acute care providers. Usually these offer a continuum of post-acute care services (skilled nursing facilities, home health agencies, inpatient rehabilitation facilities, hospice care) that ensure appropriate geographic coverage, high-quality care and strong patient experience, and efficient use of resources.

Partners are selected based on evaluation against carefully developed criteria, with a heavy emphasis on quality performance and cost management, as well as willingness to accept hospital/system input into post-acute care standards and protocols. STAR ratings and LOS in post-acute settings, as well as readmission rates to acute care, are also among criteria commonly considered (for more detail on criteria for evaluating post-acute care facilities as part of a network, see [Post-Acute Partners: A Make or Break Choice](#)).

Once selected, partners should be reevaluated quarterly or semi-annually. Preferred post-acute partners should be willing to share quality and outcomes data with health system partners.

SHIFTING CARE TO LOWER COST SETTINGS

Successful health systems will use strong relationships with post-acute care providers to shift some proportion of care to lower cost settings. That could take the form of discharging patients to skilled nursing homes rather than inpatient rehabilitation when appropriate, or discharging patients to home health services rather than the higher cost skilled nursing or inpatient rehabilitation settings when feasible.

It could also mean using outpatient therapy or getting patients back to their primary care physicians for follow-up care in a more timely fashion. Telehealth services are facilitating the shift to home care by allowing remote patient monitoring and guidance.

ENHANCE CARE MANAGEMENT AND CARE COORDINATION

To maximize the benefits of a post-acute care preferred provider network, health systems should proactively extend more robust care management and care coordination efforts to their post-acute care partners, including:

- Having health system-affiliated geriatrics specialists serving as medical directors
- Having patient care managers or navigators as well as community health workers making visits at the post-acute setting post-hospitalization
- Improving patient handoffs from acute to post-acute care, to enhance medication management and to minimize falls and infections
- Providing strong care plans that include expectations about future care transitions
- Providing hospital-developed, evidence-based care protocols that extend into the post-hospitalization period
- Developing required specialized clinical skills at the post-acute care organization through training by hospital nurses and clinicians
- Establishing guidelines for management of patient readmissions
- Sharing of patient clinical data

Those who are engaged in effective partnerships, shifting care to lower cost settings, and extending care management efforts into the post-acute phase, are better positioned to succeed in a value-based payment environment. ●