EXECUTIVE BRIEFING

Advisory Board

10 Keys to an Efficient Post-Acute Episode

Strengthen collaboration with post-acute care providers and improve patient management

Part 1: Prepare for an efficient discharge

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Post-Acute Care Collaborative

advisory.com/pacc

programinquiries@advisory.com

About the 10 Keys to an Efficient Post-Acute Episode Series

Variation in post-discharge quality and costs, as well as related readmissions, make post-acute care critical to managing an effective episode of care. This two-part briefing outlines how health systems can prepare for an efficient discharge process, while strengthening post-acute provider collaboration and effective patient management strategies following the hospital stay.

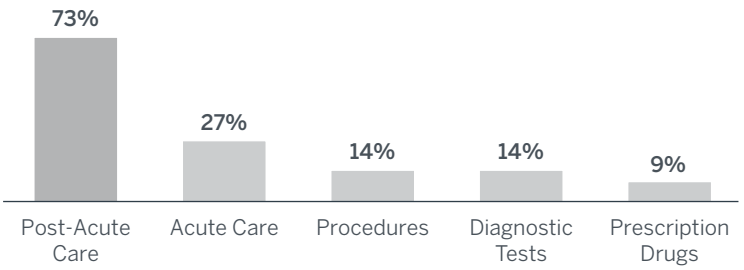
Post-acute care is critical for hospital success under mandatory episodic efficiency.

CMS's latest alternative payment model—Comprehensive Care for Joint Replacement (CJR)—gives us a glimpse into a future where bundled payments are commonplace.

While other programs have been voluntary, CJR is mandatory for roughly 800 hospitals in 67 markets. How can hospitals succeed in CJR and other bundled payment models? One strategy to control episodic costs is to create a more efficient post-acute care (PAC) episode. Why? Post-acute care is the largest contributor to cost variability across an episode.

Reduction in Total Geographic Medicare Spending Variance if Variance in Each Category Eliminated[1]

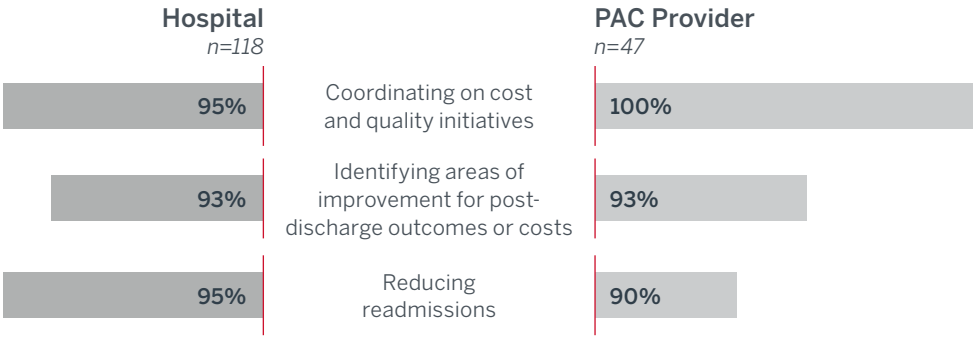
Among Dartmouth Atlas of Healthcare Hospital Referral Regions, 2013



Further, as our survey of more than 260 health system members shows, hospitals recognize the critical link between managing PAC costs and thriving under episodic payment programs.

Providers are willing to invest time and money for better episodic efficiency.

Advisory Board member poll: Do you anticipate that your organization will be more likely to invest resources in the following areas?



1) Categories sum to more than 100% because of covariance terms.

10 key ways to ensure an efficient post-acute care episode

Variation in post-discharge quality and costs, as well as related readmissions, makes post-acute care critical to managing an effective episode of care. Through primary research and literature review, the Post-Acute Care Collaborative has identified two distinct areas that can enhance patient management across the post-acute episode. First, providers must deliver efficient post-acute care from admission to discharge; second, post-acute providers must address gaps in the patient's routine care.

Part 1: **Prepare** for efficient discharge

01 Partner with PAC providers that will support your goals.

02 Evaluate CMS-enabled partnership opportunities.

03 Front-load discharge planning.

04 Place patients in the setting that's most appropriate.

05 Promote use of preferred providers.

Part 2: **Achieve** effective patient management post-discharge

06 Share critical patient information with downstream partners.

07 Extend care pathways into the post-acute setting.

08 Share clinical knowledge, and clinicians themselves, with PAC providers.

09 Develop and maintain patient engagement in self-management.

10 Manage the tail end of risk with primary care as well as social and medical support.

Part 1:

Prepare for efficient discharge.

An efficient post-acute episode begins before the patient has even been discharged from the hospital.

From a strategic standpoint, an efficient episode is dependent on meaningful connections with post-acute partners. Position yourself for episodic success by establishing strong downstream partnerships and steering patients to the right destination for their needs—and yours. Take a closer look at how you're communicating with your PAC partners to identify any gaps that could lead to readmissions or other issues that will affect your bottom line.

From an operational perspective, if discharge planners do not identify and plan for patients' post-discharge needs soon after admission, the scramble to meet these needs at the last minute may delay discharge. Therefore, ensuring a timely and safe PAC referral begins on hospital admission with steps to align post-discharge resources to patient needs.

Partner with PAC providers that will support your goals.

Hospitals are forming narrow post-acute networks with high-quality, low-cost partners to help reduce outcomes variability, as well as facilitate meaningful collaboration on care transitions and other initiatives that are not possible with a wider range of stakeholders.

There's major variability in post-acute quality and cost performance across individual providers, and many hospitals don't have information to assess a potential partner's performance. But it's critical to find the right PAC partners.

Quality Measures Varied Considerably Across SNFs[1]

	Risk-adjusted rates			
Quality measure	**Mean**	**25th percentile**	**75th percentile**	**Ratio of 75th to 25th percentile**
Discharged to the community	39.5%	31.4%	48.5%	1.5
Average mobility improvement across the three mobility ADLs[2] during SNF stay	43.6	36.0	51.5	1.4
No decline in mobility during SNF stay	87.1	82.7	92.5	1.1
Potentially avoidable readmissions during SNF stay	10.8	7.7	13.5	1.8
Potentially avoidable readmissions within 30 days after discharge from SNF	5.8	3.7	7.6	2.1

Note: 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 mobility 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: Analysis of fiscal year 2016 Minimum Data Set and hospital claims data.

1) Skilled nursing facilities.
2) Activities of daily living.

Where should you begin? First, **build a scorecard** with the key clinical, operational, and strategic metrics that are relevant to your system's goals. Then, ask potential PAC partners to **report data** in those areas—and gather external data to validate that information when possible. Be sure to engage directly with PAC partners during this process as an initial step toward building a long-term partnership.

Here are five key metrics to get you started:

- 30-day all-cause readmission rate
- Average length of stay (for SNFs)
- Average response time to referrals
- Existence of aligned specialty program
- **Relationship with health system physicians (e.g., medical director)**

Once you've completed your initial assessment, you should develop a strong working relationship with your PAC partners. Regular, in-person forums give partners the ability to share best practices or collaborate on clinical objectives. Take it a step further by establishing targeted work groups that focus on specific challenges, such as readmission reduction, and encourage ongoing performance improvement.

POST-ACUTE CARE COLLABORATIVE MEMBERS HAVE ACCESS TO

Our **Hospital Scorecards for Post-Acute Providers**, which provides suggested clinical, operational, and strategic metrics for identifying the most viable partners across several PAC sectors.

Our **SNF Performance Profiler**, which provides visibility into potential SNF partners' outcomes on quality and efficiency metrics, benchmarked against a custom cohort to easily contextualize performance.

Our **Post-Acute Pathways Explorer**, which provides quick access to comprehensive data reports covering all of the acute and post-acute providers in a market via a single, streamlined interface.

All resources are available to members on advisory.com/pacc.

MEMBER SPOTLIGHT

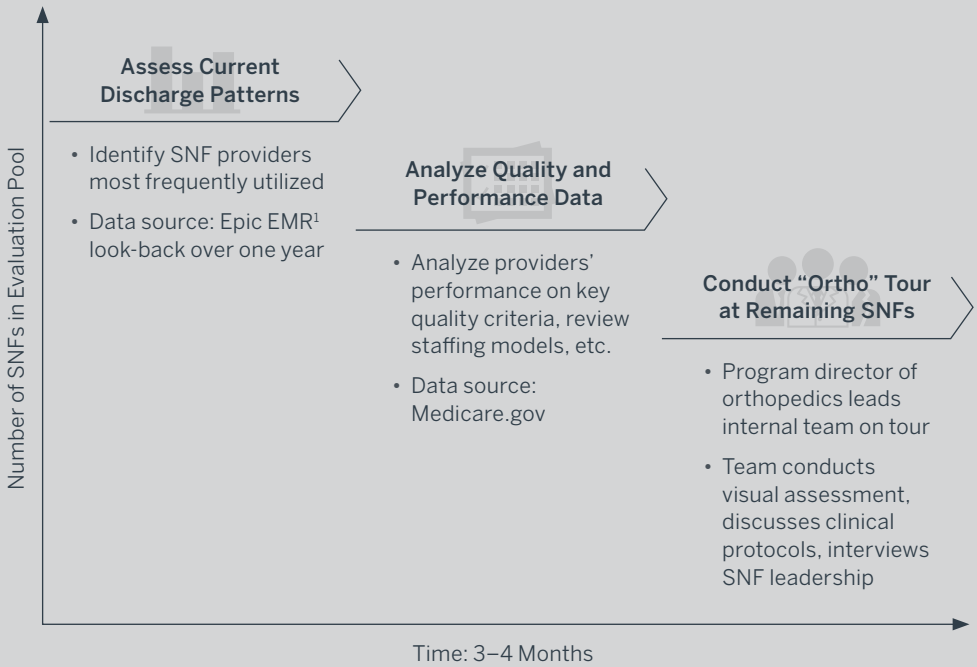
A Rigorous Selection Process for Population-Specific Partners

TriHealth, a two-hospital system in Ohio, launched an initiative to select the best SNF partners for its high-volume orthopedics service line.

First, TriHealth assessed discharge patterns to identify all SNFs that had cared for TriHealth joint replacement patients in the last year. Next, TriHealth analyzed the performance of each SNF, collecting data and eliminating any that did not meet minimum quality standards. An internal team with representatives from the service line then toured remaining SNF facilities and completed their own evaluations.

Ultimately, the team selected 13 orthopedic partners from an initial pool of over 100. These preferred providers now receive 88% of orthopedic discharges.

TriHealth's SNF Selection Process for Orthopedic Service Line



1) Electronic medical record.

Evaluate CMS-enabled partnership opportunities.

CMS typically restricts certain types of coordination between health care providers. However, there are two ways hospitals can collaborate with PAC partners under new CMS programs, such as CJR and BPCI (Bundled Payments for Care Improvement) Advanced.

1 Gainsharing with PAC partners

PAC providers' Medicare incentive structures are often at odds with those of hospitals. Offering to share savings with PAC partners can encourage aligned behavior—and reward PAC providers for supporting hospital goals.

2 Leveraging waivers

Episodic payment programs offer waivers of certain Medicare requirements to encourage cost-effective care. Hospitals, in partnership with PAC providers, can use these exemptions to discharge patients earlier, or to lower services' cost structure by using telehealth. See specific information on waivers available through the CJR program in the table below.

Waivers Commonly Available Under Bundled Payment Programs

3-DAY STAY WAIVER[1]	
Overview	*Limits*
Waives the requirement of a 3-day inpatient stay for subsequent SNF stay coverage	Available only for SNFs with 3-star rating or higher; CMS will keep an updated list of eligible SNFs

TELEHEALTH GEOGRAPHIC AND ORIGINATING SITE WAIVER	
Overview	*Limits*
Allows providers to bill for telehealth regardless of patient's geographic location or care setting	Only for services on CMS's approved list; for those in an HH[2] episode, cannot be visits covered under HH PPS[3]

POST-DISCHARGE HOME VISIT WAIVER	
Overview	*Limits*
Permits home visits incident to physician care to be delivered without direct physician supervision	Home health and community-based providers are excluded from offering home visits under this waiver[4]

1) Available beginning in performance year 2.
2) Home health.
3) Home health prospective payment system.
4) These providers are not considered "auxiliary personnel" of the supervising physician.

Front-load discharge planning.

An efficient episode of care, including the post-discharge portion, begins during the hospital stay. Care teams should develop a comprehensive understanding of each patient's needs early, to optimize the hospital stay and beyond. Failing to do so can result in delayed discharge, improper post-acute patient placement, or unnecessary readmissions.

And soon, this won't be optional: CMS has proposed changes to current discharge planning requirements that would mandate a front-loaded discharge planning process.

> "We would clarify the requirement by requiring that a hospital would begin to identify anticipated discharge needs for each applicable patient within 24 hours after admission or registration, and the discharge planning process is completed...without unduly delaying the patient's discharge."
>
> CMS's Proposed Discharge Planning Rule

To succeed in this area, hospitals should equip discharge planners with comprehensive risk stratification assessments—including both clinical and psychosocial factors—and conduct assessments soon after admission. The table on the next page describes various assessment tools that strengthen clinical patient management.

Early engagement with patients ensures that hospital and care management staff can effectively provide needed interventions and support. Discharge planners also will have the information they need to more efficiently prepare for discharge—without a last-minute scramble. Removing logistical hurdles is crucial to a timely, effective discharge.

POST-ACUTE CARE COLLABORATIVE MEMBERS HAVE ACCESS TO

Our **Post-Acute Resources for Hospital Discharge Planners**, which help discharge planners make PAC referrals safe, easy, and efficient.

Available to members on advisory.com/pacc.

Evidence-Based Risk Stratification Tool Compendium

RISK MODEL	CRITERIA ASSESSED
LACE Index Predicts risk of readmission and death within 30 days, using both primary and administrative data.	• LOS in days for index hospitalization • Acuity of illness at time of index admission • Charlson comorbidity score • ED visits in previous six months
Krumholz/Yale Model Predicts risk of 30-day all-cause readmissions for heart failure (HF) patients 65 years or older. Available as an online calculator and iPhone app.	• Demographics • Occurrence of in-hospital cardiac arrest • Medical history • Diagnostics on admission (e.g., LVEF)
Philbin Tool Predicts risk of readmission for HF patients 65 years or older using administrative data.	• Demographics • Comorbidities • Hospital type and location • Processes of care • Clinical outcomes
Patients at Risk of Rehospitalization (PARR) Algorithm Predicts risk of readmission within one year for patients with a wide range of reference conditions that improved care management has the ability to influence.	• Demographics • Comorbidities • Substance abuse • Past utilization • Hospital's past performance
Project BOOST 8P Screening Tool Risk assessment tool intended for use at admission to identify patients at increased risk of adverse events post-hospitalization. Tool includes risk-specific interventions hospitals can use throughout the patient's hospitalization to mitigate post-discharge risk.	• Problem medications • Psychological issues • Principal diagnosis • Polypharmacy • Poor health literacy • Patient support • Prior hospitalization • Palliative care
Patient Activation Measure Thirteen-item, evidence-based measure that assesses patient knowledge, skill, and confidence to self-manage after discharge. Administered to patients as a questionnaire for self-evaluation. Score allows caregivers to infer a patient's risk of noncompliance post-discharge and tailor self-management education and follow-up contact accordingly.	• Thirteen-question patient self-assessment of their knowledge and ability to self-manage. For example: – *I understand the nature and causes of my health condition(s)* – *I know how to prevent further problems with my health condition* – *I know what each of my prescribed medications do*

Place patients in the setting that's most appropriate.

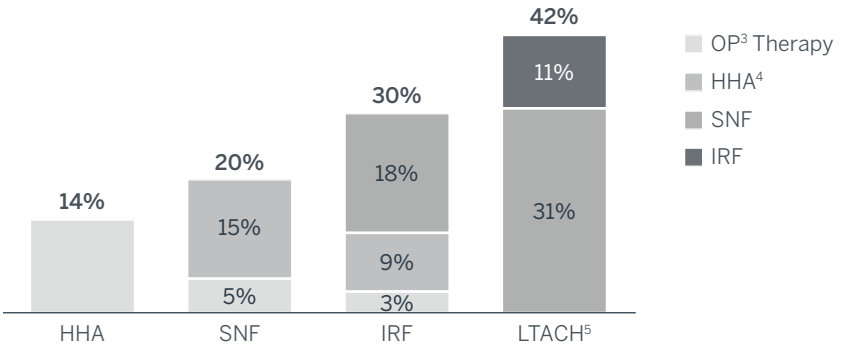
Placing patients in the appropriate PAC setting is no easy task. There's a wide range of post-acute care settings, and there's limited standardization around appropriate patient placement criteria for each PAC provider. Even within providers of the same setting, specialized capabilities can vary significantly. For example, only some SNF providers may be able to care for patients on ventilators. This lack of standardization creates a confusing environment for discharge planners to determine the best post-acute options for a given patient.

> "Currently, there is no standardized process for placing each patient in the appropriate PAC setting. Patients with the same acute-care hospital discharge diagnosis may be referred to different PAC settings. For example, patients who have undergone joint replacement surgery may be treated at a SNF, IRF[1] or HHA after discharge from the hospital."
>
> AHA Trendwatch

The risks from inappropriate placement are high. The longer it takes a discharge planner to determine the right setting, the more unnecessary time the patient spends in a hospital bed. At the same time, patients placed in settings that are unequipped to care for them may end up returning to the hospital, while patients placed in unnecessarily high-acuity settings can drive up costs. One study found that between 14% and 42% of post-acute patients, depending on the setting, could be treated in a lower-cost environment.

Proportion of Medicare Patients Placed in an Avoidably High-Cost Setting

Study Findings by Post-Acute Setting[2]

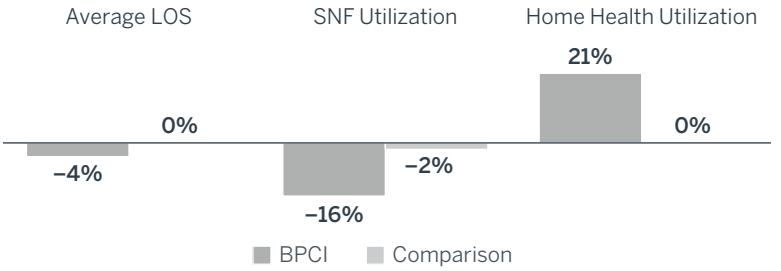


1) Inpatient rehabilitation facility.
2) Study assessed top 100 most costly DRGs but excluded those with high concentration of spending in any one PAC setting.
3) Outpatient.
4) Home health agency.
5) Long-term acute care hospital.

It's no surprise, then, that bundled payment participants' post-acute care patterns emphasize utilization of lower-cost settings—notably the home environment.

Bundled Payment Care Improvement (BPCI) Model 2 Participants' Performance Relative to Comparison Group

Surgical Orthopedic, Excluding Spine



How can you facilitate easy and accurate post-discharge placement of your patients?

1 Implement a post-acute level-of-care decision guide.

A level-of-care decision guide is a set of criteria mapping specific clinical parameters to the post-acute sectors generally equipped to care for these patients. Case management teams can create their own guide, or select an existing guide such as Interqual® in partnership with referring clinicians.

2 Work with PAC partners to create a database of contacts and capabilities.

Given the variation in individual providers' capabilities, discharge planners should also collaborate with local PAC partners to develop a centralized information database with regularly updated information on each PAC partner's capabilities and a phone number for 24/7 contact. This enables discharge planners to tell at a glance which PAC providers can meet a patient's needs.

Promote use of preferred providers.

Patients aren't likely to choose high-quality, preferred PAC partners if they don't know who they are. And if too few patients receive care from preferred providers, your PAC network will have a limited effect on overall outcomes, even if it achieves high care quality and collaborative clinical programming.

What's the answer? During the discharge process, tell patients which providers are preferred—while respecting their freedom to choose any provider.

Medicare patient choice requirements prevent hospitals from selecting a patient's post-discharge provider—but that doesn't mean discharge planners can't simply inform patients about the clinical quality of their post-acute options. In fact, the CJR final rule specifically notes that although hospitals cannot restrict patient choice, they can recommend providers.

> "Participant hospitals may recommend preferred providers and suppliers, consistent with applicable statutes and regulations."
>
> CMS, CJR Final Rule

POST-ACUTE CARE COLLABORATIVE MEMBERS HAVE ACCESS TO

Our publication **The Blueprint for a Successful Post-Acute Network**, which not only outlines the critical steps to building a high performing Post-Acute network, but also how to identify and manage a group of preferred providers.

Available to members on advisory.com/pacc.

MEMBER SPOTLIGHT

Guiding Patients to Top PAC Providers While Respecting Their Right to Choose

Baystate Medical Center in Springfield, Massachusetts, is participating in a BPCI program for coronary artery bypass graft (CABG). Baystate successfully reduced episodic costs for its CABG patients by building—and using—a high-quality network of 12 SNFs.

To promote these preferred partners, Baystate discharge coordinators provide BPCI CABG patients a list of preferred SNFs. The list includes facts on each provider's comparatively high quality, and it emphasizes the continuity of care a patient will receive because of the provider's close working relationship with the hospital. At the same time, the list makes clear that every patient has the right to choose their own provider.

The results? At Baystate, 60% of BPCI CABG discharges now go to one of the preferred SNFs. At the same time, Baystate achieved a $1,900 reduction in cost per episode for CABG, which leaders largely attribute to more efficient use of SNFs.

Promoting Top Providers but Preserving Legally Protected Choice

Case managers give patients information guiding them to preferred SNFs

Information clearly states that patient has freedom to choose where to be discharged

Information emphasizes preferred providers' high quality, close relationship with hospital, and continuity of care

Success in Patient Placement Leads to Financial Results

60%

Of CABG patients who are discharged to a SNF go to a preferred provider

$1,900

Reduction in cost per case for CABG achieved through bundled payment program; significant portion attributable to SNF coordination

Conclusion

Hospitals are in a bind when it comes to discharge planning to post-acute care. There are no clear industry standards for determining the appropriate care setting. And for that reason, there's a high degree of variability in where PAC patients go after discharge—and the associated costs.

But hospitals can greatly reduce this variability and enhance their post-acute care management by creating a high-performing PAC network and optimizing discharge procedures.

Check out the second installment in this two-part series, *Achieve Effective Patient Management Post-discharge*, to learn about information sharing and efficiently managing the end of an episode.

Want more on **post-acute strategy**?

This report is a publication of the Post-Acute Care Collaborative, a division of Advisory Board. Members of the Post-Acute Care Collaborative have access to a wide variety of material, including webconferences, research reports, implementation resources, our blog, and more. Examples of our resources on post-acute strategy are listed below. Talk to your contact or visit advisory.com/pacc to learn more about membership in the Post-Acute Care Collaborative.

The Playbook for Hospital/Post-Acute Care Collaboration

Access our best resources on partnership development—from best-practice guidance to data analysis to ready-to-use tools. Together, these resources provide start-to-finish support across every stage of relationship development.

Care Transitions Mapping Tool

Gain market-level insights on patient movement and readmissions between acute and PAC providers within 30 days of discharge.

Hospital Scorecards for Post-Acute Providers

Learn what metrics best indicate post-acute partnership viability, then get started identifying your partners with our ready-to-use dynamic scorecards.

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Project Director
Jared Landis

Contributing Consultants
Carolyn Swope
Julia Burgdorf

Executive Director
Amanda Berra

Designer
Stefanie Kuchta

Sources

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Remainder of this briefing is based on Post-Acute Care Collaborative interviews and analysis.

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2445 M Street NW, Washington DC 20037
1-202-266-5600 | **advisory.com**