EXECUTIVE BRIEFING

Advisory Board

10 Keys to an Efficient Post-Acute Episode

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

Part 2: Achieve effective patient management post-discharge

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Post-Acute Care Collaborative

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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.

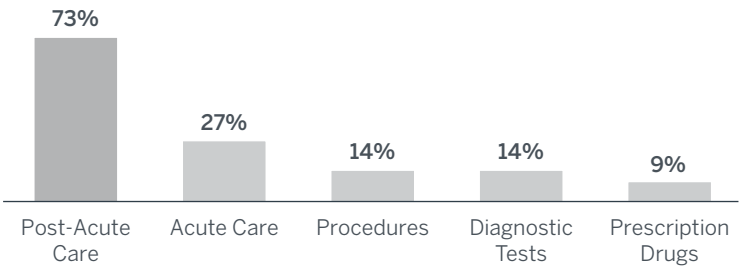
Post-acute care is critical for hospital success under mandatory episodic efficiency.

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]

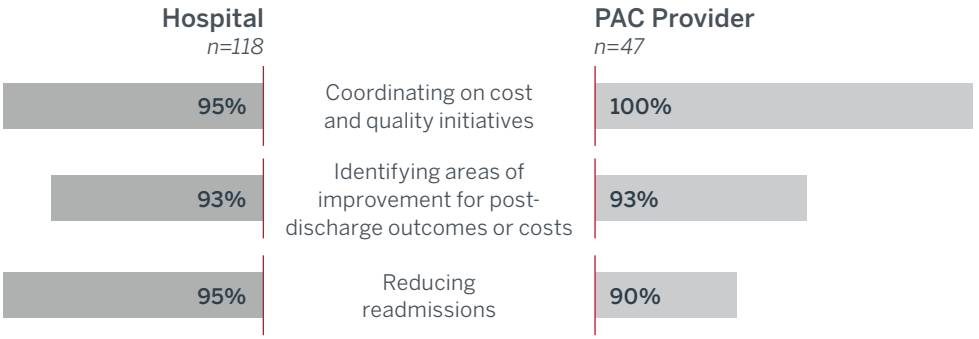
Among Dartmouth Atlas of Healthcare Hospital Referral Regions, 2013



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 2:

Achieve effective patient management post-discharge.

Managing patients post-discharge is critical to ensuring patient recovery, avoiding unnecessary readmissions, and hardwiring appropriate post-acute utilization—all vital parts of success under episodic payments.

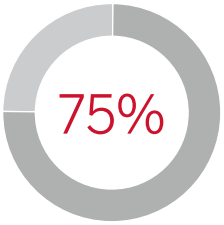
To achieve these goals, build a collaborative clinical infrastructure with preferred post-acute partners focused on effective patient information exchange and enhanced clinical supports. Sharing information and clinical resources promotes care coordination and reduces gaps in a patient's care plan.

Lastly, connect patients back to their primary care physicians and needed social support to ensure that clinical progress continues once a patient has returned to the community.

Share critical patient information with downstream partners.

Sharing complete yet concise information about patient care with downstream partners is a crucial step to ensure quality and efficiency post-discharge. PAC providers are better able to customize patient care and prevent deteriorations when they have critical clinical details about the acute care stay. Unfortunately, post-acute providers oftenr eceive information that is incomplete or arrives too late to act upon.

What happens when the process of exchanging information is flawed?



of hospital discharge summaries do not mention pending test results

9.4%

of unreported pending results required change in patient management

Train your discharge planning staff on the types of information to share with PAC providers and consider creating **targeted teams** to oversee the exchange of critical information such as patients' lab results. Using "warm" handoffs—transitions where hospital staff and post-acute staff speak directly—can enhance the process.

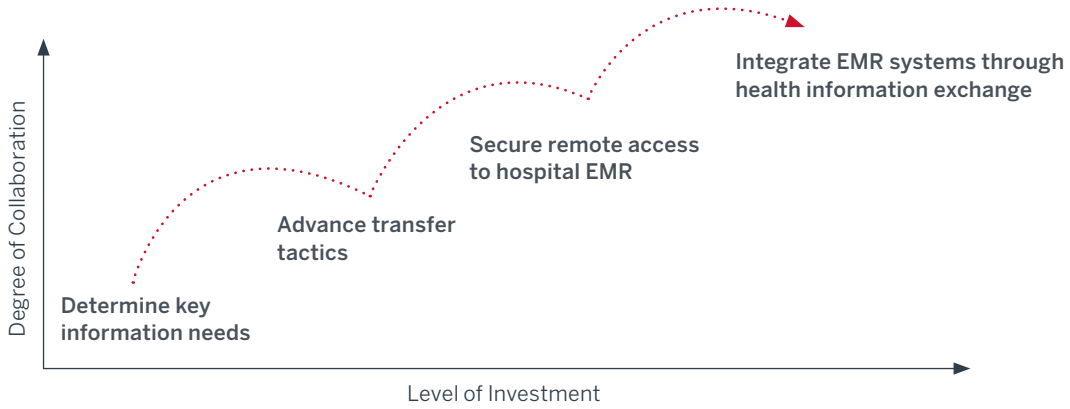
Effective information exchange between acute and post-acute providers is:

Complete
All critical information is sent

Clear and Concise
Critical information is easily and quickly identified

High-Speed
Timely exchange avoids service gaps

Clear and complete information exchange doesn't happen overnight. Break down the process into steps to achieve fluid communication with your PAC partners.



MEMBER SPOTLIGHT

How Identifying—and Addressing—Communications Gaps Can Affect Outcomes

Shaw Medical Center, a pseudonym, wanted to reduce readmissions from the skilled nursing setting. After discussing care challenges with their skilled nursing facility (SNF) partners, Shaw discovered that it was not communicating lab results in a timely manner.

Shaw's next step was to build the Discharge Advocacy Center. The nurses staffing the center are responsible for ensuring that patients and post-acute providers understand and follow discharge instructions and that PAC providers receive timely lab data. Based on comparison against historic data, the center prevents around 15 readmissions per month of patients discharged without antibiotics or without the appropriate antibiotic(s).

POST-ACUTE CARE COLLABORATIVE MEMBERS HAVE ACCESS TO

Our **Blueprint for Effective Acute/Post-Acute Information Exchange**, which is an on-demand webconference that delves into the three main goals for information exchange and how acute and post-acute partners can execute on these goals today, regardless of their present information-sharing mechanism.

Available to members on advisory.com/pacc.

Extend care pathways into the post-acute setting.

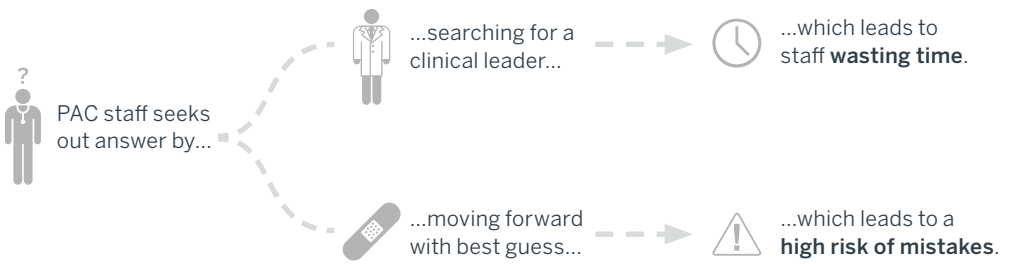
Evidence-based care pathways support efficient, high-quality care in the acute space by **minimizing variation.**

To ensure patients continue to receive cost-efficient, high-quality care after discharge, collaborate with PAC providers to adapt existing acute-care protocols to the post-acute setting—and build new pathways that go beyond inpatient treatment and address common challenges to care plan execution in the post-acute setting.

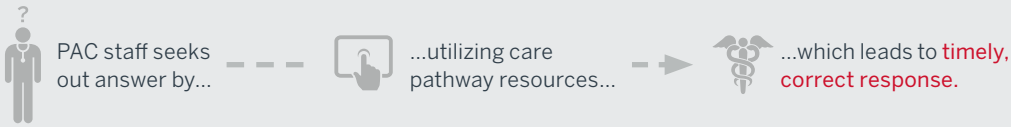
Challenge: Frontline staff in the post-acute setting may be unfamiliar with the expectations hospital staff have regarding a patient's recovery plan and anticipated timeline, or there may be an unexpected change in a patient's condition that impacts that plan.

Solution: Create clinician-informed, evidence-based pathways detailing clinical protocols for post-acute care.

What happens when frontline staff need clinical questions answered and there is no care pathway?



Institute proper care pathways to connect frontline staff to clinical expertise.



MEMBER SPOTLIGHT

Care Roadmap Sets the Tone for Treatment Post-discharge

Baystate Medical Center and its partner SNFs have teamed up to reduce costs and prevent readmissions as part of its participation in bundled payments for care improvement (BPCI) for coronary artery bypass graft (CABG) patients. Baystate provides the SNFs with a comprehensive care road map that details post-acute care protocols for CABG patients.

The road map outlines expected care for each day the patient spends in the SNF and lists milestones for discharge. For example, during the first few days, treatment guidelines include incision assessment and dressing changes. Education goals include exercise plans and nutrition counseling. The road map also includes lists of common side effects, as well as instructions for when further intervention may be needed. The care road map is a standard part of the patient's discharge packet—ensuring it is highly visible for SNF frontline caregivers.

In addition to the road map, Baystate provides additional ongoing support to its partner SNFs. For instance, Baystate's CABG care coordinator holds education sessions to walk SNF frontline staff through the protocols and answer questions.

Standardized Care Road Map Impacts Quality of Care at All SNFs

A+

Reflects Hospital's Standard of Care

Road map created by CABG care coordinator, allowing hospital to influence care provided in SNFs

Used to Educate Preferred SNFs

CABG coordinator brings care road map on site to teach SNFs about ideal care upon beginning partnership

Standard Part of Discharge Packet

Care road map is sent to any SNF to which a patient is discharged—even if it's not a preferred provider

Keys to Care Roadmap Implementation

- Engage frontline SNF staff, not only medical leadership
- Put road map front and center (i.e., in discharge packet)
- Educate PAC providers about challenges (e.g., equipment, diet)

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

Evolving industry incentives and outcomes transparency have resulted in a concerted effort among post-acute providers to strengthen clinical capabilities. However, because PAC providers care for an increasingly elderly and complex patient population, their ability to make further clinical gains is complicated.

One way hospitals can support their downstream partners is to **provide training** around specific patient populations and offer on-site clinician support. Collaborating to upskill post-acute staff, especially around high-risk patient populations, helps PAC providers better meet hospitals' **post-discharge expectations** and placement needs.

By sharing staff with PAC providers, hospitals can give downstream caregivers an in-the-moment resource for clinical questions and help align post-acute operations with episodic goals. Further, post-acute providers' financial incentives are usually not aligned with health system priorities related to episodic or total cost management. But extending clinical support into the post-acute setting can both **improve outcomes** and **reinforce alignment** with system goals.

Is Post-Acute the New Acute?

> "We have to accept, as an industry, the paradigm shift. What used to be hospital med-surg unit work five years ago is now going to be the typical short-stay patient in SNF."
>
> Richard Tuvell, Director of Quality
> *Reliant Senior Care*

POST-ACUTE CARE COLLABORATIVE MEMBERS HAVE ACCESS TO

Our **Episodic Efficiency Resource Suite for Post-Acute Care** toolkit, which includes a number of tools and resources designed to help providers improve episodic efficiency, including insight into how post-acute providers are adapting to clinical protocols and staffing practices to manage a higher acuity patient population.

Available to members on advisory.com/pacc.

Targeted Instruction and Support Improves Downstream Care for Complex Patients

Palmetto Health, a South Carolina-based acute care provider, found it challenging to place high-acuity Medicaid patients in skilled nursing facilities. Most local SNFs struggled to clinically manage these patients and were reluctant to accept such referrals.

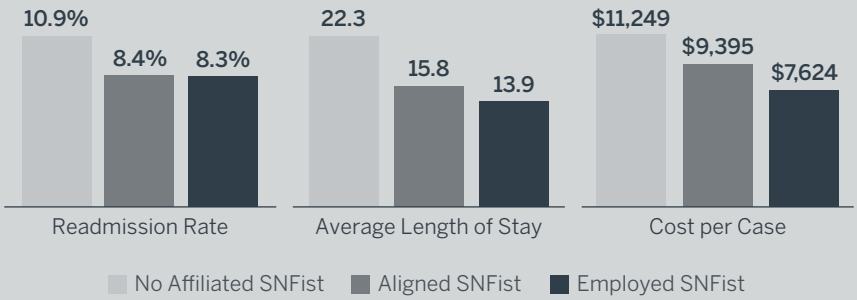
However, Lutheran Homes of South Carolina, a skilled nursing and senior living provider, stepped up to the plate. Palmetto provides training for Lutheran Homes staff, along with a medical director and nurse practitioner to support their high-acuity care. In turn, Lutheran Homes has developed the capability to care for these complex patients.

Lutheran Homes is now a trusted post-acute partner for Palmetto Health and also cares for these hard-to-place patients for other hospitals in the market.

Atrius Health, an accountable care organization (ACO) based in Massachusetts, employs SNFists who practice at Atrius's high-volume, preferred SNF partners. Atrius also collaborates with aligned SNFists at SNFs that lack the critical volumes of Atrius patients to justify an employed SNFist on site, while other SNFs in the market lack a SNFist presence entirely.

Atrius found that, regardless of employment status, the presence of a SNFist was effective in driving quality improvement. However, a difference appeared with regard to the efficacy of employed SNFists versus affiliated SNFists in managing utilization: length of stay and cost per case is markedly lower at SNFs with employed SNFists. This illustrates a larger reality: **SNFist promote improved clinical outcomes, but financial alignment is hard if there aren't sufficient volumes to justify employing one directly.**

Atrius Health's SNFist Alignment Impacts Patient Outcomes



Develop and maintain patient engagement in self-management.

To influence episodic outcomes beyond their site of care, providers must successfully engage patients in self-management initiatives focused on real-world education and skill building. Patient self-management is crucial to avoiding readmissions, especially for people with chronic illness. One important factor in the self-management process is a patient's activation level, which refers to an individual's ability and likelihood to practice self-care.

Activation levels in Medicare patient population

28.1%	Low activation
38.1%	Moderate activation
33.8%	High activation

POST-ACUTE CARE COLLABORATIVE MEMBERS HAVE ACCESS TO

Our resource **11 Insights on Engaging Patients in Ongoing Management**, which delves into how to hardwire patient engagement, including the critical steps to recruit, equip, and graduate patients to self-management.

Available to members on advisory.com/pacc.

PROVIDER SPOTLIGHT

Interactive Patient Education Modules Set Patients Up for Further Recovery at Home

Benedictine Health System, a post-acute continuum provider, has created a self-management infrastructure with a focus on patient activation to keep patients safe at home following discharge from the transitional care unit.

Benedictine's interactive patient education modules focus on practical self-management opportunities, such as proper medication administration and supply use, ensuring patients have the tools they need after discharge. At the same time, nurse transition coordinators have bedside conferences with patients and their families to choose and discuss custom recovery goals—ensuring everyone is on board with the post-discharge objectives.

Transitional Care Unit-Based Patient Activation at Benedictine Health System

Interactive patient education

- Electronic education modules provide and reinforce teaching throughout stay, promote discharge readiness
- Fulfillment of education modules incorporated as a discharge requirement

Bedside care conferences

- Facilitate patient goal-setting to tailor discharge requirements to realistic patient and family goals

Standardized supplies

- Coordinated with hospital and home care for teaching consistency

Example modules

- Administering oral medications and injections
- Lifestyle management for congestive heart failure
- Recognizing diabetes warning signs

Ease of use a critical factor

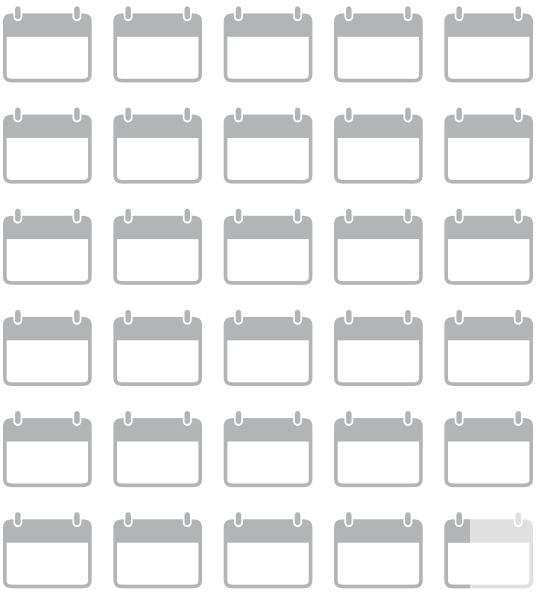
- Education written at eighth-grade reading level
- Modules last five to eight minutes, a manageable commitment
- Materials remain available online to patient and family

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

Ensuring quality and efficiency throughout an episode care means supporting patients at the tail end of risk, when they return to their daily lives. For a hospital managing a 90-day episode, a patient may be discharged from a post-acute setting or conclude a home health encounter before the episode ends. This means the hospital remains financially responsible for the patient once they have exited the health care system. Simultaneously, research indicates that patients are especially vulnerable after a hospital or post-acute stay.

This means providers must prioritize continuing recuperation via primary care, while ensuring a patient's social needs are met.

Reconnect patients with their community providers, including primary care physicians, specialized providers (such as psychologists), and community support systems to ensure continued recovery and avoid deterioration at the end of an episode.



29.3 days

National average wait time to see a family practice physician

POST-ACUTE CARE COLLABORATIVE MEMBERS HAVE ACCESS TO

Our resource **Building the Post-Acute Care Management Network**, which delves into how post-acute care providers can support gaps in primary care and ensure a patient's safe return to the community.

Available to members on advisory.com/pacc.

Two Visiting Nurse Services Fill the Gap in Primary Care

Home health provider **Visiting Nurse Service of New York** (VNSNY) offers a nurse practitioner-led interim primary care program. This service developed to fill the gap in care for patients who cannot obtain timely access to a primary care physician (PCP) post-discharge.

The nurse practitioner (NP) provides support, via both in-home visits and telephone consultations, for 30 days after the patient leaves the hospital. The NP also works with the patient's health plan to identify a PCP with available appointments. As a result, 93% of patients receiving this interim care are able to secure a PCP appointment within 30 days.

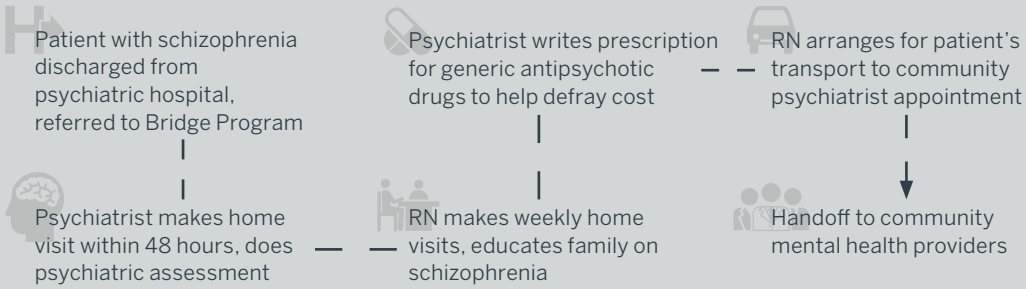
Key Elements of Transitional Care Program

- Identify patients at high risk for readmission
- Deploy NPs to provide interim primary care at patient's home
- Coordinate patient access to PCP after intervention

49% reduction in 30-day hospital readmissions

93% of patients in VNSNY Transitional Care Program see PCP within 30 days

VNA Ohio, a home health provider with a strong behavioral health program, created a transitional care solution, called the Bridge Program, for patients with mental health needs. As these patients transition back into the community, VNA Ohio provides psychiatric support. During these visits, VNA Ohio staff monitor and support patients' physical and mental health and connect patients with the medications they need until they can transition to community-based mental health care.



Conclusion

A successful post-acute network should facilitate the health system's broader post-acute strategy. Frequently, PAC networks are built in a silo or to address a specific post-acute need (e.g., bundled payment program). Such a process results in duplicative infrastructure and limited impact.

Instead, hospitals should strive to build a holistic post-acute infrastructure that can be effective regardless of the system's payment initiatives and other goals. Networks, and overall post-acute strategy, should be designed flexibly to support any goal the hospital might have now or in the future.

For further information on developing a post-acute strategy, please visit **advisory.com/pacc** to learn more about the Post-Acute Care Collaborative and how our research and insights provide best practices and actionable tools for creating collaborative relationships between hospitals and post-acute providers.

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.

Visit us at: **advisory.com/pacc**

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Sources

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

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The best practices are the ones that work for **you.**SM

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