Preferred post-acute care network

Intervention in brief

System wide:	**Preferred post-acute care (PAC) networks** are groups of post-acute care providers (usually skilled nursing facilities) selected by a provider organization to collaborate and solve post-discharge challenges. The goal is to improve PAC outcomes for patients (e.g., lowering readmissions and costs).
Strength of evidence	 Medium Intervention has not been frequently studied in the last ten years. Evidence is based on cross-sectional, cohort, and case studies.
Impact	• **Decreased cost:** $322-1,124 decreased Medicare reimbursement costs • **Decreased utilization:** Insignificant to 11 percentage point decreased readmissions from partner PACs; 1.2 percentage point decreased readmissions per 10 percentage point increased discharges to a SNF; 0.3-6.8-day decreased inpatient length of stay • **Improved quality, clinical outcomes:** Not demonstrated • **Increased access:** Not demonstrated • **Improved stakeholder satisfaction:** Not demonstrated
How to succeed	To build an effective post-acute care network: • Select partner PAC facilities based on performance (e.g., costs, readmissions, clinical improvement rates), PAC leadership willingness to collaborate, patient utilization patterns, and convenience for patients (e.g., distance from hospital and patient homes) • Establish formal processes for data collection (e.g., monthly quality, staffing, patient experience, and utilization report cards from PACs) and evaluation (e.g., multidisciplinary team reviews data and conducts on-site qualitative assessments) • Prioritize your most-used SNFs when discharging patients, since data shows that readmission rates decrease as concentration of patients treated at the same facility increases • Hold regular meetings with PAC partner consortium for education and best practice sharing • Engage physicians in educating patients on PAC choices by holding quarterly leadership meetings (e.g., discuss evaluation criteria and patient choice laws) and distributing monthly reports that clearly compare partners' performance with those not participating in the network • Make it easy for time-pressed discharge planners to support patient decision-making (e.g., include details about in-network PAC capabilities in the support tool to filter out facilities unable to meet patient needs) • Develop patient-facing resources to inform patients about discharge options, emphasizing that in-network options meet specific quality standards (e.g., offer threshold for inclusion) To learn more about developing an evidence-based approach, check out our Assembling a High-Performing Post-Acute Care Partner Network brief here and our Post-Acute Care Performance Improvement Assessment tool here.

Source: Population Health Advisor research and analysis.

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Demonstrated impact

Literature review summary

Title: Effects of Hospital-SNF Referral Linkages on Rehospitalization
Publication: Health Services Research
Date: 2013
Type: Cross-sectional study
Study population: All fee-for-service Medicare beneficiaries discharged from 2,477 U.S. hospitals to a SNF between 2004 and 2006
Major findings: As hospital discharges to a SNF increased 10 percentage points, the likelihood of patients readmitting from a partner SNF decreased 1.2 percentage points. Fewer readmissions within one week of discharge largely drove the decrease. Compared with patients discharged to less preferred SNFs, patients discharged to preferred SNFs experienced:

- Shorter lengths of hospital stay (1.8 days for hospitals that do not own a SNF; 3.4 days for hospitals that own a SNF)
- Lower Medicare reimbursement costs ($1,124 lower for hospitals that do not own a SNF; $322 lower for hospitals that own a SNF)

Source: Full article here.

Title: Reducing Hospital Readmissions Through Preferred Networks of Skilled Nursing Facilities
Publication: Health Affairs
Date: 2017
Type: Cohort study
Study population: 81,000 Medicare patients across eight U.S. markets treated at hospitals with and without formal SNF networks from 2009 to 2013
Major findings: SNF readmission rates for hospitals with formal SNF networks decreased 4.5% more than for hospitals without formal networks. The change in the overall readmission rate for hospitals with a formal SNF network was not significant (3.7 percentage point decrease).
Source: Full article here.

Source: Population Health Advisor research and analysis.

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Title: Assessing the State of the Acute/Post-Acute Relationship
Publication: Advisory Board
Date: 2018
Type: Case study
Study population: Patients discharged from TriHealth, a nonprofit health system based in Cincinnati, Ohio, who received post-acute care from in-network facilities
Major findings: TriHealth undertook a strategic initiative to improve utilization of highest quality post-acute providers, in part by encouraging physician involvement in promoting the network. PAC providers share monthly quality and utilization data with TriHealth physicians. Physician leaders meet monthly to assess partners, refine the metric list, and identify clinical problem areas for improvement. TriHealth's partner SNFs demonstrate better outcomes across a range of conditions:

- Reduced length of stay
    - Cardiac patients (6.8 days)
    - Infectious disease patients (5.4 days)
    - Orthopedics patients (2.7 days)
    - Pulmonary patients (1.9 days)
    - Advanced wound care patients (0.3 days)
- Reduced readmissions
    - Pulmonary patients (11.8%)
    - Advanced wound care patients (10.7%)
    - Orthopedics patients (10.2%)
    - Infectious disease patients (5.5%)
    - Cardiac patients (4.1%)

Source: Full article here.

Title: Assembling a High-Performing Post-Acute Care Partner Network
Publication: Advisory Board
Date: 2016
Type: Case study compilation
Study population: Patients receiving post-acute care from an in-network facility across three organizations, including OhioHealth and Summa Health System
Major findings: Following the formation of a post-acute care network, readmissions from post-acute care reduced 3-11 percentage points.
Source: Full article here.

Source: Population Health Advisor research and analysis.

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Appendix

- Rahman M, et al., "Effects of Hospital-SNF Referral Linkages on Rehospitalization," *Health Services Research,* 48, no. 6 (2013), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3844283/.
- McHugh JP, et al., "Reducing Hospital Readmissions Through Preferred Networks of Skilled Nursing Facilities," *Health Affairs,* 36, no. 9 (2017), https://www.ncbi.nlm.nih.gov/pubmed/28874486.
- "Assessing the State of the Acute/Post-Acute Relationship," Post-Acute Care Collaborative, Advisory Board, https://www.advisory.com/members/request-access?item=%2f-%2fmedia%2fAdvisory-com%2fMicrosite%2fResearch%2f2017%2f2017-PACC-National-Meeting%2fPresentation+PDFs%2f35725_PACC_SpeechB_ForDownload.pdf&user=advisory%5cwirthcl%40advisory.com&iPath=%2fsitecore%2fmedia+library%2fAdvisory-com%2fMicrosite%2fResearch%2f2017%2f2017-PACC-National-Meeting%2fPresentation+PDFs%2f35725_PACC_SpeechB_ForDownload.
- "Assembling a High-Performing Post-Acute Care Partner Network," Population Health Advisor, Advisory Board, https://www.advisory.com/research/population-health-advisor/white-papers/2016/assembling-a-high-performing-post-acute-care-partner-network?WT.ac=Inline_PHA_ExRB_x_x_x_CTC_2018Dec18_Eloqua-RMKTG+Blog.

Source: Population Health Advisor research and analysis.