Prioritizing Partners Across the Continuum

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Prioritizing Partners Across the Continuum

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A B S T R A C T

With the advent of accountable care organizations, bundled payments, value-based purchasing, and penalties for preventable hospital readmission, tight connections and collaboration across the care continuum will become critical to achieve successful patient outcomes and to reduce the cost of care delivery.

Lehigh Valley Health Network (LVHN), the largest provider of health services in eastern Pennsylvania, set out on a journey to build collaborative relationships with skilled nursing facilities (SNFs) in their eastern Pennsylvania community. LVHN desired SNF partners with mutual interests in improving quality of care and lowering costs of delivery where possible.

Recognizing that not all SNFs are alike, LVHN developed a Collaborative Partner Prioritization Tool to assess and prioritize skilled nursing facilities in an effort to determine those that would make the best collaborators. SNFs were reviewed based on their volume of mutual patients, quality of care delivery, and their perceived willingness to align with LVHN. Six variables were used to assess these facilities, including (1) patient discharge destination volume by SNF; (2) 30-day all-cause readmission rate to an LVHN hospital; (3) Medicare's Nursing Home Compare 5-Star Overall Rating; (4) the health network affiliation of the SNF's medical director; (5) the level of LVHN-employed or -affiliated physician presence at the SNF; and (6) the SNF's current participation in LVHN-sponsored programs and meetings.

Through use of the Collaborative Partner Prioritization Tool, it was discovered that roughly 70% of LVHN patients who required skilled nursing care following their inpatient stay received care at 1 of 20 SNFs. Of these, 5 facilities performed well on the 6-variable assessment, deeming them the "Tier 1 Facilities" to initially focus collaborative efforts.

LVHN has strategically deployed physician resources and has increased physician presence at these "Tier 1 SNFs." These facilities have also gained remote read-only access to LVHN's inpatient electronic medical record and have had opportunity to participate in LVHN-sponsored programs. Special projects have been co-developed with several SNFs, including a telemedicine-based Parkinson's disease program to increase patient access to a neurologist specially trained in movement disorders.

The Collaborative Partner Prioritization Tool has become a powerful tool when used for prioritization of relationships and allocation of LVHN physicians and resources. Collaboration with strong SNF partners has offered a shared opportunity to improve quality of care, reduce costs, and prepare for the many policies affecting the health care industry.

Future outcomes of this work will include quality metrics, such as readmissions, patient satisfaction with care, time for decision to admit, and overall costs of care. The data and metrics used to define the prioritization tool will continue to be adapted as the post-acute market and hospital-SNF relationships continue to evolve.

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The Affordable Care Act outlined several legislative actions to achieve the triple aim of better care for individuals, better health for populations, and cost containment associated with the delivery of care.[1] This signed law is actively changing the landscape of health care and payment reform in the United States, with the advent of programs such as the Readmission Reduction program, the Bundled Payment for

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Care Improvement initiative, value-based purchasing, and the development of multiple payer-sponsored accountable care organizations.

The Agency for Healthcare Research and Quality reports that approximately 40% of Medicare beneficiaries "are discharged to a post-acute setting, and roughly half of these enter a nursing home" or skilled nursing facility (SNF).[2] This high volume of patients transitioning from one care setting to another necessitates strong collaboration between care providers to ensure the delivery of efficient, high-quality care in this new era of health care reform.[3] SNFs have been a long-standing component in the elder care continuum, offering diversified services and providing multiple levels of postacute care. In response to the decrease in hospitals' average length of stay and the trend of discharging patients "quicker and sicker," the SNF setting has seen an increase in the acuity of patient care.[4] Because of this expanded role in managing medically complex patients, many facilities are moving away from the "nursing home" nomenclature of previous decades to a greater use of the more accurately descriptive term "skilled nursing facility" or "SNF."

While the delicate balance of quality and cost remain at the forefront for hospitals, the notion of throughput, or the cycle time of patient admission through discharge, is a critical component to alleviate ambulance diversion, improve emergency department length of stay, reduce operating room holds, and maintain a financially viable patient length of stay.[5] For this reason, many hospitals are seeking collaborative arrangements with SNFs in an effort to further improve quality and associated costs of care delivery, *and* to sustain throughput to accommodate inpatient capacity.[6] Ensuring that patients stay within the health network's continuum of care is also paramount in allowing for greater management of care across numerous clinical environments.

Given the national emphasis on better care and lower costs for mutual patients across the continuum, SNFs are also looking at ways in which they can become more comprehensive partners with hospitals and primary care physicians.[7] Similar to hospitals, skilled nursing facilities are facing increasing pressures to reduce costs while providing high-quality care to a patient population with ever-increasing acuity and comorbidities. Hospital collaboration may allow skilled nursing facilities to have expanded access to patient information[8] and clinical and educational resources,[9] as well as sustain an active referral relationship. In addition, collaboration with a hospital partner may afford the SNF an opportunity for onsite resources to support disease management and decrease exacerbations of chronic illness, allowing patients to receive a greater breadth of acute care at the skilled nursing facility. Hospital-SNF collaborations also provide the SNF with potential halo-effect benefits of association with a strong acute care organization.

Background

Following the introduction of the Affordable Care Act in 2010, Lehigh Valley Health Network (LVHN) set out on a journey to build collaborative relationships with SNFs in its eastern Pennsylvania community. LVHN is the largest provider of health services in east-central Pennsylvania, serving more than 800,000 people living in the Lehigh Valley, which comprises the cities of Allentown, Bethlehem, and Easton, as well as their surrounding communities. LVHN includes 3 hospital facilities: a large tertiary care campus and 2 smaller community campuses totaling 1000 beds, with 66,858 inpatient admissions and 166,885 emergency department visits in fiscal year 2011. In that same year, LVHN discharged more than 7000 patients to local skilled nursing facilities, the large number serving as an impetus for gaining a better understanding of where our patients are receiving post-acute care, and taking a more active role in the transition and delivery of this care.

With the advent of the Centers for Medicare and Medicaid Services' (CMS) Rehospitalization Reduction program, local hospitals' scope of responsibility now transcends beyond the inpatient stay, as they risk incurring potential future payment penalty for select readmissions within 30 days of patient discharge. In addition, hospitals face the impending imposition of value-based purchasing as well as bundling of payments for an entire episode of care. All 3 of these scenarios will require tight connections and collaboration across the continuum to achieve successful patient outcomes.

LVHN, having defined its ideal state as an environment in which all patients receive care from LVHN providers in the varied settings of the postacute environment, launched a collaborative initiative with local SNFs. Encompassing priorities were threefold in nature: a greater understanding of the postacute-care continuum (as it offers lower cost care environments), prioritization of potential collaborative SNF partnerships, and alignment of goals to more adequately care for their collective older adult patients. Equally important to this effort was the desire to find partners with mutual interests in improving quality and lowering costs.

It was with these objectives in mind that LVHN recognized the need to closely examine the Lehigh Valley area SNFs and determine which organizations would make the best collaborating partners. Our goal was to identify like-minded organizations with an accountable vision for the future delivery of care. This article describes the rationale and methodology used to create a Collaborative Partner Prioritization Tool, which was instrumental in identifying and prioritizing the most mutually beneficial collaborative relationships.

Methods

The principal investigator identified 6 metrics, covering both subjective and objective material, to guide LVHN's collaboration efforts. The selected variables included (1) patient discharge destination volume by SNF; (2) 30-day all-cause readmission rate to an LVHN hospital; (3) Medicare's Nursing Home Compare 5-Star Overall Rating; (4) the health network affiliation of the SNF's medical director; (5) the level of LVHN-employed or -affiliated physician presence at the SNF; and (6) the SNF's current participation in LVHN-sponsored programs and meetings. These variables allowed us to measure not only the SNF's quality of care delivered but also its perceived readiness for collaboration with LVHN. Availability of information and ease of collection were also critical determining factors in establishing these metrics.

Variables

The volume of patients discharged to a particular SNF following an inpatient stay at an LVHN hospital demonstrates current patient and physician preferences as well as the relationships already in place with payers and discharge planners. Because patient volume offers a significant leveraging opportunity, only those facilities that received greater than 40 LVHN patients in fiscal year 2010 (FY10) were included for prioritization.

Rate of readmission to an LVHN hospital within 30 days of the initial inpatient discharge was determined to be a "meta-metric," indicating the SNF's immediate ability to care for the patient after discharge, the overall quality of the patient placement, and the SNF physician's comfort with the aptitude of the facility's nursing and clinical practice staff. The importance of this metric is heightened with the impending payment penalties scheduled to begin in October 2012. Both the volume of LVHN patients discharged to a particular SNF and the SNF's readmission rate were calculated using LVHN admission and discharge data.

The CMS office publishes an annual rating for each SNF participating in Medicare and Medicaid. Facilities are eligible to receive 1 to 5 stars based on their past health inspections, current staffing levels, and performance on quality measures. Although not a perfect measure, this rating provided objective insight into the quality of care delivered at SNFs.

All SNFs are required to have a medical director on staff to provide oversight for quality improvement and overall care delivery. Additionally, it is quite typical for this physician to act as the default attending physician, providing care to most long term care residents and short-term care patients at the facility. We identified SNF medical directors through market research and conducted physician and SNF leadership interviews. Because of the influence in clinical quality and the potential for patient volume, this measure acknowledges those facilities having a medical director who is employed by or closely aligned with LVHN.

Similar to the importance of an aligned medical director, the presence of an LVHN-aligned or -employed attending physician is essential for an LVHN partnership and future programmatic development. A health network's market share of the SNF can be calculated based on the number of patients cared for by one aligned or employed physician, further making the case for a strong physician presence. Physician presence was identified through assessment of billing data along with interviews of LVHN-aligned internal medicine, family medicine, and geriatric physician practices. Market share was calculated based on approximate size of the physician's panel: the number of patients assigned to a particular physician compared with the facility's overall census. In addition, current participation in LVHN-sponsored programs and meetings is a strong indicator of the SNF's interest and engagement in topics affecting our mutual patients. Committee rosters and meeting attendance records were reviewed to identify level of SNF participation.

Scoring

Each of the 6 variables was assigned a score. Varied weighting, reflecting the importance of a measure regarding the overall value of the potential SNF relationship, was applied to each score. Table 1 shows a sampling of SNF performance on each of these metrics, with a total score of 50 possible points assigned to each facility.

Because patient discharge destination volume was recognized as a critical component to SNF alignment, this variable was assigned the greatest weighting. All skilled nursing facilities were ranked in descending order by volume of patients discharged to the SNF in FY10. Facilities ranking as the top 5 discharge destinations received the full 20 points available. Facilities ranked as 6th to 10th received 15 points; those ranked 11th to 15th received 10 points; and facilities ranked 16th to 20th received 5 points. Points were awarded only to those facilities ranking 1st to 20th, as the 21st ranked facility fell below the eligibility threshold of 40 patient discharges in the fiscal year.

Following the calculation of readmission rates for these 20 facilities, SNFs with readmission rates below 18% received the full 5 points available. Facilities with a readmission rate of 18.1% to 19.9% received 4 points; 20.0%, 3 points; 20.1% to 22.0%, 2 points; and higher than 22.1%, 1 point. We based these point assignments on Medicare's average 30-day readmission rate of 19.9% and the national 30-day readmission rate of approximately 25.0%.

The point allotment for the CMS 5-star rating corresponds with the number of overall stars that a facility was rated. Facilities were awarded a point total equal to that of the number of stars received, of an available total of 5 stars. Facilities were also awarded 5 additional points for having a medical director employed by or aligned with LVHN. In addition, the facility received up to 10 points based on the presence of LVHN attending physicians. Using each SNF's census as a guide, those with LVHN physicians caring for more than 50% of the facility's patients received 10 points, facilities with LVHN physicians caring for 50% or fewer received 5 points, and those facilities with no LVHN physician presence received no points.

Lastly, the point allotment for the SNF's participation in LVHN-sponsored programs and meetings was calculated based on the facility's meeting attendance and contribution. Facilities with high levels of participation received 5 points, facilities with some participation received 3 points, and facilities that did not participate in LVHN-sponsored programs and meetings received no points. Our point system for identifying SNFs that would serve as strong LVHN partners led to the development of a Collaborative Partner Tool (Figure 1).

Figure 2 visually demonstrates the prioritization of the potential collaborative SNF partners. The size of the bubble represents the overall volume of patients discharged to the SNF in FY10. The x-axis measures quality of care, which is a combined score of the facility's FY10 readmission rate and its performance on the CMS 5-star rating scale. The y-axis represents the facility's readiness for collaboration with LVHN using a combined score representing the medical director's health network affiliation, the presence of LVHN-employed or -aligned physicians, and the facility's current participation in LVHN programs.

Identifying strong SNF partners was only half the work, as LVHN resources also had to be assessed and garnered. Building on the physician presence variable in the Collaborative Partner Prioritization tool, we reviewed all LVHN-aligned or -employed physicians practicing in a skilled nursing setting. Although there were 20 physicians practicing in this setting in more than 29 SNFs, only 14 of the facilities matched those receiving the highest volume of LVHN patients. In one instance, we identified that 2 physicians from the same practice were caring for fewer than 3 residents each at an area SNF. This lack of

Table 1
Collaborative Partner Performance Scoring

			Quality of Care			Readiness for Collaboration						Combined Collaboration Score
Top 5 SNFs	LVHN FY2010 Patient Discharges		CMS 5-Star Rating	FY2010 30-Day All- Cause Readmission Rate, %		Medical Director Affiliation		LVHN Physician Presence		Participation in LVHN Programs		Total Available Points:50
	Available Points: 20		Available Points: 5	Available Points: 5		Available Points: 5		Available Points: 10		Available Points:5		
SNF A	479	20	3	15.35	5	LVHN	5	SOME	5	GREAT	5	43
SNF B	394	20	4	23.58	1	Competitor	0	SOME	5	NONE	0	30
SNF C	375	20	3	19.02	4	LVHN	5	SOME	5	GREAT	5	42
SNF D	279	20	3	14.14	5	LVHN	5	GREAT	10	GREAT	5	48
SNF E	265	20	2	20.05	2	Competitor	0	SOME	5	GREAT	5	34

CMS, Centers for Medicare and Medicaid Services; LVHN, Lehigh Valley Health Network; SNF, skilled nursing facility.

Hospital/Health Network Name: _____
Skilled Nursing Facility Name: _____ Licensed Beds:_____
Medical Director Name: _____ Medical Director Health Network Affiliation(s):_____

The following provides a worksheet to assist you in measuring your performance for partner prioritization for each of your referring hospitals/health networks. Please complete each variable and calculate your estimated score using the provided methodology.

Partner Prioritization Variable	Significance	Variable Calculation	Scoring Methodology		Facility Score
			Metric	Score	
1. Annual Discharge Destination Volume	Volume of patients reflects current patient/physician preferences and relationships.	How many patients did your SNF receive from the health network in most recent fiscal or calendar year? How does this compare to other SNFs in your market?	Top 5 Facilities	20 points	
			6 - 10	15 points	
			11 - 15	10 points	
		Volume:	16 - 20	5 points	
			>20	0 points	
2. 30 day All Cause Re-admit Rate	Reflects SNF's ability to care for patients post discharge. A measure of quality of care and comfort/aptitude of staff.	What is your 30-day all-cause readmission rate? Note: Return to Hospital (RTH) is different than Readmission Rate.	<18%	5 points	
			18.1 - 19.9%	4 points	
		Readmission Rate:	20%	3 points	
			20.1 – 22%	2 points	
3. Medicare Nursing Home Compare Overall 5 Star Rating	Public information available related to inspections, staffing and quality of care.	Access your rating at: www.medicare.gov/NHCompare	5 stars	5 points	
			4 stars	4 points	
			3 stars	3 points	
		Overall Rating:	2 stars	2 points	
			1 star	1 point	
4. Affiliation of SNF's Medical Director	Network alignment or employment reflects ability of Network to influence clinical quality.	Is your Medical Director aligned and/or employed with the hospital/health network?	Medical Director is clinically aligned with, or employed by, Network	5 points	
		Employment Status: Alignment Status:			
5. Level of Network's employed physician presence at SNF	Network panel size and patient management by Network physicians reflects ability to develop programs and extend partnerships.	How many of your LTC residents and short-term patients are cared for by a health network-affiliated or employed physician?	>50% patients	10 points	
			<50% patients	5 points	
		Panel Size: Percentage of Total Census:	0 patients	0 points	
6. SNF's current participation in Network-sponsored programs and meetings	Indicator of SNF's interest and engagement in mutual topics.	Are you participating in any Network-sponsored programs or do you attend Network-sponsored meetings?	High participation	5 points	
			Some participation	3 points	
		Participation:	No participation	0 points	
				Total Score	

Fig. 1. Lehigh Valley Health Network Partner Prioritization Tool.

coordination and collaboration had a negative impact on the practice in terms of efficiency and highlighted the need for a more strategic deployment of resources.

In addition to physician resources, our team also compiled a list of other resources that could potentially be provided to SNF collaborative partners. Identified resources included (1) education of SNF staff on evidence-based guidelines for chronic illness, (2) use of telemedicine and other patient-centered technologies, (3) access to mutual patient medical records, (4) access to specialty and primary care physician practices, and (5) information related to care coordination.

Results of Partner Prioritization and Subsequent Alignment

Through use of the Collaborative Partner Prioritization Tool, it was discovered that roughly 70% of LVHN patients who required skilled nursing care following their inpatient stay received care at one of 20 SNFs. On further analysis, we discovered that several of these 20 facilities were affiliated with larger organizations, thereby allowing our collaborative efforts to be further concentrated. The SNFs listed in Quadrant I of Figure 2 identify the "Tier 1 Facilities" that LVHN prioritized for its alignment efforts. These facilities received a large number of LVHN patients in FY10 and performed well in both quality and readiness for collaboration.

We began our collaborative efforts first through intentional assignment of physicians to Tier 1 SNFs, working with these organizations to credential LVHN physicians. Subsequently, these newly credentialed physicians would provide care to patients transferred from LVHN who were not being followed by their own primary care physicians. These physician placements not only had the desired effect of increasing the number of SNF patients under care by an LVHN physician, but have also demonstrated additional benefit in cultivating growing relationships with SNF leadership. In one example, a SNF was receiving roughly 30 patients each month from LVHN, yet had no LVHN physician on staff. Our team worked with the facility's leadership to place an LVHN physician onsite. After working with this facility for 2 months, the LVHN physician built up a steady patient panel and achieved high satisfaction among patients, families, and nursing staff. These proactive relationships have also helped LVHN physicians attain corporate medical director positions in 2 multisite SNF organizations, an outcome that has led to collaborative opportunities at a broader level.

To date, focused efforts in SNF collaboration have resulted in a presence of 23 LVHN physicians in 27 facilities, with 9 physicians serving as medical directors. To further integrate the LVHN-SNF partnership, we established a quarterly physician forum for these providers to share successes and challenges of caring for their

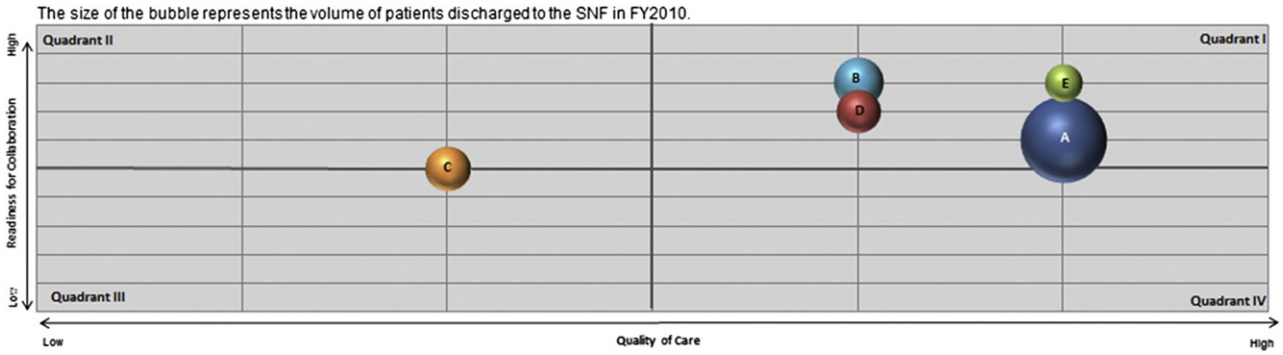

Fig 2. Collaborative Partner Tiering Quadrants.

patients in the SNF setting. One of the medical directors shared an INTERACT-II[10] Situation Background Assessment Recommendation (SBAR) communication tool that he trained the SNF staff to use when calling physicians about patient-related issues. Staff members follow the outlined communication steps beginning with characterizing the situation, then discussing the background with the physician and completing an assessment, and finally requesting the necessary action. This simple instrument developed by Ouslander et al[10] helps guide the call, encouraging SNF staff to relay a comprehensive picture of the patient's state.

Once LVHN physician presence was established in a facility, we provided access to LVHN's inpatient hospital records with the requirement that Directors of Nursing and admissions staff members first submit confidentiality agreements. They are then trained by the LVHN Information Services department in the use of an electronic read-only version of the medical record. Whereas anecdotal reasons for use are varied, there is agreement regarding the increased efficiency that this vital access to information brings.

Using the prioritization tool as a framework, collaborative opportunities have grown to include specialty program development as well as bi-directional involvement in LVHN and SNF leadership meetings. A special focus has been placed on development of evidence-based protocols for the care of patients with congestive heart failure, post myocardial infarction, and pneumonia to mirror those diagnoses with the highest readmission rates.

This collaborative partner prioritization was also responsible for other unexpected outcomes. As work progressed, the need for timely specialty care became evident, particularly for groups of patients with certain neurological disorders, such as Parkinson disease. This observation led to a new telehealth initiative with one of our most aligned and integrated SNF partners, using remote access to provide neurological consultation for patients while in the comfort of the SNF environment. Preliminary results demonstrate a decrease in patient transfer for traditional office visits and an increase in patient satisfaction with care. Additionally, this same SNF facility has shared other positive outcomes, including closer relationships among care managers and between primary care and specialty programs of both organizations.

In addition to facilitating improved relationships as a result of prioritized SNF collaboration, we have begun to deliver educational and knowledge-sharing sessions for all SNF personnel involved in the care of our mutual patients. One example is the newly created "LVHN Community Forum," developed as a means to share information and lessons learned with all our collaborating SNFs. These meetings have provided a platform for education, relationship development, identification of areas for improvement, and feedback exchange opportunities between SNF providers and LVHN. The forums, conducted quarterly with the goal of improving patient care across the continuum, have featured many diverse and pertinent topics, such as Medicare's Recovery Audit Contractor's program (RAC), Act 52 (Health Care–Associated Infection and Prevention Control), Complex Case Management Program, Role of Emergency Department Case Manager, InterQual Criteria (3-day qualifying stay for SNF placement), Observation Status, Handover Communication, and Transitions of Care to Decrease Unnecessary Readmissions.

Over the past 2 years, the Community Forums have evolved from didactic presentations to tabletop exercises for brainstorming of ideas for improving transitions of care to, more recently, panel discussions featuring SNFs and Home Health Agencies in describing their efforts to decrease readmissions. These events have provided a constant source of community partners to participate in LVHN's patient transition work teams and have been invaluable in providing ideas and feedback. A scorecard currently under development will serve to exchange key information with SNF participants, including patient volumes, readmission data, and other important quality and cost information. Figure 3 outlines each of the outcomes driven by the collaboration between LVHN and collaborator organizations.

Conclusion

The Collaborative Partner Prioritization Tool is a powerful instrument that has resulted in more mutually beneficial relationships with and more effective allocation of resources to, SNF partners caring for

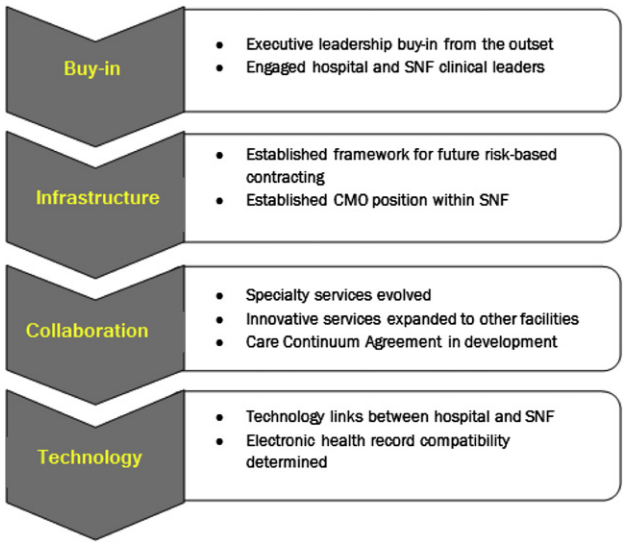

Fig. 3. SNF–hospital collaboration outcomes.

our shared patients. Like all relationships, alignment between hospitals and SNFs requires significant time and effort to fully mature. To that end, we have created a director-level position to manage and grow our priority SNF relationships while, at the same time, developing programs that will benefit all LVHN patients receiving care in the SNF environment. To further establish relationships with these SNFs deemed as "priority," our legal team is crafting a memorandum of understanding that will outline the framework for our continued mutual work. The memorandum of understanding will embody components related to quality of care, such as readmission rates, agreement on clinical practice guidelines, standard forms to process our patients smoothly, and other alignment parameters that will improve the care of our mutual patients.

In the future, as the project matures and data become available, we plan to publicly report the results of our SNF collaboration. These outcomes data will include the impact on preventing readmissions, patient satisfaction with care, time for decision to admit to a SNF, and overall costs of care. Additionally, the data and metrics used to define the prioritization tool will be adjusted as the market and our SNF relationships continue to evolve. This work has been invaluable to effectively dedicate resources where we will see the greatest return. We believe that other health care organizations can also benefit by cultivating strong SNF relationships and collaborating across the continuum, making us all better poised to improve the quality of care, reduce costs associated with care delivery, and gain success in providing accountable care.

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