WEB FEATURE

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implementing post-acute care networks to support a bundled payment program

Often lacking experience in delivery of post-acute care, hospitals face a challenge in creating successful value-based programs that rely on improving efficiencies in the post-acute care environment.

AT A GLANCE

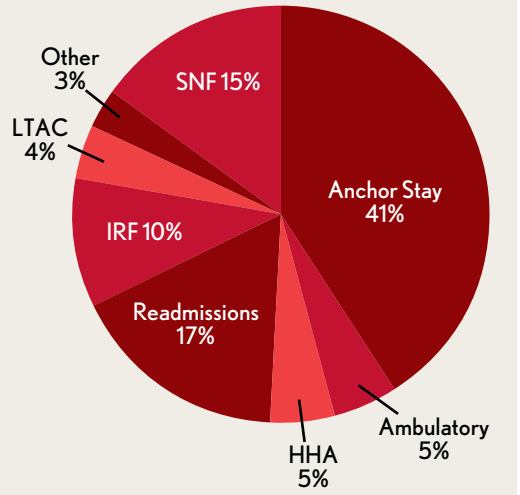
A strategy for post-acute care is essential in a bundled payment program. Some elements for an optimal program include:

- A formal process for working with preferred providers
- Regular communication about performance and patient status
- Appointment of a care navigator as single point of contact to ensure consistency

Bundled payment programs are almost always centered on and measured by performance improvement in the area of post-acute care. In particular, the Centers for Medicare & Medicaid Services (CMS), through the Center for Medicare and Medicaid Innovation (CMMI), has launched several programs in this area, including the Acute Care Episode (ACE) Demonstration and the Bundled Payments for Care Improvement (BPCI) Initiative, and proposes to implement the mandatory Comprehensive Care for Joint Replacement (CCJR) Model in January. Such programs, including those initiated by commercial payers, have provided some valuable lessons that can be applied by hospitals that are just getting started with bundled payments.

As the primary contractor for bundles, hospitals assume responsibility for post-acute care costs while generally having little experience in that area, creating a significant challenge for them to develop successful and profitable programs. The exhibit on page 2 shows an example of a percentage breakdown of inpatient and post-acute care costs for a representative hospital system for 48 bundles under BPCI.

EXAMPLE OF BUNDLED PAYMENT COST PERCENTAGE BREAKDOWN FOR ONE HEALTH SYSTEM: WHAT MEDICARE PAID PROVIDERS



Developing a Strategy for Post-Acute Care

DRGs already put hospitals at risk for the inpatient portion of the bundle (referred to as the *anchor stay* in the exhibit), so the key to financial success lies in the ability to effect positive change after discharge. Shifting post-acute care services to lower-cost venues or eliminating them altogether can yield great financial rewards. For example, the average daily spend by Medicare for a home health agency (HHA) is less than half that of a skilled nursing facility (SNF), as detailed in the exhibit on page 3. The two big spending drivers in the post-acute care experience are readmissions and direct care in the post-acute care setting. Readmissions can account for more 40 percent or more of post-acute care expenditures, yet if the cause for the readmission is a surgical site infection or ineffective medication management, such problems could be better addressed during inpatient care, for example, as part of a hospital readmission reduction program (HRRP).

Patient care delivered directly in post-acute care settings such SNFs, inpatient rehabilitation facilities (IRFs), and long-term acute care hospitals (LTACs) represent the other spending driver in bundled programs. SNFs alone can account for almost 25 percent of post-acute care spending, with about 25 percent of SNF patients being readmitted to the hospital.[a]

Optimal financial results can be achieved by enlisting post-acute care partners that support initiatives to address both readmission and direct spending. But further complicating the situation is the fact that Medicare patients cannot be required to use specific post-acute care providers, unlike commercially insured patients who may have benefit limitations that drive them to a limited network.

Themes for a Successful Post-Acute Care Partnership

A tightly integrated, almost seamless continuum of care from admission throughout the bundle timeline will provide optimal patient care with minimal necessary spend. Key issues in developing a strategy for an effective post-acute care network include:

> Analyzing the past performance of post-acute care providers to ascertain which providers the organization's patients have been using
> Identifying the key success factors for a post-acute care network partner (e.g., effectiveness in reducing readmission rates and length of stay and in improving patient satisfaction) and establishing operational metrics for these factors
> Creating a formal process for identifying and contracting with the best (preferred) post-acute care providers (i.e., those that will commit to the new performance goals and pathways)
> Developing a method to enlist and integrate preferred providers into the care process

A successful post-acute care partnership requires:

> Setting expectations up front at point of selection, through contracting, and on an ongoing basis

a. Mor, V., Intrator, O., and Feng, Z., The Revolving Door of Rehospitalization from Skilled Nursing Facilities, *Health Affairs,* 2010.

> Establishing regular, two-way communication about patient status and provider (both hospital and partner) performance
> Developing consistent care pathways and protocols for patient conditions with similar acuity
> Maintaining a single point of contact/responsibility for the program. This might be a new hire or an existing department or manager depending on the organizational structure and where responsibility for bundled payments fits.

Ultimately, when developing partnerships with post-acute care providers for bundled payment, hospitals should take the following steps:

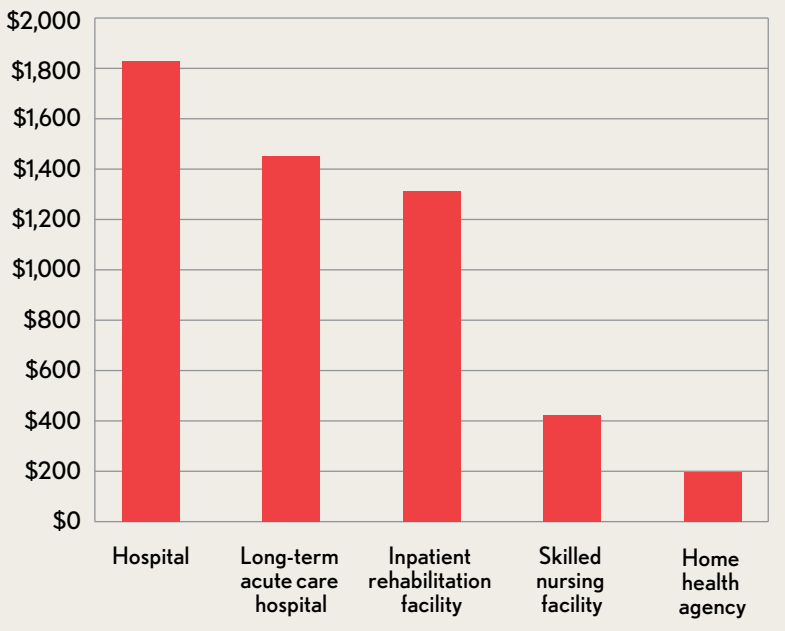
> Weigh the post-acute care opportunity against the potential risk it poses.
> Use historical data to gain insight into post-acute care utilization patterns.
> Develop care pathways that align partner performance and integrate the network.
> Establish success thresholds, for example reducing readmission rates or average length of stay by a certain percentage, or adherence metrics to agreed-upon care pathways.

Identifying Post-Acute Care Opportunities for Success

Although establishing a preferred post-acute care provider network is a critical success factor for bundled payment programs, not all bundles represent opportunities for hospitals to generate savings from post-acute care. For example, if a bundle consistently demonstrates that most SNF spending occurs within 30 days of discharge—as is often the case with elective joint replacements—and a care pathway can be constructed to reduce or eliminate that SNF spending (for example by moving patients to their homes with some home health services), an opportunity exists to reduce spending.

On the other hand, if SNF care is an integral part of the care pathway, as often is the case with patients with hip fractures, it might not be possible to reduce SNF spending significantly. Such situations constitute a risk in a bundled arrangement.

AVERAGE DAILY SPEND FOR MEDICARE: COMPARISON OF INPATIENT AND POST-ACUTE CARE PROVIDER TYPES



Source: "Medicare and the Healthcare Delivery System," Medicare Payment Advisory Commission, June 2013.

Note: In BPCI and CCJR, both elective joint replacement and fractures are included in a single bundle.

Using Data to Drive Analysis

When developing a strategy for deploying a post-acute care network to drive savings, historical performance data can be instrumental for determining which bundles make sense (i.e., where there is opportunity). An essential part of the strategy should be to review care pathways to optimize the use of post-acute care, with a particular focus on creating pathways specific to patient acuity.

At this point, initial metrics and thresholds should be identified that support network performance targets. These metrics generally will be sets of financial, clinical/quality, and patient satisfaction measures. Obvious examples include metrics such as SNF/IRF length of stay, readmission rates from those settings, surgical site

8 Essential Requirements of an Effective Network for Bundled Payment

- A narrow network of select post-acute care partners with a high-quality record
- A dedicated care navigator to oversee the operational aspects of the network
- Data availability as close to real-time as possible
- Practical, usable technology, starting with the basics
- Ongoing education of all internal and external stakeholders
- Optimized care pathways and transitions involving all parties
- Engagement of all staff to keep patients in the network
- C-level support

infection rates, and patient satisfaction scores (e.g., from HCAHPS).

Performance thresholds should be a function of the bundled payment program's goals. For example, a hospital likely will want to require its partners to commit to a reduced readmission rate from the current figure, but by how much? This question will require analysis of historical data so that both parties can agree on a mutually acceptable benchmark.

Designing a Post-Acute Care Network

Hospitals should focus on four key steps when designing a post-acute care network:

> Defining the partnerships
> Building the network
> Aligning partner performance
> Securing C-suite support

Defining the partnerships. It is important for a hospital to consider the nature of its relationship with its prospective partners. Hospital leaders should create an inventory of potential partners and their roles, particularly for informal partners that may help support the socioeconomic needs of patients, such as providing nutrition and transportation.

Establishing formal contractual relationships is essential for partners with which the hospital will be establishing formal performance requirements. Formal contracting is probably overkill, however, for informal relationships, such as informal arrangement with a service that provides discounted transportation for your patients on an as-needed basis.

Clearly, the hospital's major post-acute care partners will be SNFs, IRFs, HHAs, and LTACs. Each of these entities will have a different level of participation depending on the bundle. However, once the network is established, the hospital should be able to use each partner's services as needed, depending on the opportunity and or requirements of the bundle. For example, an orthopedic bundle will rely heavily on SNFs and HHAs, but less so on IRFs, whereas a cardiac bundle may have limited need for SNFs and IRFs, but require HHAs to a much greater extent.

Building the network. When forming a network, a hospital should not only establish an acceptable selection process for preferred partners, but also set a reasonable timeline in which to complete the partner selection. The process should be open to all potential candidates identified through the hospital's analysis. A transparent process with a reasonable timeframe and the hospital's availability to interact with partner candidates and address their questions sends a message of the hospital's intent to be a cooperative partner in this new model.

Of course, most of the partner candidates in this process will be rejected, and the hospital should establish a protocol for dealing with objections. A prudent approach would be to notify rejected candidates that they might still have an opportunity to participate in the network in the future if, for example, a selected partner drops out. This message could even encourage rejected partners to work to improve their performance with hopes of a future opportunity. A "bench" of alternate candidates is a good asset.

Aligning partner performance. Incentives of all partner organizations must be aligned if the network is to achieve optimal performance. Therefore, it is imperative that a hospital's

SKILLED NURSING FACILITY (SNF) PERFORMANCE ANALYSIS

SNF Name	Number of Episodes	Total Payments	Average Payment	Number of Readmissions	Readmission Rate	Average LOS
SNF 1	82	$779,133	$9,502	5	6%	19.0
SNF 2	24	$296,205	$12,342	3	13%	27.4
SNF 3	23	$191,976	$8,347	1	4%	17.6
SNF 4	22	$345,637	$15,711	1	5%	28.4
SNF 5	16	$198,958	$12,435	3	19%	29.3
SNF 6	13	$163,762	$12,597	2	15%	19.4
SNF 7	12	$247,794	$20,650	3	25%	41.5
SNF 8	11	$89,181	$8,107	0	0%	19.5
SNF 9	10	$119,593	$11,959	0	0%	28.4
SNF 10	7	$153,908	$21,987	2	29%	53.2
SNF 11	7	$47,988	$6,855	1	14%	13.4
SNF 12	6	$43,031	$7,172	0	0%	14.9
SNF 13	4	$52,540	$13,135	0	0%	23.8
SNF 14	3	$13,591	$4,530	1	33%	13.2
SNF 15	3	$37,697	$12,566	0	0%	30.3
SNF 16	3	$12,085	$4,028	1	33%	12.1

partners understand the long-term value proposition of being in the network in terms of preparing for the future value-based world of health care.

Ultimately, the hospital's goal should be to create a "narrow network" of providers in each segment.[b] Thus, a hospital whose patients are currently being discharged to as many as 100 SNFs, should seek to limit SNF referrals to three or four preferred partners. Such a limited network will make it easier for hospital to contract and manage going forward.

The exhibit above shows a breakdown of discharges to SNFs (using Medicare claims data and presenting only the first 16 of about 100 SNFs). The range of discharge volume, average payment, and readmission rate demonstrates the performance variability that a hospital must address in developing and managing its network.[c]

Consider that the objective is to standardize care pathways for up to 90 days after discharge. It is far easier to work with a limited set of willing partners than a large number of lukewarm participants. Having fewer preferred providers simplifies the process and reduces errors and miscommunication.

Channeling patients to a limited number of partners also means that each partner will receive, on average, more referrals. This trading of census in return for improved performance (particularly reduced length of stay or utilization which translates to lower top-line revenue) is a negotiating point that will work in a hospital's favor, but only if the hospital has a limited partner network.

Securing C-suite support. Whatever method is used to evaluate and formalize the partnership, C-suite

b. For an example about the success of narrow networks, see Haeder, S.F., Weimer, D.L., Mukamel, D.B., "California Hospital Networks Are Narrower In Marketplace Than in Commercial Plans, But Access and Quality Are Similar," *Health Affairs*, 2014.

c. See Nursing Home Compare at Medicare.gov.

support is imperative. Every partner needs to know that the bundled payment program has support at the highest levels of the hospital's organization.

Integrating the Preferred Partners

From the outset, the hospital should establish a formal integration plan to bring partners into its new care continuum. This plan should address issues such as data sharing, patient records sharing, and standardized care pathways. As care protocols and pathways are redesigned (with partners' input), the role of each partner will become clear. The analysis required for such care redesign should be seen not only as a means to prepare for the integration process, but also as an ongoing exercise that the hospital routinely employs to strive for best quality outcomes.

One of the biggest challenges a hospital will face, both internally and with its partners, is managing change to existing workflow. Every attempt should be made to use existing processes to support the program. Minimizing disruption will spur more rapid adoption and help ensure successful implementation.

Redesigning Care Transitions and Pathways

The specific information that the hospital and its post-acute care partners will need to exchange will be a direct function of the organization's care pathways. As pathways are redesigned, consideration should be given to the information requirements at each care transition point. The network's care navigator (a possible new role within the organization responsible for overseeing the operation of your post-acute network—discussed below) will require access to all of these.

Evaluating and redesigning care pathways creates an opportunity to implement changes that a hospital's team may have previously considered but were unable to implement (for example, due to budget constraints). Issues such as the development of assessments, home visits prior to discharge, and tightening of medication reconciliation at discharge are a few examples. Other items to consider include formalizing patient progress reports to share with family and primary care physicians, enhancing palliative care, and establishing a patient-specific risk stratification strategy and methodology.

Key factors to consider are risk stratification process, information sharing, and notifications for intervention. The risk stratification methodology should drive patients to specific care pathways, ideally using patient-specific predictive analytics, with the goal of allocating resources to the neediest patients. The results will dictate what information needs to be shared, between which parties, and when (even real time). Care should be taken not to create processes that bombard people with updates and notifications. Notifications by exception should be the order of the day.

The most resource intensive part of network implementation is the ongoing effort of educating the organization and its partners. Bundled payments require a new way of thinking—a culture change—that will be difficult for some people to adopt. Ongoing reinforcement of the message and program goals is essential. Moreover, all stakeholders should be involved, including both internal stakeholders such as leadership, finance, and all clinical areas (e.g., surgeons, nurses and extenders, social work and discharge planners, behavioral management) and external stakeholders, which constitute all post-acute care providers.

Appointing a Care Navigator

As noted previously, a care navigator should be appointed to manage network operations. This (probably) new role within the organization should include oversight of all of care redesign processes. The navigator should have constant interaction with preferred and nonpreferred partners as well as patients and their primary care physicians. Such interactions, both manual and electronic, can give the navigator unique and valuable insight into how the program is performing over the long term.

The navigator will need real-time electronic access to internal and external systems to view patient status and assessments. For example, SNF connectivity could allow the navigator to be notified that a patient is showing signs of inadequate blood circulation at the very time the situation is occurring. Rather than simply readmitting the patient to the hospital, an automated notification could trigger the navigator to have a clinician review the situation first, perhaps even using a telehealth solution.

Typically, a navigator will access such information in a variety of ways, including through electronic access, phone calls, and personal visits. Consolidating all of the information—even using a simple spreadsheet—enables the navigator to develop a complete picture of the patient's status and care/outcome trajectory, enabling reporting to the organization and the driving of corrective action.

As the central operational point of contract for the network, the navigator is in a position to drive partner compliance by measuring performance and collaborating to improve results. Using reports, dashboards, and technology tools, the navigator identifies at-risk patients who will require more attention and care resources. Working with partners (internal and external), the navigator acts to optimize resource utilization toward the best outcomes.

Technology: Following Patients Through the Care Continuum

The effectiveness of the partner network will be greatly enhanced if the organization has a technology solution that connects hospital, patients, and the post-acute care partners and that provides each partner with accurate information precisely when it is needed. Although no single technology solution can deliver this level of performance, a hospital can work with its partners to implement data exchange connections that work within existing workflow. Augmented with rudimentary manual/spreadsheet processes, such a solution can be cost-effective, quickly implemented, and expandable over time.

Initially, spreadsheets can provide a viable technology solution for the navigator given that the number of patients in your program will tend to be small at the outset, making manual

Considerations for Gainsharing with SNFs

Skilled days are economically essential to the financial health of a skilled nursing facility (SNF). One of the key saving strategies for bundles is to reduce SNF length of stay (LOS). For those SNFs selected for the "preferred provider" relationship, reducing LOS will not be a problem, because these facilities will receive more referrals to keep their short-stay beds full, thereby eliminating any negative financial impact. However, SNFs not selected as preferred providers would not enjoy the benefit of increased referrals and, therefore, would experience a significant negative financial impact from reducing LOS, which would give them cause to be uncooperative with the goals of a hospital's bundled payment program.

However, if SNFs were offered a "per-reduced-day" payment, such that the hospital would realize a net gain, the hospital might generate a larger return than if no sharing was offered. For example, by reducing LOS for a patient by one day, the SNF might generate $500 in savings for the hospital's bundle. The hospital then would pay the SNF a "per-reduced-day" payment of $100, resulting in a $400 net gain for the hospital.

Whether such an arrangement is acceptable under the terms of the bundle arrangement needs to be determined. Moreover, this type of arrangement should be considered only as a "fallback" position as most bundle arrangements do not include gainsharing with post-acute care providers.

Another issue is that of Continuing Care Retirement Communities (CCRCs) that have SNF units primarily serving their own clients. If some of these communities are responsible for a large number of admissions to the hospital, it is unlikely that any of these facilities will be selected as a preferred provider because of the limitations they have on accepting referrals other than returning members of their community. Such facilities lack any financial incentive to reduce LOS, but a "per-reduced-day" payment could serve as a potential incentive.

processes more palatable. This initial period also affords an opportunity to determine what information is needed, from whom, when, and how often. In addition, existing technology capabilities such as transmission of electronic or printed continuity-of-care documents, SNF registries, and regional health information exchanges can serve as a backbone to support the necessary information exchange capabilities with each partner's electronic health record. Case management and guided care pathway software can also provide technology pieces to support the program. Invariably, the plan should include integration with hospital's data warehouse.

To help patients access the network's preferred providers, hospital staff must be proficient in explaining the network and its value to patients. Therefore, staff should be thoroughly educated about the program, the network, and the clinical and financial value to the patient of using a preferred partner. Everyone should be trained on possible patient objections, how to deal with them, and, most important, how to convey the message that the hospital used a rigorous process to select the post-acute care partners to provide patients with the best possible outcomes.

In every instance where a patient chooses a non-preferred provider, the situation should be reviewed to determine how it might have gone differently. Lessons learned should be shared with staff on an ongoing basis.

Aligning Metrics with Desired Operational Outcomes

It also will be important to investigate whether the network is working as designed. The answer to this and most other questions will be found in the operational metrics established at the beginning of the program (e.g. reducing readmission rates, reducing length of stay, and improving patient satisfaction). With just a few such metrics, the navigator will have a good sense of what is not going well and needs attention. For example, an IRF showing high readmission rates will prompt the navigator to drill down further, both into the data and working directly with the partner, to determine the factors causing this high rate.

A good partner also works with underperformers to help them. While monitoring the program's operation, the navigator will inevitably encounter circumstances in which things are not going well. In such circumstances, the navigator should maintain ongoing communication and provide opportunities to improve the situation. Nonetheless, the navigator's efforts sometimes may not work, and senior leadership may need to step in.

Even after formal agreements have been signed, a hospital occasionally will find that a partner is not fully cooperative. Such a partner should be given a reasonable chance for remediation, but if the problem persists, the partner should be replaced, following a process spelled out in the formal agreement governing the partnership.

The key to success in a hospital's bundled program is the ability to deploy an effective post-acute care network of willing providers dedicated to value-based care. This network should reflect a two-way partnership, with the full dedication of all parties. Identifying the best partners is an important start. Setting realistic expectations, ongoing communication, and mutual dedication to providing the right care at the right time will help ensure the network is effective and able to achieve long-term success under the bundled payment model. ■

About the author

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