



Meeting Healthcare's Challenges Through the Formation of Networks

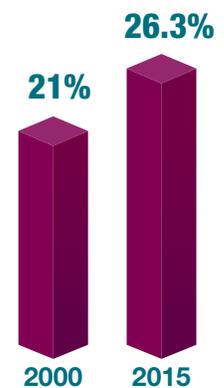
In today's healthcare environment, no provider can afford to live in a vacuum, focused only on the level of care they are providing without regard to what happens before and after a patient comes through their system. The IMPACT Act of 2014 imposed concrete deliverables on healthcare providers related to the use of standardized patient assessment data, and the requirement and reporting of new quality measures,¹ all with an eye to the future and CMS and MedPAC reports on prospective payments, which could further alter the healthcare landscape.

In this new environment, post-acute care has become very important to short-term acute care (STAC) providers and vice versa.

Why Is Post-Acute Important to STAC Providers?

According to a research letter in the *Journal of the American Medical Association*, the adjusted percentage of hospital discharges to post-acute care among Medicare beneficiaries increased from 21 percent in 2000 to 26.3 percent in 2015.² Readmissions are costly and can hurt a system financially while reflecting negatively on patient outcomes. Short-term acute care providers know that by handing patients off to post-acute providers with no further thought, they risk seeing those patients return to the hospital, which can lead to penalties. On top of that, consumers are pushing for coordinated care. That is, patients want to feel as though they are being handed off warmly, rather than pushed out the door to start anew with the next provider. Also, the number of medically complex patients is rising – patients whose care is more complicated and requires greater coordination for successful results. According to the American Academy of PAs, the professional organization for physician assistants, “the absolute number of patients seeking care is increasing, and many more patients have multiple chronic conditions than they did a generation, or even a decade, ago.”³

A 2014 paper from Acumen, LLC, posited that “integrated delivery models, such as those used by managed care plans, [could] achieve a superior level of care for highly complex patients given their systems for sharing patient histories.”⁴ Altogether, a focus on continuing the care, in an era where care is shifting from the acute to the ambulatory setting, has lead STAC providers to explore the option of a identifying a network of post-acute care providers in order to meet the challenges of healthcare policy while providing better and more comprehensive care to their patients.



Hospital Discharges to Post-Acute Care Among Medicare Beneficiaries



Why Are STAC Providers Important to Post-Acute Providers?

Post-acute care (PAC) providers are feeling the same pressures as STAC providers. Reducing readmissions is critical to business success; no STAC provider would continue to send patients to a post-acute facility that keeps sending those patients back to the STAC for avoidable reasons. PAC providers are also subject to fines and penalties related to avoidable readmissions as we transition from a fee-for-service to a value-based care model. Penalties are incurred if the Medicare spend is higher than the average cost of care 30 days post discharge.

PAC providers know that safe and timely transitions have been proven to decrease length-of-stay, mortality, readmissions and penalties.

Creating a Network

So, both STAC and PAC providers are committed to improving care transitions for better outcomes, more fluidity and a decrease in avoidable readmissions. Now what?

Identifying the challenges is the first step. Common challenges are:

- Effective care coordination with the inpatient team and upstream and downstream providers
- Medication reconciliation, patient and family education and engagement
- Quality-driven relationships with care managers and community partners

Next comes identifying transformational steps toward partnering around clinical quality:

- The creation of forums for jointly advancing efficiency and quality
- Implementation of institution-specific solutions and processes for enhancing clinical care
- Design of episodic clinical pathways and evidence-based discharge protocols based on patient complexity and individual care needs

And then, determination of ultimate ambition:

- Evaluation of population trends in discharges, outcomes through data transparency
- Conducting analysis to understand cost of care by setting
- Risk-based contracting using select quality metrics

The environment is and has been ripe for the formation of networks. There is currently no universal standard for determining post-acute destination.

According to the *AHA Trendwatch*, “Post-acute care (PAC) providers play an essential role in ensuring that patients receive the care they need to heal and have a smooth transition back to a community-based setting, typically after a discharge from a hospital. These providers face an increasingly complex regulatory and market environment as healthcare transforms from a system that rewards volume to one that encourages and rewards value.”⁵

Hospital discharges to a PAC setting trended upward between 2008 and 2013, and most of these patients were then transferred to a second PAC facility.⁶

New research has shown that for certain patients, treatment in an inpatient rehabilitation setting such as an inpatient rehabilitation facility (IRF) or an acute rehabilitation unit (ARU) can improve outcomes and help patients regain more function than treatment at a skilled nursing facility (SNF), thus defining a course of care for those patients that had not been previously outlined.

Guidelines issued by the American Heart Association/American Stroke Association (AHA/ASA) in 2016 state that whenever possible, initial rehabilitation should take place in an inpatient rehabilitation setting (an IRF or ARU), rather than a SNF.

Similarly, a study published in the *Journal of the American College of Surgeons* found that trauma patients treated in an inpatient rehabilitation facility are significantly more likely to be discharged home. Patients treated in an inpatient rehabilitation facility are significantly less likely to be rehospitalized or die after one year.

According to the study, post-trauma therapy provided by SNFs can vary from facility to facility; furthermore, the range and extent of rehabilitation services provided by SNFs are typically significantly less than those provided by IRFs.⁷

These are just two examples of the increasing level of complexity that is involved when considering discharge destination, underscoring the need for appropriate care transitions.

Components of a Good Collaborative

So we know that the formation of networks can help to effectively meet the challenges of the healthcare landscape. How do you form a high-performing network? Below are some steps that can help you formulate a plan.

1

Identify team members and clinical point persons from each member of the network

2

Agree upon, and clearly define, expectations around common processes such as:

- Referral decision turnaround time
- Admission criteria by setting type
- Transparency: “Never Admit” conditions

3

Design communication processes; referrals, transitions and real-time concerns

Design transition processes/pathways (upstream and downstream)

5

Identify reporting format and frequency

6

Outline joint quality committee meeting frequency, attendance and objectives

A network can improve communication between clinicians and settings and further supports partnerships between acute and post-acute providers, leading to improved patient empowerment, improved clinical outcomes, prevention of over-utilization/duplication of services, prevention of delays in care and promotion of progress towards goals, while encouraging accountability for all.

Defining Success

Once a network has been formed, it's critical to define the metrics you will use to determine success. Some suggested metrics are:

- Readmission rate: Do you see a decrease?
- Length of stay: Do you see a decrease?
- Patient volume within the network: Do you see an increase?
- Have gaps in care been identified and addressed? Are there any trends?
- Has patient satisfaction with transition and/or Net Promoter score increased?
- Have follow-up calls been completed on time?
- What trends are you seeing with direct admits from home to LTACH, IRF or SNF, bypassing the hospital ED?
- Have Functional Improvement Measures (FIM) scores improved?

How to Get Started

After you have identified your potential partners, you will want to gather and review your referral partner's data, as well as your data and your competitors' data.

Prepare your data to showcase your strengths via a visual dashboard. Approach your referral sources as well as preferred discharge providers to discuss formation of a post-acute collaborative.

When considering potential partners, you will want to consider:

- Geography
- CMS quality scores/DPH scores/readmission rate
- CMS quality websites: Hospital, IRF, nursing home, HH Compare
- Clinical programming and available services
- Physician alignment
- Genuine interest in participating
- Palliative and hospice care availability

When you're both ready to move forward, you will want to complete a formal agreement (contract, affiliation, collaborative, etc.) and discuss with your legal team.

The KHRS Difference

Kindred Hospital Rehabilitation Services (KHRS) is part of Kindred Healthcare, and is the leading provider of contract rehabilitation services in the country. **We work in acute rehabilitation settings in over 150 hospitals nationwide, and operate 23 freestanding inpatient rehabilitation hospitals in partnership with care providers through joint or tri-venture agreements. We see over 45,000 patients per year, cared for by our nearly 7,000 therapists.**

KHRS has a relationship with the AHA/ASA, the benefits of which are extended to clients and JV partners, as part of an effort to expand adoption and exposure for their stroke guidelines, in order to get more appropriate patients to the right level of care after stroke. This effort includes the use of jointly branded educational materials with client and AHA/ASA logos and messaging.

Kindred Healthcare operates in nearly every sphere in the post-acute continuum, and has a long history of continuing the care, from the hospital and beyond. Alignment with Kindred means a partnership with a company that knows

the importance of continuity of care and understands the complexities of delivering care at each level of care, from transition from the STAC, through rehabilitation and on to home.

Through collaboration and engagement, we can work together to meet the challenges of today's healthcare climate and thrive, for ourselves, and most importantly, for our shared patients.



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