When Texas Health Resources began investigating Medicare spending in the Dallas-Fort Worth region, leaders saw that outlays for skilled nursing, home care and other post-acute settings were above the national average. Hospital spending, by comparison, was below average.

That’s when Texas Health prioritized post-acute care management, says CEO Barclay E. Berdan, FACHE. “Traditionally, hospitals have focused on lengths of stay, but patients sometimes go on to incur high post-acute costs. We’re redefining that. At the earliest possible
moment, we are thinking about the appropriate services patients will need once they leave the hospital.”

Post-acute care is low-hanging fruit for hospitals and health systems working to achieve the Triple Aim of lower costs, improved patient experience and enhanced population health, says Kenneth Adams, MD, vice president, post-acute care, Texas Health Resources. “It has been an unmoderated black hole of care delivery,” he says. “There are great opportunities to put processes and procedures in place that will bring dramatic benefits to patients.”

Potential cost reductions are eye-opening as well: If Texas Health could bring post-acute care utilization down to national averages, it could expect to reduce Medicare spending by $129 million a year.

Recognizing the savings potential, the Centers for Medicare & Medicaid Services is encouraging acute and post-acute partnerships through bundled payment demonstration projects, including the Comprehensive Care for Joint Replacement model. Medicare readmissions penalties are also fostering cross-continuum conversations.
Healthcare leaders who have been working to strengthen ties between acute and post-acute services attest to the benefits of collaboration, including reduced readmission rates and improved patient satisfaction. Here, they cite eight strategies that have been key to their progress.

Strategy 1: Determine the Right Partnership Models

Few health systems own the entire post-acute continuum, but MedStar Health comes close. A 10-hospital integrated health system serving the Baltimore-Washington, D.C., area, MedStar encompasses home health, an inpatient rehabilitation facility and outpatient physical therapy. To round out the network, MedStar has preferred provider relationships with skilled nursing facilities and long-term acute care entities.

Advantages of ownership include a common EHR and ease-of-care planning, says ACHE Member John D. Rockwood, president, MedStar National Rehabilitation Network, and senior vice president, MedStar Health. “It’s an advantage having clinicians from the different settings at the table thinking about the best path for the patient. That is possible but more difficult in a partnership environment.”

Sometimes clinical and business reasons merge to make ownership the best choice. In 2013, Trinitas Regional Medical Center opened a 25-bed LTAC unit on its seventh floor to fill a need in central New Jersey. Trinitas leases the unit to CareOne Management to operate. Other health systems, including Texas Health, have similar arrangements for SNFs within their walls.

“Ventilator-dependent and other complex patients were languishing on our general medicine floor,” says James Dunleavy, director, physical medicine and rehabilitation, Trinitas. “Our leaders saw the ability to move these patients into a more appropriate level of care through a symbiotic business arrangement with CareOne.”

Strategy 2: Narrow the Network

While hospitals tend to partner with only one or two IRFs and LTACs, many are overwhelmed by the number of SNFs and home care agencies in their service areas. “Patients are bouncing around a lot,” says Gerben De Jong, PhD, senior fellow and director, health policy and post-acute care, MedStar National Rehabilitation Network. “There’s no way to really treat people effectively if you have to deal with such a great variety of destinations.”

For example, Texas Health determined that patients were being discharged to 300 different SNFs. Through a data-driven process, the system narrowed this list to 103 preferred providers.

To rank SNFs by quality, Texas Health leaders relied on Medicare’s Nursing Home Compare ratings and state reports. To measure efficiency, they turned to detailed Medicare cost data, which Texas Health receives as an accountable care organization in the Medicare Shared Savings Program. “For a particular diagnosis, we can see which facilities bill patients at a higher rate than others and keep patients longer,” Adams says.

“At the earliest possible moment, we are thinking about the appropriate services patients will need once they leave the hospital.”

—Barclay E. Berdan, FACHE
Texas Health Resources

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Eventually, Adams plans to narrow the list of 103 SNFs to 60 and increase volumes to these select facilities. After studying seasonal variations in joint replacement discharges to SNFs, he found that SNFs tended to reduce lengths of stay for patients during high-volume months, compared with low-volume periods. Yet, no corresponding increase was seen in returns to acute care, suggesting that SNF patients did not suffer serious problems after discharge.

“Market economics is playing out when volumes are high,” Adams says. “The facilities discharged the healthiest patients home to create a bed for us.”

Texas Health also has worked diligently to reduce unnecessary home care recertifications, or approvals of additional home care visits. “Our Outpatient Care Management Services area is mandating that physicians get involved in chart reviews, bring their patients in for in-person evaluations or have our Transitions House Calls nurse practitioners visit at home to determine if additional home health services are necessary,” he says. “As a result, we have cut our recertifications by 70 percent.”

Another factor to consider when narrowing a network is the geographic proximity of post-acute providers to the hospital and patients’ homes, DeJong says. When looking at discharges for one hospital, MedStar leaders realized patient diagnosis influenced post-acute choices, particularly for emergency versus elective cases. For instance, many joint replacement patients traveled a fair distance to the hospital for surgery and sought rehabilitation near their home, compared with stroke patients, who tended to live near the hospital at which they were treated.

DeJong notes, “If you’re an acute care hospital in charge of an entire bundled payment, where do you put your outpatient centers? What skilled nursing facilities do you want to work with? You really have to think about geographic distributions.”

**Strategy 3: Align Financial Incentives**

Trinitas is in one of the geographic regions (New Jersey) required to participate in CMS’ joint replacement bundled payment program, which began in April 2016. While still in the first year, the single-hospital system is already seeing a shift in perspective across the acute-to-post-acute continuum, Dunleavy says. “Instead of the hospital, sub-acute, home care and outpatient rehab having their own financial agendas with regard to joint replacement cases, we now have one agenda.”

Trinitas approached the SNF that admits most of the medical center’s joint replacement patients. “We’ve agreed to a much lower length of stay for these patients, and we linked the facility up with a home care agency,” Dunleavy says. “The
sub-acute facility and home care agency send me reports twice a week on the joint cases they have, their functional status and their expected discharge date.”

**Strategy 4: Identify the Right First Setting**

Jacksonville, Fla.-based Brooks Rehabilitation is one of a limited number of post-acute providers to take on financial risk under Medicare’s Bundled Payments for Care Improvement initiative. A not-for-profit, Brooks is a convening organization under BPCI Model 3, which begins at the initiation of post-acute services after an acute hospital stay.

“We thought it was important to show that post-acute care providers could develop the capabilities to take on financial risk and perform at a high level,” says Brooks President and COO Michael R. Spigel.

Now in year three of the BPCI initiative, Brooks has reduced Medicare spending by 15 to 25 percent from baseline, depending on the quarter measured. In addition, readmissions have decreased by 17 to 27 percent across various patient diagnoses, and patient functional status and satisfaction ratings have improved significantly.

A close partnership with St. Vincent’s HealthCare, Jacksonville, Fla., has been critical to Brooks’ success. Brooks operates a specialty SNF for postoperative orthopedic patients in one of St. Vincent’s hospitals. Spigel calls the unit ground zero of Brooks’ bundled payment approach because it has served as a testing ground for determining how best to manage patients. “For example, we changed some of the patient selection criteria for the unit,” says Kyle Sanders, FACHE.

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**Policy Levers Driving Post-Acute Partnerships**

The federal government has rolled out, or is planning to roll out, four programs to accelerate collaboration among acute and post-acute providers.

**Readmission Penalties**
The Hospital Readmissions Reduction Program, created by the Affordable Care Act, withholds up to 3 percent of Medicare payments from hospitals with high readmission rates for six conditions: chronic obstructive pulmonary disease, coronary artery bypass surgery, heart attacks, heart failure, hip and knee replacements, and pneumonia.

**Bundled Payment**
After rolling out a mandatory joint replacement bundled payment program to 67 geographic regions in April 2016, the Centers for Medicare & Medicaid Services has proposed launching a new mandatory bundled payment program for cardiac care, including heart attack treatment and bypass surgery, in July 2017. Beginning in that month, hospitals in 98 randomly selected geographic areas will pilot test the cardiac program. At the same time, hospitals already involved in the joint replacement program also will be paid a bundled payment for hip/femur fracture surgeries. A final rule has not yet been released.

**Discharge Planning**
A proposed CMS discharge planning rule released in October 2015 requires hospitals to put a systematic discharge planning process in place for all patients, including observation and emergency department patients. The rule requires hospitals to send each patient’s discharge summary to the practitioners responsible for the patient’s care within 48 hours of discharge. A final rule has not yet been released.

**A Unified Post-Acute Payment System**
Currently, the four post-acute settings (skilled nursing facility, inpatient rehabilitation facility, home care and long-term acute care) have different Medicare payment systems with different financial incentives. In June 2016, as directed under the Improving Medicare Post-acute Care Transformation Act, the Medicare Payment Advisory Commission outlined a proposed unified post-acute payment system. Under this future system, Medicare would base post-acute payments on a patient’s characteristics regardless of the setting in which the patient receives care. The process of developing this new payment system is still in its early stages.
president, population health and care continuum/COO, St. Vincent’s. “Historically, if patients met Medicare criteria for skilled nursing, they were automatically referred to the unit. But clinically, many of those patients were ready to go home and receive rehabilitation in an outpatient therapy setting.”

Identifying the most appropriate setting for inpatients to be discharged to is one of Brooks’ key improvement strategies, Spigel says. “It challenges everybody’s belief system to consider, ‘How can we move patients from higher-cost settings to lower-cost settings and ensure better outcomes?’ The important thing here is not just using a lower-cost setting over a higher-cost one; rather, the real challenge is using a lower-cost setting and bringing about a better outcome. This is the essence of care redesign and the promise we made to our physicians and other clinical team members.”

Nurse liaisons help Brooks ensure inpatients are discharged appropriately. “A core group of nurses working at the acute facilities assess patients to determine the best first-care setting to put them in,” says Debbie Reber, vice president, clinical services, Brooks.

**Strategy 5: Position Physicians**

Brooks also has partnered with hospitalist groups to ensure its community-based SNFs have dedicated internists available full time. “By far, that was the most important thing we did,” says Spigel. “Many skilled nursing facilities really struggle to get the same doctors to spend the day.”

Texas Health is one of the few health systems to dedicate a group of physicians specifically to post-acute care. Approximately 40 physicians—including internists, geriatricians and physiatrists—and a number of nurse practitioners have been placed in each of the 103 SNFs in Texas Health’s preferred provider network. “Because we have boots on the ground and eyes within a facility, we can drive care protocols that guide how patients are treated,” Adams says.

Most of the post-acute physicians are employed by Texas Health. Some serve as medical directors in partner SNFs, while others regularly visit patients and manage their care. “The more time a physician spends in a skilled nursing facility, the better the care,” Adams says. “When nursing staff know the physician’s going to be there, they go to that physician with questions and concerns about their patients. That doesn’t happen when the physician’s not there. That’s when people get sick and end up back at the hospital.”

**Strategy 6: Implement Comprehensive Care Coordination**

MedStar Health has a group of post-acute care coordinators who track and support patients throughout their post-acute experience. The coordinators—who can be nurses, social workers or physical therapists—are currently assigned to patients with four types of diagnoses: orthopedic, stroke, cardiac and spine. Clinical protocols and pathways that cross acute and post-acute settings have also been

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—Gerben DeJong, PhD

MedStar National Rehabilitation Network
developed to guide clinical decision making for these diagnoses.

“For elective surgeries, the post-acute care coordinator will be involved in the patient’s presurgical screening and then follow the patient to whatever post-acute services are needed,” says Rockwood. “We’ve seen patient satisfaction improve now that patients have someone to help them navigate a complex environment, and we’ve seen reductions in length of stay and quicker care transitions. When there are deviations from the care paths, the care coordinators are able to provide more seamless communication back to the physician and the care team.”

Brooks Rehabilitation also employs nurse care navigators who follow patients across care settings. The navigators attend team conferences to keep up with each patient’s progress and risks. They also may conduct home visits, attend physician or other medical appointments and solve complex social issues that can arise. All post-acute providers in the Brooks system use the same patient assessment tool, making it easier for navigators and other staff to monitor and discuss patients. The lack of standardized assessment tools has always been a challenge in post-acute care.

“As patients are being discharged, the cloud-based system pulls relevant information from Texas Health’s EHR to create a continuity-of-care document. The document is then electronically pushed out to the post-acute facility and the admitting physician. “It allows the physicians to view that information before their patient even arrives at the skilled nursing facility,” Adams says. “This way they know, ‘Oh, this is a really sick patient who’s being discharged out to me on a Friday afternoon. I need to stop by the SNF tonight to see this patient.’”

Acute and post-acute organizations also need to share cost and outcome data as they partner to improve care transitions, says Sanders. As part of their bundled payment arrangement, St. Vincent’s and Brooks share data on average cost of care, readmission rates, infection rates, fall rates and other key metrics. “We’ve come to trust each other, and that manifests itself in the sharing of data,” Sanders says.

“We thought it was important to show that post-acute care providers could develop the capabilities to take on financial risk and perform at a high level.”

—Michael R. Spigel
Brooks Rehabilitation
Strategy 8: Innovate for the Future

Brooks has made a number of technology investments to better serve patients, including an IT tool that allows staff to monitor and plan a patient’s care across post-acute settings. The tool includes a predictive analytics algorithm that stratifies patients according to clinical risk, which is used to identify the best care setting for these patients as well as to estimate length of stay and total cost of care.

In addition, Brooks has launched two telehealth initiatives. One is telerehabilitation, which allows patients who meet certain clinical criteria to receive physical therapy at home through a remote patient progress monitoring system.

“In a very gamified way, patients can receive rehab on demand using technology installed in their home with an exercise program prescribed and monitored by their physical therapist,” Spigel says. “A therapist can also dial in to watch and coach the patient as well as monitor the patient’s compliance with the exercises.”

Brooks also has deployed virtual handoffs. A few days before a patient is discharged from the SNF to home care or from the IRF to the SNF, for example, the nurses and therapists at the two organizations conduct a clinical handoff with the patient in the room, using technology that is something like Skype, according to Spigel.

“Patients get to meet the home care nurse and therapist who will be coming to their homes,” Spigel says.

Meanwhile, Texas Health is looking for ways to “Uber-ize” post-acute and outpatient care, recognizing that some patients end up in skilled nursing or back in the hospital due to a lack of support at home or in the community, transportation to primary or outpatient care or food in the refrigerator. “If we’re sending patients to a skilled nursing facility at $450 a day because they can’t prepare their own meals, then we need to send food to their house and pick up that cost because it’s less than $450 a day,” says Spigel. “Likewise, if patients don’t have transportation to their outpatient appointment, we hire a private ridesharing vendor for them.”

The Beginning of a Shift

As acute and post-acute providers collaborate and innovate to improve patient care, DeJong predicts that many of the current boundaries between traditional post-acute settings will begin to blur (e.g., whether to discharge to an SNF or an IRF). “Many of the boundaries in post-acute care are not very clinically meaningful. They are mainly governed by CMS rules, such as the three-day hospital stay requirement before an SNF stay is covered. These are artificial benchmarks that are not necessarily correlated with what the patient needs.”

Under bundled payment arrangements, providers can reinvent the rules. “You have to forget about the silos that we live in clinically,” says Dunleavy. “You have to think globally about the patients you’re responsible for over a 90-day period, make sure the next phase of care is preparing that patient for getting home and do that in the most cost-effective way possible.”