Developing Successful Hospital Partnerships

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DEVELOPING SUCCESSFUL HOSPITAL PARTNERSHIPS

Those aging services providers able to effectively measure, manage and market clinical care performance, as well as present their "value proposition" will be better prepared to develop successful acute care partnerships and will increase their likelihood of surviving in the new world of health care reform.

INTRODUCTION & BACKGROUND:

On October 20, 2011, the Centers for Medicare & Medicaid Services (CMS), an agency within the Department of Health and Human Services, finalized new rules under the Affordable Care Act to help doctors, hospitals, and other health care providers better coordinate care for Medicare patients through Accountable Care Organizations (ACOs). ACOs create incentives for health care providers to work together to treat individual patients across care settings, including doctors' offices, hospitals, and long-term care facilities. Hospitals discharge 17.3 percent of post-acute care patients to skilled nursing facilities, second only to home discharges. As a result, in an increasingly competitive long-term care environment, those aging services providers who provide skilled care to the Medicare population will need to adapt to the overall demands of health care reform and seek collaborative acute-care partners in order to successfully expand their market presence and sustain their organization's mission to serve its constituencies.

On October 1st, 2012, the Hospital Readmissions Reduction Program, (HRRP) in the CMS Medicare Inpatient Prospective Payment System proposed rule, reduces Medicare inpatient payments for acute care hospitals with higher than expected risk-adjusted readmission rates related to certain conditions. The inpatient Medicare payment reductions under this program are capped at 1.0 percent for FY 2013 and will increase over time. In response to HRRP, acute care hospitals are seeking to partner with skilled nursing facilities (SNFs) that can effectively reduce the number of hospital re-admissions and improve clinical outcomes through effective management of high-acuity hospital discharges and development of care protocols (clinical pathways) that address the first 30 days of admission into skilled nursing. As a result, those SNFs demonstrating expertise in managing high-resident acuity, reducing hospital readmission rates, and improving overall clinical outcomes will be better prepared to develop successful acute care partnerships.

A primary goal for acute care hospitals and health systems under health care reform is to develop a collaborative relationship with skilled nursing providers. While the role of SNFs is not defined, acute care providers are seeking selected SNF partners to serve within their continuing care networks. Those selected partners will agree to work with the care network on patient placement solutions, maintaining and improving quality outcomes, and cost reduction measures, as well as expanding sub-acute capacity, integrating clinical pathways, partnering on covered-population health management, and ultimately entering into risk-based partnerships.

In order to develop successful hospital partnerships, skilled nursing providers will need to first address their institutional readiness, understand local hospital discharge data, create a hospital relationship action plan, review their specific clinical outcomes data and demonstrate strong clinical outcomes and their overall value proposition to potential hospital partners.

HOSPITAL PARTNERSHIP READINESS:

The first step in developing a successful hospital partnership is to determine your organization's readiness. This process may benefit from a collaborative approach that includes forming a hospital partnership readiness committee comprised of the organization's board members, medical director, executive management, and marketing and social services personnel, as well as key clinical care associates.

A hospital partnership readiness committee seeking to conduct their organization's readiness should consider these key areas:

- Assessment of established and potential local hospital relationships in order to determine areas of strategic opportunities.
- Strengths and weaknesses of current clinical care programs.
- Availability/access to funding for potential repositioning, infrastructure and technology improvements that may be necessary.
- Identification of current and/or desired primary care and specialty physician relationships.
- Assessment of the ability to provide continuum of care services, including but not limited to, outpatient therapy services, hospice, home health, companion care, respite care, assisted living and long-term care.
- IT infrastructure capabilities and limitations.
- Assessment of organizational structure and leadership capabilities, such as performance improvement experience, ability to manage complex clinical care, commitment to culture change and knowledge of SNF clinical metrics.
- Historical hospital readmission rates.
- Current clinical outcomes data illustrating overall quality of care.

Conducting an organizational readiness assessment allows management to determine whether or not their organization is able to meet the clinical expectations of a potential hospital partner. Moreover, through embracing an organizational readiness exercise, management will be able to assess how a proposed hospital partnership fits into their existing mission and overall strategic plan.

Importance of Clinical Outcomes Data:

A significant challenge for many skilled nursing providers is their ability to define quality of care to their key stakeholders. Historically, many SNFs have defined quality of care as resident satisfaction. As health care reform continues to place a higher value on quality of care metrics, SNFs will need to demonstrate that they can deliver high-quality clinical care at a lower cost than their competitors. In order to assist in this process, skilled nursing providers should consider developing a clinical quality report card (CQRC) in order to illustrate areas of clinical care improvement and report their clinical care progress over time.

When developing a CQRC, it is important that what a skilled nursing facility measures is directly correlated with what their acute care hospital partners' measure on a regular basis. For example, most acute care hospitals measure their clinical outcomes per 1,000 resident days. Utilizing the same key clinical metrics, definitions, and calculation methods will further enhance transparency between the SNF and acute care providers, and will provide a solid foundation for successful partnership discussions.

Measuring Clinical Outcomes Data

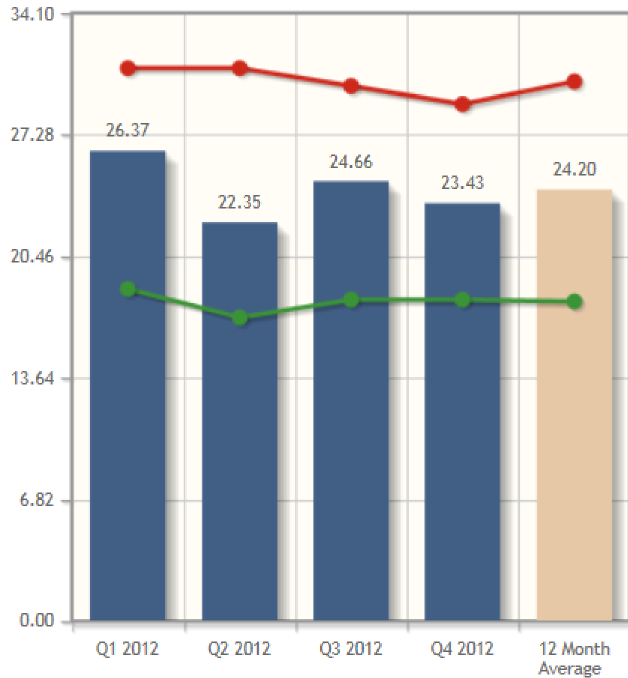
Skilled nursing providers should consider focusing on certain key clinical outcomes when discussing overall clinical quality of care with potential acute care hospital partners. These key clinical outcomes include: short term rehabilitation average length of stay, antipsychotic medication utilization, resident falls with injury, in-house acquired pressure wounds (Stage I, II, II, and IV), nosocomial infection rates, nursing staff hours per patient day, and hospital re-admission rates. By measuring and sharing those key clinical indicators, skilled nursing providers will be able to focus their discussions with potential hospital partners around specific clinical quality measures that demonstrate their best practices and value proposition.

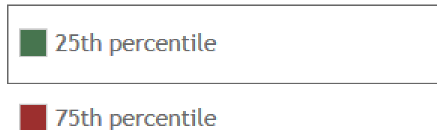
When benchmarking clinical quality indicators, it is important that skilled nursing providers consider who and what they are benchmarking against, the source of their research benchmarks, and the measurement timeframe. Common benchmarking sources include, but are not limited to: CMS, Centers for Disease Control and Prevention (CDC), National Database of Nursing Quality Indicators (NDNQI), and select applied health services research studies. Providing quarterly data, as well as rolling 12-month data, will allow SNFs to identify areas of recent improvement, as well as showcase their quality of care over time.

*SNF Quality Indicator Examples – XYZ Community compared to industry benchmarks**

**Sawgrass Partners, LLC & LeadingAge Indiana "Mission Metrics Software"*

Short-term Rehabilitation Avg. Length of Stay (days)





Short-Term Rehabilitation Avg. Length Of Stay

Q1 2012

- 25th PCTL: 18.60 days
- 75th PCTL: 31.00 days
- You: 26.37 days

Q2 2012

- 25th PCTL: 17.00 days
- 75th PCTL: 31.00 days
- You: 22.35 days

Q3 2012

- 25th PCTL: 18.00 days
- 75th PCTL: 30.00 days
- You: 24.66 days

Q4 2012

- 25th PCTL: 18.00 days
- 75th PCTL: 29.00 days
- You: 23.43 days

Benchmarks	Source
• ALOS National Benchmark 27 days.	• CMS Medicare and Medicaid Research Review Statistical 2011
• IN State ALOS Benchmark 32 days.	• CMS Medicare and Medicaid Research Review Statistical 2011

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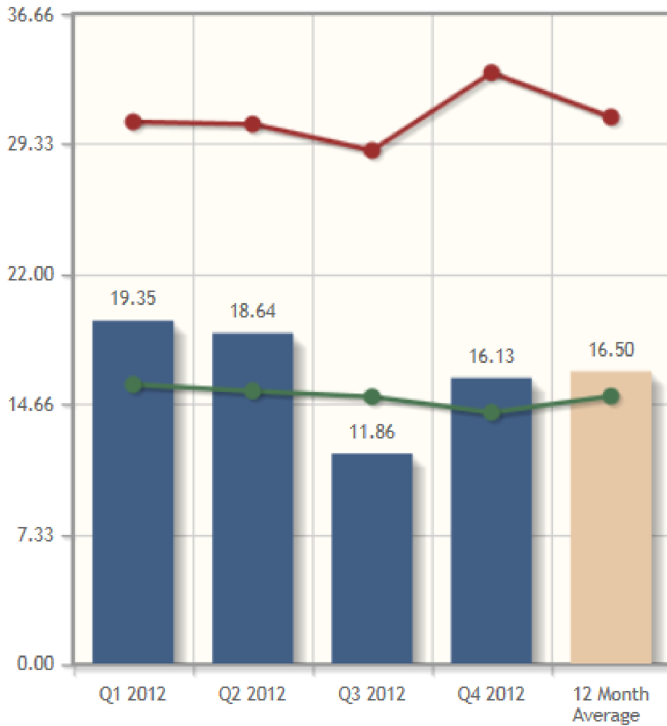
** Sawgrass Partners, LLC & LeadingAge Indiana "Mission Metrics Software"*

Antipsychotic Medication Utilization (%)



25th percentile

75th percentile

Antipsychotic Medication Utilization

Q1 2012	Q2 2012	Q3 2012	Q4 2012
• 25th PCTL: 15.75 %	• 25th PCTL: 15.38 %	• 25th PCTL: 15.06 %	• 25th PCTL: 14.17 %
• 75th PCTL: 30.56 %	• 75th PCTL: 30.43 %	• 75th PCTL: 28.95 %	• 75th PCTL: 33.33 %
• You: 19.35 %	• You: 18.64 %	• You: 11.86 %	• You: 16.13 %

Benchmarks	Source
• IN State average 23.5%. • National average 23.4%.	• Bonner, Alice PhD, RN, "Improving Dementia Care and Reducing Unnecessary Use of Antipsychotic Medications in Nursing Homes"
• CMS Recommended Reduction in overall Antipsychotic Medication Utilization: 15%	• CMS and www.medicare.gov/nursinghome compare

Managing Clinical Outcomes Data

SNF nursing and administrative management typically measure clinical indicators on a quarterly basis through a Quality Assurance (QA) Committee. The QA Committee should evaluate their current metrics to ensure they include those clinical outcomes that enhance the SNF's image as a quality, value-based provider of skilled nursing services. Moreover, skilled nursing providers should consider whether adopting more evidence-based protocols, such as the INTERACT 2 and SBAR tools, would help to effectively measure and report clinical outcomes. Skilled nursing providers should ensure that clinical outcomes are managed consistently and, if needed, appropriate action plans are developed, which may include staff training, clinical audits, procurement of equipment, and technology utilization.

Marketing Clinical Outcomes Data

Historically, SNFs have generally not shared their clinical outcomes data with those not formally associated with their facilities. The importance of clinical outcomes data is two-fold — improving clinical outcomes, and marketing those clinical outcomes data to a broader constituency, including adult children, hospital discharge planners, key primary care physicians, hospital executives, and hospital social workers. It is paramount that skilled nursing providers embrace a more marketing-based approach about sharing their clinical outcomes data.

In many cases, the general public's knowledge and impression of your community is limited to information obtained through recommendations, nursing home comparison websites, or hearsay. More and more adult child and hospital discharge planners are basing admission decisions on a community's CMS 5-star rating, which considers factors such as RN staffing, quality indicators, and most recent annual state inspection results. While there has been discussion within the SNF community about whether the CMS 5-star rating system is fair and illustrates a true picture of nursing home quality, the system is likely to be here to stay, and long-term care referral sources, including adult children, are becoming more aware of and reliant on the CMS 5-star rating system.

Skilled nursing providers should consider using their CQRC with their key clinical outcome indicators as a marketing tool to shift what may or may not be a positive CMS 5-star rating conversation into a conversation based on objective clinical outcomes and quality of care. More importantly, your social services and admissions coordinators will be able to showcase your facility's specific clinical outcomes as a representation of quality of care to hospital discharge planners and adult children, as well as provide an educational in-service to key hospital stakeholders on what programming your facility is implementing to achieve better clinical outcomes. Lastly, SNFs should consider posting key clinical outcomes in a prominent location within their buildings where potential residents, adult children, physicians, trust officers, attorneys, and the broader general public are able to see actual clinical quality results. This instills a culture of transparency and accountability, and indicates the provider's commitment to measuring and improving outcomes within their community

CQRC Example – XYZ Community

XYZ Community Clinical Quality Report Card (CQRC) January 1st 2012 to December 2012			
	XYZ Community	**State Benchmark**	**National Benchmark**
Total Resident Falls	**3.0 % 10 per 1,000 days**	3.8%	3.4% *and/or* 11 per 1,000 days
In-house acquired pressure wounds (stage I, II, III, IV)	**2.8% 0.55 per 1,000 days**	6.8%	11.0% *and/or* 2.1 per 1,000 days
# of Nosocomial Infections	**3.5% 7.5 per 1,000 days**	3.8%	2.7% *and/or* 6.7 per 1,000 days
# of UTI Infections	**8% 2.8 per 1,000 days**	6.8%	7.6% *and/or* 2.4 per 1,000 days
% Antipsychotic Medication Utilization	**16.5%**	23.5%	23.4%
Re-Admission to Hospital within 30-days	**18%**	22.4%	23.50%
Short-term Rehabilitation Average Length of Stay	**ALOS: 24 days**	ALOS: 32 days	ALOS: 27 days

Understanding your Local Hospitals' Discharge Data:

Patient discharges to post-acute providers vary greatly among hospitals. While some acute care hospitals will aggressively utilize SNFs, some health systems may utilize their own home health care network. Skilled nursing providers must understand the key differences among their local hospitals and acute care networks in order to develop specific post-acute programming and protocols that match the post-acute care needs of the referring local hospitals and systems.

Individual hospital average length of stays (ALOS) may vary, depending on the hospital's clinical competencies. When considering the development of specialized care protocols and services within a short-term rehabilitation unit, SNFs may want to target high-volume diagnoses treated at their local hospitals and engage in conversations with hospital administration regarding their ALOS and individual diagnostic related group (DRG) profit goals. For example, as shown in the table below, Hospital #2 has a high volume of major joint replacements or reattachments of lower extremities, but averages a net loss of $6,750 per patient. A skilled nursing provider in Hospital #2's market may consider developing a specific joint replacement program that will effectively reduce the ALOS for joint replacements, allowing Hospital #2 to improve its operating results within that specific DRG. As a result, Hospital #2 will be incentivized to refer its major joint replacement patients to that particular SNF over others in the market.

Individual Hospital Statistics within XYZ Community's Primary Market Area (PMA) – Example

	Acute Care Hospital #1				**Acute Care Hospital #2**			
Top 10 Hospital DRG Billed	DRG Description	Number of Patients	ALOS	Average Net Gain/ Loss	DRG Description	Number of Patients	ALOS	Average Net Gain/ Loss
#1 Billed DRG	Major joint replacement or reattachment of lower extremity	149	3.51	($1,798)	Major joint replacement or reattachment of lower extremity	206	4.72	($6,750)
#2 Billed DRG	Heart failure & shock	140	4.00	($92)	Heart failure & shock	160	3.60	($98)
#3 Billed DRG	Simple pneumonia & pleurisy	102	4.28	($151)	Rehabilitation	154	3.97	$2,085
#4 Billed DRG	Septicemia or severe sepsis w/o MV 96+ hours	88	4.94	$1,149	Simple pneumonia & pleurisy	152	4.35	($638)
#5 Billed DRG	Chronic obstructive pulmonary disease	82	3.18	$906	Chronic obstructive pulmonary disease	151	3.63	($120)
#6 Billed DRG	G.I. hemorrhage	79	3.49	$579	Septicemia or severe sepsis w/o MV 96+ hours	144	5.29	$826
#7 Billed DRG	Intracranial hemorrhage or cerebral infarction	72	3.61	$1,123	Esophagitis, gastroentral & digestive disorders	95	2.87	$167
#8 Billed DRG	Cardiac arrhythmia & conduction disorders	68	2.46	$442	Psychoses	85	6.25	($793)
#9 Billed DRG	Spinal fusion except cervical	57	3.91	($13)	G.I. hemorrhage	82	3.52	($389)
#10 Billed DRG	Renal failure	55	4.69	($117)	Cardiac arrhythmia & Conduction disorders	77	2.39	$333

**Source: www.ahd.com*

CREATING A HOSPITAL ACTION PLAN:

Skilled nursing providers will need to assess local hospital statistics and review the DRG discharge-related data in order to identify those hospitals that may benefit from specific short-term rehabilitative programs in a skilled nursing setting. Moreover, it is also important to assess relevant qualitative factors related to each hospital, such as hospital reputation, quality of care, status of ACO development, other providers (especially SNFs) already in the hospital network, travel distance to facility, geographic barriers, and socio-economic factors.

Skilled nursing providers should consider developing a hospital action plan to help them prioritize the tasks associated with developing a successful hospital partnership. An action plan should address the following key items:

- Identified hospitals for preferred partnership
- Defined skilled nursing provider value proposition
- Sub-acute care specialties, such as a cardiopulmonary program and return to home program
- Primary care physician integration
- Hospital discharge planning engagement
- Outreach marketing.
- Clinical quality outcomes
- CQRC
- Employee development and training
- IT integration
- Care coordination
- Care pathways
- Defined roles within leadership, including administration, marketing, nurse management, charge nurse, infection control, staff development and social services
- Establishment of accountability for each strategic initiative
- Timeframe for completion

After an established hospital partnership action plan is completed, skilled nursing providers should consider integrating the action plan into the organization's overall strategic plan. This helps ensure that the whole organization, and not just the skilled nursing facility, is focused on the action plan. Building consensus, embracing collaboration, and achieving organization-wide support for the hospital partnership is integral to the overall success of the action plan.

PRESENTING YOUR VALUE PROPOSITION

After creating a hospital action plan, skilled nursing providers should develop a presentation to their target hospital constituency. Historically, skilled nursing providers may have met only with the hospital discharge planning department in order to generate increased patient referrals. As competition within the long-term care market continues to increase, those skilled

nursing facilities seeking collaborative hospital partners must consider expanding their audience to those hospital stakeholders that refer patients to post-acute providers. Those stakeholders include utilization review, clinical quality improvement and behavioral health and social services departments, as well as hospital executives (CEO, CFO, COO, CNO and CQO) and the physician chair responsible for the hospitalist department. Creating presentations illustrating the skilled care programs and services catering to specific hospital stakeholders will allow SNF providers to successfully persuade those individuals who have the most influence in discharging patients to post-acute care providers.

A value proposition presentation should include the following components:

- Description of the skilled nursing provider and service offerings
- Current hospital discharge and referral data
- Explanation of how a SNF/Hospital partnership can benefit the hospital in addressing average length of stay and re-admission issues
- Description of the SNF's clinical service programs, such as cardio-pulmonary, rehabilitation and stroke programs
- Quantitative evidence of clinical outcomes
- Qualitative factors such as private suites, 7-day rehabilitation offerings, and hospitality and dining service programs
- Current hospital re-admission rates
- Short-term rehabilitation resident satisfaction results
- Staffing ratios
- Employee training programs
- Relevant technology and equipment capabilities

CONCLUSION:

The unsustainable economics of the current U.S. health care system provided the catalyst for health care reform. As a result, all healthcare providers will need to collaborate on overall population health care management through: improving/maintaining quality outcomes, focusing on preventative care, eliminating duplication/waste, reducing hospital re-admissions, and improving the overall coordination of care. Skilled nursing providers will continue to see reductions in reimbursement and increased competition, and will be challenged to deliver high-quality care at the lowest cost. The speed of change within the post-acute environment will continue to increase. The new era of health care reform is here to stay. Those skilled nursing providers who begin the process of organizational readiness, measure and improve clinical outcomes data, understand local hospital discharge statistics, and establish working hospital partnerships, will be better prepared to survive within the new era of health care reform.

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