Robert Wood Johnson Foundation

LEAVITT PARTNERS

Defining High-Value Post-Acute Care Providers for ACO Partnerships

A leader's guide to potential partner assessment

As the health care industry moves toward population-based models of care, providers are seeking partnerships to help manage the continuum of services. Many will rely on existing partnerships while others will need to develop new relationships. The overall brief series is designed to give provider leadership guidance on how to begin that evaluation process in a time when performance data is scarce. This brief looks particularly at post-acute care providers and the specific considerations that should be included in a qualitative assessment of a potential post-acute care partner.

AN ESSENTIAL PARTNER

By virtue of the large portion of the care spectrum they cover,[1] post-acute care (PAC) providers are indispensable partners in accountable care. Consequently, these providers also account for much of the expenditures[2] and are frequently the stewards of the highest cost patients, especially those in their last years of life. For patients recovering from acute or chronic illness, PAC providers represent the most common and consistent touchpoint from the long-term care hospital to skilled nursing facility (SNF) to home health care.[3]

OPPORTUNITIES FOR POST-ACUTE CARE IN AN ACO

PAC providers cover so much of the care spectrum that an effective partner can have a disproportionately beneficial effect on costs and quality of patient care. An ACO's care management efforts for the highest cost patients are most effective when intervention strategies can be carried out directly in all settings, especially those included under the post-acute care category.[4] If partnered with effectively, PAC providers can maximize their value to an ACO by enabling smooth care transitions and supporting an ACO's effort to move patients to the most appropriate and lowest cost PAC setting[5] (for example, when to safely move a patient from a SNF to home health care). A good PAC partner will work with primary and acute care providers to design and follow an effective care plan. As part of that plan, PAC providers can continue complex care management post-discharge, improving outcomes, and significantly reducing the likelihood of hospital readmissions.[6,7]

EVALUTATING POST-ACUTE CARE PROVIDERS

The PAC industry is unique in that it encompasses a large variety of provider types[3] at differing levels of consolidation whose degree of infrastructure sophistication and health reform acumen vary greatly. Therefore, evaluations will have to take into account several degrees of readiness and adjust the PAC partnership strategy accordingly.[1] Because accountable care partnerships with PAC providers are fairly new,[8] an ACO may have to develop its own partnership approach and would therefore find the greatest value in a PAC provider who conveys new ideas and an openness to experimentation. Additionally, individual market developments will have determined what services specific PAC providers cover[9] and the ACO may have to experiment with different combinations to cover the PAC spectrum of care.

The following page includes a table with a list of suggested high-value indicators (or characteristics) along with potential questions for the evaluating provider to consider. Given the various provider types included within the PAC industry, the table's characteristics and associated criteria include a mix of setting-specific and overarching factors.

EXAMPLE HIGH-VALUE ATTRIBUTES

- **Recognizes the pivotal role of post-acute care in health reform**
- **Places patients and caregivers at the center of the care team**
- **Welcomes the influence and presence of the ACO in their daily operations**
- **Exhibits thoughtful attention and commitment to transitions of care**

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RESEARCH METHODOLOGY

Research findings represent an 18-month project which included: (1) Literature review of resources discussing high value in health care; (2) Expert panel meeting with 13 leaders from a variety of health care sectors to establish high-value domains and provider categories; (3) Interviews with ACOs and provider associations to field-test high-value criteria; and, (4) Transcript coding and qualitative analysis of interview findings.

"Post-acute care provider" definition: A provider who delivers services to patients after, or in some cases instead of, a stay in an acute care hospital. Depending on the intensity of care the patient requires, treatment may include a stay in a facility, ongoing outpatient therapy, or care provided at home.

Example settings:
- Long-term care hospital
- Skilled nursing facility
- Inpatient rehabilitation facility
- Home health agency
- Hospice

1. The Right Care for the Right Cost: Post-Acute Care and the Triple Aim; Leavitt Partners. **2.** Large Increases in Spending on Post-Acute Care in Medicare Point to the Potential for Cost Savings in these Settings; Health Affairs. **3.** The Long-Term and Post-Acute Care Continuum; W V Med J. **4.** The Role of Post-Acute Care in New Delivery Models; AHA TrendWatch. **5.** The Importance of Transitional Care in Achieving Health Reform; Health Affairs. **6.** After Hospitalization: A Dartmouth Atlas Report on Post-Acute Care for Medicare Beneficiaries; Dartmouth Atlas. **7.** Bridging Acute and Post-Acute Care; HFMA. **8.** Accountability Across the Continuum: The Participation of Postacute Care Providers in Accountable Care Organizations; Health Services Research. **9.** Examining Post-Acute Care Relationships in an Integrated Hospital System: Final Report; ASPE

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HV DOMAIN	CHARACTERISTIC/ABILITIES	POTENTIAL CRITERIA
 Patient-centeredness	Prioritizes the patient and caregiver experience	• Do they thoughtfully assess and incorporate patient-centered goals in care planning? • Does the patient care environment foster personal dignity, privacy, and autonomy? • How friendly and attentive is the care staff? How does the facility smell?
	Enables ready access for hospitals' patient discharges	• Where are they located in relation to the ACO's hospitals? Do ACO-aligned patients already engage with this provider? • Do they allow admissions 24/7? Are they able to start home care within 24 hours of hospital discharge?
 High Value Culture	Recognizes the pivotal role of post-acute care in health reform and demonstrates an organizational commitment to value-based care	• Does their leadership view value-based care as an opportunity or a threat? • Have they already made efforts to adapt to value? • Do both leadership and staff feel ownership of their organization's transition to value?
	Seeks to move patients to the appropriate setting at the appropriate time	• What does the data suggest (e.g., average LOS)? • Do they have connections with home health and hospice services? • Do they provide rehabilitation therapies to help patients be successfully discharged home and improve functional status?
	Acknowledges and seeks to lead in value-oriented competition	• Do their strategies for obtaining referrals reflect a commitment to high-value care (e.g., clinical outcome-focused vs. marketing-focused)?
	Demonstrates innovative thinking to solve PAC industry problems	• Do they have data-driven processes for prioritizing limited financial resources? • How do they plan to manage the clinical and financial burdens of caring for increasingly complex patients? • What is their staff turnover rate?
 System & Public Accountability	Exhibits thoughtful attention and commitment to transitions of care	• What documents do they send to the ED physician/hospital with each transfer (e.g., INTERACT forms)? • Do they leverage the help of community and social services for patients who may need additional support post-discharge (e.g., housing, transportation, meal prep)?
	Welcomes the influence and presence of the ACO in their daily operations	• Are they willing to have an ACO physician round in their facility on a daily basis? • Are they willing to integrate care managers and other ACO staff into their care teams? • Are they willing to track, report, and ultimately be accountable for ACO quality metrics?
	Willing to collaborate with other ACO providers to establish joint goals and protocols	• Do they currently adhere to the care goals set by other hospital partners? • Are they willing to meet regularly with the ACO to discuss opportunities for improvement (e.g., readmissions, LOS, adverse events)?
 Team Based Care	Utilizes tools and protocols to improve communication within the facility and with outside providers	• Do clinical staff follow careful protocols for communicating changes in condition? • Do they have telephonic communication between the hospitalist and PAC physicians during the hospital discharge process, and between the nurse managers of the hospital unit and PAC?
	Enhances care coordination through partnerships with support services	• Do they work with medical equipment specialists to ensure appropriate selection and adjustment of DME (e.g., home oxygen)? • Do they work with post-acute pharmacists (e.g., long-term care, home infusion, or specialty pharmacy) to perform medication reconciliation and consulting services?
	Facility and care teams are adequately and appropriately staffed	• Do they have physician oversight with daily on-site coverage by advanced practice nurses and weekly visits by a primary care provider? • Do they have 24/7 RN care providers and an adequate RN to patient ratio? • Is home-based care management staffed with social workers?
 HIT Systems	Regularly collects data on clinical quality, utilization, functional and experience	• Do they have an EHR? Do they enforce timely inclusion of paper documents? • Do they track their own costs (e.g., especially important for bundled payments)? • Do they track and analyze the source of their referrals?
	Actively seeks to exchange clinical data with care partners	• Have they enabled cross-setting linkages for the EHR? • Do they have access to a regional or state HIE?
	Creatively leverages HIT tools to enable care coordination and other improvements	• Does their use of technology demonstrate creative problem-solving (e.g., identifying high-risk patients, secure direct messaging from PAC to hospital ED, registry of patient wishes, remote monitoring for high-risk home care patients)?
 Performance Improvement	Demonstrates organizational committed to ongoing performance improvement	• Can they show evidence of past improvement initiatives that were successful? • Do they involve all levels of staff in improvement planning (e.g., regular performance assessments with administrator, director of nursing, social worker and unit manager)?
	Quality approach goes beyond quality assurance (QA) to include continuous quality improvement (QI)	• How have they used the Plan-Do-Study-Act (PDSA) model for systematic improvements? • Do they regularly conduct root cause analyses and study trends? • Have they established redundant systems that aren't reliant on human behavior?
 Financial Readiness	Open to non-FFS payment models	• Are they willing to assume some level of financial risk for certain metrics (e.g., avoidable readmissions, failed discharge goals)?
	Willing to invest in long-term population health management over immediate financial returns	• Are they financially prepared to decrease lengths of stay? LOS • Are they prepared to pay-in to a performance-based bonus pool for the ACO's PAC provider network?