The Advisory Board Company | Post-Acute Care Collaborative

Membership Resource Guide

An Overview of Frequently Utilized Resources within the Post-Acute Care Collaborative – January 2016

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Best Practice Research

Acute/Post-Acute Collaboration

The Playbook for Hospital-Post-Acute Collaboration
Toolkit

This toolkit addresses the challenges of identifying and developing strong partnerships between acute and post-acute providers to create successful overarching alignment. It includes resources on partnership development from best practice guidance to data analysis to ready to use tools.

By using this toolkit, members will be supported across every one of the following stages of relationship development:

- Step 1: Gathering Information
- Step 2: Establishing Partnerships
- Step 3: Hardwiring the Relationship

Agenda for Hospital Outreach
Resource

This resource offers step-by-step guidance for post-acute and long-term care providers to clearly identify how their organizations' services and capabilities support hospital goals and form effective structures to facilitate partnership efforts.

By using this resource, members will learn:

- How to secure, conduct, and follow up on hospital partnership conversations
- What information to convey to hospitals and how to best position it

Ready-to-Use Presentations on Post-Acute Partnerships
Resource

This resource brings post-acute providers a series of ready-to-use presentations, complete with talking points and discussion recommendations, to help structure impactful conversations when trying to create health system/post-acute partnerships.

Topics include:

- The Value of Post-Acute Alignment
- Post-Acute Partnership Options for Health Systems

The Rationale for a Post-Acute Network
White Paper

This white paper explains the reasoning driving closer alignment with networks of post-acute provides, and provides strategic recommendations for building a successful network.

By reading this study, members will:

- Learn the relevant economic incentives guiding post-acute network formation
- Get ideas for forming or influencing the development of a successful network
- Be able to educate health care leaders regarding the importance of post-acute strategy

Acute/Post-Acute Collaboration

Hospital Scorecards for Post-Acute Care Providers
Customizable Templates

These briefings offer frameworks for optimizing scorecard use, as well as suggested metrics for different post-acute sectors to ensure identification of partners equipped to support accountable care goals.

A ready-to-use Excel version accompanies each scorecard briefing. Available templates include:

- SNF
- Home Health
- Hospice

Post-Acute Resources for Hospital Discharge Planners
Resource

This resource guide provides templates and sample resources to help discharge planners smooth post-acute referrals across five key areas. It includes templates for creating customized resources, expert advice on implementation, and case studies of successful use.

By using this resource, members will be able to:

- Support discharge planners and improve upstream processes that affect post-acute outcomes
- Collaborate with post-acute providers by customizing the included tools

Inside the Mind of the Hospital Discharge Planner
White Paper

This white paper provides guidance for post-acute providers on developing successful relationships with discharge planners.

By reading this study, members will gain access to:

- Insights into the roles and challenges of the discharge planning process
- Implementable strategies for effective collaboration
- Job descriptions, day-in-the-life summaries, and task overviews

Next-Generation Partnership Strategy
Strategies for Promoting Growth through Enhanced Alignment with Acute Care Providers –Webconference Part 1 & Part 2, or Publication Version

This two-part webconference and accompanying publication outline the case for improved acute/post-acute strategic alignment, provides 15 tactics to achieve superior care transition execution and development of joint quality and risk sharing initiatives, and explores the impact of the evolving health care environment on an historically competitive landscape.

By using this study, members will learn how to:

- Strengthen provider outreach messaging and organizational value proposition
- Reduce refer-to-admit time and ease care transition with key referrers
- Enhance clinical collaboration around targeted populations and specific performance initiatives
- Serve as a cost containment and care management partner

Acute/Post-Acute Collaboration

Hardwiring Cross-Provider Collaboration

Integrating Across the Full-Continuum – Webconference Part 1 (PDF) & Part 2 (PDF)

This two-part webconference examines the post-acute provider's need to integrate with entities beyond just the acute care hospital to drive referrals in modem, highly complex, and intertwined health systems.

By watching this presentation, members will learn how to:

- Enhance relationships with key referral partners including hospitals, physician groups, and payers
- Demonstrate clinical expertise and become a high-efficiency solution
- Strengthen core businesses
- Seek out new roles in the system to expand business opportunities

Strategies for Implementing and Managing a Hospital-PAC Affiliation Agreement

White Paper

This white paper examines the key considerations post-acute providers should keep in mind while forming affiliation agreements, which are non-financial commitments between post-acute care and acute care providers to collaborate on care transition improvement, adhere to a set of negotiated care standards, and fulfill information sharing requirements.

By reading this study, members will learn how to:

- Identify important legal questions and implementation considerations for constructing an affiliation agreement
- Maintain an awareness of patient choice requirements

Establishing Joint Operating Committees

White Paper

This white paper investigates the creation of Joint Operating Committees, the primary mechanism for fostering a successful affiliation between acute and post-acute providers and for developing goals to which both parties can be held accountable.

By reading this study, members will be able to:

- Take steps to establish a Joint Operating Committee
- Review case studies from organizations who have successfully implemented those steps

Managed Care Environment

Thriving Under Medicaid Managed Long-Term Care

Webconference

This webconference examines new incentives to equip seniors to live safely in the community rather than in a nursing facility and presents strategies for senor care providers to navigate shifts to managed Medicaid long-term services and support models.

By watching this presentation, members will learn how to:

- Implement strategies for alignment with MCOs
- Identify opportunities for program development
- Prepare for potential shifts in demand

Getting Noticed by Managed Care Payers: Strategies to Address Commoditization

Webconference (PDF)

This presentation highlights post-acute and long-term care providers' need to differentiate value or achieve scale to drive contracting efficiencies in an environment dominated by a managed fee-for-service model of care.

By watching this presentation, members will learn how to**:**

- Refine and scale their value to correspond with this model of care
- Form independent provider networks to achieve a scaled, noticeable impact for payers without pursuing a merger

Supporting the Integrated Primary Care Practice: Home and Senior Services' Roles in Payer Health Management Infrastructure

Webconference (PDF)

This presentation explores how providers can best position themselves for the shift in health care contracting toward the primary care office.

By watching this presentation, members will learn how to:

- Assume greater primary care responsibilities as senior living organizations
- Build stronger community-based linkages with primary care practices
- Refine home services for competitiveness under different risk models

Reacting to the Market's Network Ambition

Webconference

This presentation explores the market forces shaping the post-acute and long-term industry via the establishment of preferred provider networks.

By watching this presentation, members will learn:

- Underlying forces contributing to three types of networks
- Strategies to succeed in solving the challenge that underlies all networks: striking the balance between delivering high-quality and cost-efficient care

Leveraging Traditional Competencies to Meet Emerging Market Trends

White Paper

This white paper offers a guide for post-acute providers in creating a specialty line based on organizational strengths, as well as worksheets to help facility leadership through each stage of development.

By using this study, members will learn how to

- Identify organizational strengths
- Surface market priorities
- Map strengths to market needs
- Develop a service plan
- Secure referrer interest

Achieving Return on Specialty Investment

Study

This study presents a thorough explanation of ten tactics post-acute providers can use to build a strong clinical specialty with the potential to drive volumes, solidify partnerships with referrers and payers, and open access to new revenue.

By using this study, members will learn how to

- Maximize volume driven specialty reimbursement
- Strengthen the specialty's value-based appeal
- Leverage existing specialty expertise to access new revenue streams

The Independent Post-Acute Network Toolkit

Toolkit

This toolkit offers resources for start-to-finish guidance on how to develop, operate, and leverage post-acute networks to deliver low-cost, high-quality care.

Topics in this toolkit include:

- Independent Post-Acute Provider Network Overview
- Building an Independent Post-Acute Network
- Legal Considerations for Independent Post-Acute Networks
- Case Studies of Leading Independent Post-Acute Networks
- Independent Post-Acute Network Capabilities

Accountable Care Alignment Diagnostic

Tool

This tool offers guidance for discussions between post-acute providers and hospital executives regarding strategic partnership.

By using this tool, members should be prepared to:

- Analyze local markets for accountable care readiness at both the individual provider and market level

Sector-Specific Resources

LTACHs

Defining Your Place in the Market

How IRFs and LTACHs Can Drive Patient Capture Through Specialization - Webconference

This webconference discusses the potential of specializing in a specific clinical service as a means for IRFs and LTACHs to improve outcomes, define value, and differentiate themselves from competitors in their local markets.

By watching this presentation, members will be able to:

- Select and grow the right service lines
- Use data to facilitate decision making based on local market dynamics and organizational characteristics
- Review case studies from organizations who have successfully driven clinical specialization and patient capture

Specialization Decision Aid

Resource

This resource provides providers with a framework to assess organizational strengths and market realities in order to select and build clinical specialty lines that will help differentiate the LTACH from its competitors.

By using this worksheet, members will be able to:

- Understand the key market forces impacting their organization
- Identify the area of specialization with the greatest potential to increase patient capture

Trends in Long-Term Acute Care Hospitals

Webconference

This webconference explores the challenges facing LTACHs – such as addressing the rapid growth in chronic critical illness while grappling with intensifying national cost control – and LTACHs' potential as a strategic partner for high-quality, low-cost care delivery.

By watching this presentation, members will learn:

- The forces in the political and regulatory environment impacting LTACHs
- The demands being placed on LTACHs by payers and key referral partners
- Strategies to become a key solution within a broader health care system focused on cost and quality

IRFs

Defining Your Place in the Market

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Sector-Specific Resources

Specialization Decision Aid
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Trends in Post-Discharge Rehab Services
Webconference

This webconference highlights the importance of relationships between acute care hospitals and rehabilitation facilities. In particular, it focuses on the need for rehabilitation providers to achieve competitive differentiation through improved hospital coordination, increased staffing and care specialization, strategic technology investments, and hardwired outcomes tracking.

By watching this presentation, members will learn:
- Essential elements of a successful rehabilitation program
- Strategies for achieving competitive differentiation

Skilled Nursing Facilities

Understanding the Evolution of SNF Medicare Volumes
Webconference

This webconference examines the factors impacting SNF Medicare volumes, and explores strategies to adjust to the shifting payer mix. For many skilled nursing providers, long-term strategies will include embracing more medically complex patients and ensuring quality of care and outcomes for that population to sustain market share in a competitive environment.

By watching this presentation, members will learn:
- The factors impacting SNF Medicare volumes
- The demands SNFs must meet to thrive under value-based care
- Strategies to become a downstream, post-acute network solution

Exploring the SNFist Role and Options for Improving Staff Collaboration
Research Note

This research note examines the potential to improve the coordination of care across the continuum through the use of hospital employed or affiliated physicians providing care for patients post-discharge in a skilled nursing facility.

By reading this study, members will:
- Learn the operations and implications of a SNFist staffing model
- Explore alternative and supplementary models
- Be able to select the best option for supporting high quality, coordinated care

Sector-Specific Resources

Home Health

Home Health's Next Frontier: Complex Patient Management

Partnering with Medical Homes to Manage High-Risk Patients – White Paper

This white paper examines the transition of traditional primary care practices to the patient-centered medical home (PCMH) model—a team-based approach to primary care delivery emphasizing longitudinal patient care—and the emergence of accountable care organizations (ACOs), which assume total responsibility for patient health and cost, often leveraging the PCMH model as the cornerstone of their infrastructure.

By reading this study, members will be able to:

- Use existing core competencies to meet emerging physician group needs
- Identify the benefits a physician group partnership may hold for home health
- Understand why home health providers are poised to serve as complex patient managers
- Harness three opportunities to expand the role of home health and secure greater referrals and new revenue streams

Trends in Home Health

Webconference

This webconference provides a "state of the union" of general home health and demographic trends impacting provider relationships with particular emphasis on the role of home health within the broader health care industry.

During this webconference, members will learn:

- The rationale for a push towards home-based care
- Key home health agency operational and staffing priorities
- How to position home health in a value-based delivery system

Hospice and Palliative Care

Promoting Hospice Access in the SNF Setting

Toolkit

This toolkit presents resources to help nurse leaders empower frontline staff to take an active role in connecting patients with hospice care. It includes worksheets to connect with frontline staff, and links to external resources compiled by leading hospice organizations.

By using this study, members will learn how to:

- Make the case for hospice
- Teach staff to identify a potential need for hospice
- Encourage collaboration with onsite hospice teams

Expanding the Scope of End of Life Care

White Paper

This white paper examines the current hospice environment and highlights the possible benefits of using a concurrent care model.

By reading this study, members will explore:

- Key considerations for developing concurrent care services
- Models that peer institutions have adopted

Sector-Specific Resources

Realizing the Full Benefit of Palliative Care
Webconference

This webconference investigates the key issues causing hospital and health system CMOs to prioritize a comprehensive palliative care strategy.

By watching this presentation members will learn how to:
- Increase utilization and enhance physician executive roles in inpatient palliative care
- Growth-plan for palliative care, including prioritized utilization targets, tactics to increase referrals, levers to expand service capacity, and emerging models for cross-continuum programs

Implementing Decision Making Resources for Serious Illness
Webconference

This 60-minute presentation, jointly created with the Coalition to Transform Advanced Care, features findings from interviews with advanced illness experts in both creating and disseminating consumer resources for navigating advanced illness.

Topics include:
- A dual-population framework for building a resource dissemination strategy
- Best practices for distributing system-wide resources such as advanced directive toolkits
- Best practices for implementing resources to assist with goals of care conversations

Advanced Illness Care Models for Population Health
Webconference

In this 60-minute presentation Brad Stuart, MD and Khue Nguyen, PharmD from the Coalition to Transform Advanced Care explain the mechanics and benefits of their CMS Health Care Innovation Award winning model.

By watching this presentation, members will learn:
- The rationale for pursuing advanced illness care models and reimbursement considerations
- Best practices for forging and operating an advanced illness care model
- How to incorporate advanced illness care into a broader population health strategy

Senior Living

Senior Living Environments Focused on Resident Health
Six Must-Have Characteristics – Infographic

This infographic presents members with statistics, action steps, and the potential impacts of six characteristics that help cultivate senior living environments focused on resident health and well-being.

The six characteristics covered are:
- On-campus physician services
- Specialty environments for select resident populations
- Electronic information exchange
- A home-like clinical environment
- Health and wellness programming
- Strategic telehealth investments

Sector-Specific Resources

Conveying the Value of Assisted Living

Operational Guidance for Hospital Conversations – White Paper

This white paper explores assisted living providers' increasingly developed health care capabilities and desire to leverage those competencies to develop more productive relationships with hospitals.

By reading this study, members will learn how to:

- Determine what information assisted living providers should convey to hospitals
- Successfully convey that information
- Secure mutually beneficial relationships

Evaluating Primary Care Models for Senior Living Organizations

Strategies to Maximize the Impact of an On-Campus Clinic - Webconference

This webconference examines senior living organizations' challenge to both attract new residents and maximize care quality by testing models to expand primary care access in their communities.

By watching this presentation, members will learn how to:

- Evaluate potential on-campus primary care programs, either through external partnerships or practice ownership
- Match primary care programs to specific settings and designs

Forging Senior Living's Role in Integrated Health Networks

Webconference

This webconference highlights senior living organizations' capacity to play an important role within integrated health networks and presents several care quality and business development challenges.

By watching this presentation, members will learn how to:

- Maximize the time residents spend in senior living
- Reduce unnecessary hospitalizations and adverse health events
- Improve residents' experience and outcomes in the event of a hospitalization
- Grow clinician referrals to senior living
- Secure new real estate development opportunities within health networks

Bundled Payments

Quarterbacking the Post-Acute Episode: Key Capabilities for Bundled Payments and Engaging External Managers

Webconference (PDF)

This webconference provides a framework for post-acute providers to position their organizations as the "quarterback" of the post-acute episode offering tangible lessons to achieve success under bundled payment models.

By watching this presentation, members will learn how to:

- Identify the five capabilities providers must have to replicate the competencies of third-party managers
- Further differentiate themselves as the episode manager of choice

Frequently Asked Questions about Bundled Payments for Care Improvement

Expert Insight

This expert insight provides answers to commonly asked questions about the BPCI program to help members better understand the program and plan an effective strategy.

Topics include:

- An overview of the model including how reimbursements change in BPCI Model 3 and what a "retrospective payment" is
- Operational details such as how to apply and what services are covered
- Opportunities for post-acute providers including potential risks and benefits, and an explanation of "precedence rules"

Evaluating the Opportunity of BPCI Phase 2

Interactive Workbook

This interactive workbook examines how to successfully weigh the risks and benefits of each potential DRG transition from Phase 1 of BPCI to Phase 2.

By using this study, members will learn how to:

- Decide which DRGs are most likely to lead to financial gain
- Move forward if the data indicates that a positive financial outcome is unlikely

Navigating BPCI Model 3

Webconference

This webconference debunks four common misunderstandings about BPCI Model 3 and offers strategies for success in the program.

By watching this presentation, members will learn how providers succeeding in Model 3 have:

- Evaluated continued BPCI participation in light of ongoing organizational priorities
- Used BPCI participation to influence external market stakeholders
- Created solid upstream and downstream care management relationships
- Achieved buy-in from frontline staff and leadership alike

Frontline Clinical Staffing and Operations

Post-Acute Accountable Care Cheat Sheets
Cheat Sheets

Unprecedented changes to the post-acute care industry require frontline staff support. This series of health care cheat sheets summarize emerging concepts in delivery-system and payment reform and the implications for post-acute providers.

Topics include:
- Accountable care organizations
- Integrated delivery networks
- Medical homes
- Clinical integration

Post-Acute Industry Change 101
Infographic

This infographic presents the three major market forces impacting post-acute care in frontline friendly terms, providing insight into an industry in a state of flux and engaging staff in care transformation.

This poster explores the following topics:
- Tightening margins
- Rising patient acuity and complexity
- Increasing provider accountability for outcomes

What Your Frontline Staff Really Need to Know About Value-Based, Post-Acute Care
Webconference

This webconference and accompanying resources provide a deeper investigation into the necessity of engaging frontline staff during a time of constant organizational change and offers frontline friendly explanations of the broader industry shifts. Included is an hour webinar for clinical managers and directors, a 30-minute webinar specifically for frontline staff, and a discussion guide to help leaders engage with frontline staff

By using these resources, members will be able to:
- Understand the challenges in driving frontline staff comprehension of and investment in organizational strategy
- Present frontline staff with the information they need to know about how post-acute care is changing and what that means for them

Care Coordination

Advancing Towards Population Management: Building the Post-Acute Care Management Network

Webconference (PDF) or Publication Version

This presentation and accompanying publication highlight ten tactics post-acute providers can use to independently create meaningful, sustainable care management investments that support the overall Triple Aim goals across an episode of care.

By using this study, members will learn how to:

- Identify opportunities to use care management capabilities to differentiate themselves
- Harness six methods of delivering efficient, high quality care
- Address gaps in routine care following the end of an episode

Enhancing Medication Management Practices for High-Complexity Regimens

White Paper

This white paper examines the importance of properly managing complex medication regimens while providing care for older patients in order to maintain patient health, eliminate inappropriate medications, satisfy legal obligations, avoid readmissions, and ensure full reimbursement for care.

By reading this study, members will learn how to:

- Increase the frequency and accuracy of medication reconciliation post discharge
- Limit antipsychotic use within post-acute facilities

Managing Dementia Patients across the Care Continuum

White Paper

This white paper explores the strategies acute and post-acute care leaders are undertaking to improve memory care and overall management of patients with dementia in all care settings.

By reading this study, members will learn:

- Strategies for optimal care and transitional patient management
- Key staffing considerations and impacts of environmental design

Data and Analytics

Calculators/ Forecasters

Care Transitions Mapping Tool:
This tool offers insights on patient movement between acute and post-acute providers within 30-days of discharge from the acute care setting, including readmissions performance.

By using this tool, members will be able to understand:
- Post-discharge relationships between acute and post-acute care partners
- How these relationships impact coordination
- Where there are opportunities to forge new partnerships to improve outcomes and reduce cost of care

The All-Site Readmissions Mapping Tool:
This tool offers visibility into where a hospital's patients seek care if they are readmitted within 30 days post-discharge, whether at the original facility or a different acute care provider.

By using this tool, members will be able to:
- Generate a complete picture of readmission patterns
- Understand network integrity for patients under risk arrangements

Inpatient Market Estimator:
This tool generates estimates of Inpatient volumes for any set of US zip codes or counties.

By using this tool, members will be able to:
- Analyze inpatient market data
- Understand inpatient service trends

Outpatient Market Estimator:
This tool generates estimates of outpatient services for any set of US zip codes or counties.

By using this tool, members will be able to:
- Analyze outpatient market data
- Understand outpatient service trends

Post-Acute Medicare Market Share Assessment:
This assessment provides an organization-specific breakdown of an owned facility's share of the skilled nursing, home health, and hospice markets by state and country.

By using this tool, members will be able to:
- Identify market share for Medicare claims and payments by Clinical Classification Levels and trend data for multiple years
- Locate opportunities for strategic growth

The Hospital Performance Profiler:
This tool provides users with hospital-specific comparisons across a wide range of metrics.

By using this tool, members will be able to:
- Identify potential partners and better align their own core competencies
- Target opportunities for improvement of patient care and more cost-effective administration of the Medicare program

Care Pathway Profiler:
This assessment provides details on where patients go next for health services after being discharged from a hospital or post-acute facility.

By using this tool, members will be able to:

- View their patient care transitions by type including: hospital to hospital, PAC to hospital, hospital to PAC, and PAC to PAC

SNF Benchmark Generator:

The SNF Benchmark Generator is a web-based tool that allows skilled nursing facilities to assess how their performance stacks up against peers' across an array of financial and utilization benchmarks. Users can custom-select a narrow cohort of facilities that make the most sense to compare benchmarks against.

By using this tool, members will be able to:

- Highlight areas of high performance to refers and payers
- Identify opportunities for performance improvement

Episodic Cost Profiler:

This tool analyzes average Medicare spending by condition and site of service. This tool produces average Medicare spending by condition and site of service for 30, 60, and 90 days after admission.

By using this tool, members will be able to:

- Identify average cost of care for specific situations, to aid in benchmarking

Chronic Condition Inpatient Estimator

This tool generates estimates of inpatient services for specific chronic conditions for any set of US ZIP codes or counties. This tool supports planning for chronic care services and their impact by producing volume estimates, estimated percentages of services attributable to patients with a given chronic condition by service line, sub-service line, or DRG.

By using this tool, members will be able to:

- Understand trends in chronic condition prevalence for specific markets
- Identify clinical areas for which to develop specialty lines or focus staff training

Inpatient Market Estimator

This tool generates estimates of inpatient volumes for any US zip code or county. The tool produces current, five-, and 10-year estimates of inpatients volumes, length of stay, and bed days for specific markets by service lines, sub-service lines, or individual MS-DRGs.

By using this tool, members will be able to:

- Understand trends in overall inpatient volumes for specific markets to aid in strategic plan development