HEALTHPRO® HERITAGE

ReDesigning Tomorrow TOGETHER

Census & Network Development

TOOLKIT 2020

Guidance for Skilled Nursing Leaders

Referral Source Partnerships + Clinical Programming
Market Analytics + Communication + Analytic Strategies
Useful Templates & Checklists

Updated May 2020

Overview: Census & Network Development

Ask a skilled nursing facility operator or owner what keeps them up at night. With national occupancy levels for Q4 2019 only at ~83.8%*, it's no surprise most owners & operators worry about unpredictable, downward trending census & fiscal sustainability. Fast forward to Q1 2020, and the COVID-19 pandemic has gravely exacerbated census concerns. The impact of closures, elective surgery cancellations, and atypical/unpredictable hospital flow/surge has piled on an already pressure-tested SNF industry.

As the industry focuses on the future beyond our current public health emergency, consider the question: ***How can we ReDesign Tomorrow Together***? HealthPRO Heritage's response: Drive extraordinary outcomes by leveraging data analytics, competitive market analysis & build meaningful partnerships with multiple referral sources (hospitals, payers, physician groups, downstream providers, etc.)

Now is the time for SNFs to *Go Big or Go Home*. It is an opportunity for savvy SNFs to redesign a community's worth amidst a new world that rewards critical care and value based programming. As the country reboots in the wake of COVID-19, consider the advantages of evolving services & upgrading clinical competencies...STARTING TODAY!

HealthPRO Heritage offers support: The Census Development Toolkit. Proven strategies + meaningful tools + an innovative way forward to help operators/owners to custom design a robust census & network development paradigm.

The Toolkit can serve as the cornerstone of your successful network development strategy. The approach described is simple, yet sophisticated as it offers resources and specific guidance for leveraging data to inform & shape discussions with network partners. Recommendations for actionable internal care redesign + the importance of defining performance expectations and analyzing/tracking metrics to leverage success are included herein. Likewise, tactical resources (such as checklists, talking points and templates) are offered for the reader's convenience as well.

Strategic & Tactical Ground Rules: For Today's Healthcare Leaders

Do:	Don't:
Use data to drive decision making & collaboration	Market programs without supporting data/info
Collaborate with partners to build networks: upstream & downstream	Initiate specialty niche programs without hospitals' feedback or first identifying needs
Use specific success stories & patient case studies to target specific referral sources	Compile success stories without identifying the target referral source(s)
Understand & develop a well-honed talk track RE: what differentiates your community from peer providers who claim a similar value prop	Rely only on word of mouth marketing & patient satisfaction as census development strategy
Track, trend & share outcomes to support claims & marketable advantages	Assume upstream & downstream partners are aware of value proposition offered by your community
Leverage grass roots marketing + patient satisfaction as an **adjunct** to network development	Rely only on hospitals as a primary stream of referrals
Diversify referral sources (including *downstream partners, primary care physicians, Medicare Advantage, word of mouth, conveners (BPCIA/MSSP))*	Forget to add a personal touch to referral & case management processes
Assess data continually to determine whether census development strategy is effective	Take short-cuts to building partnerships. Trust & credibility require SNF providers to be consistent, pro-active communicators!

Inspire Confidence!

Leverage a Solid Communication Strategy Amidst the COVID-19 Pandemic

Healthcare leaders must have a specific communication strategy & well-defined talking points that address how their community is managing issues related to COVID-19. After all, how providers manage during this time of crisis will have far-reaching impact for residents, patients, families, staff, and the broader community. Having a solid communication plan in place will assure an organized response and will effectively reduce confusion, build trust, and – most importantly – keep everyone safe. HealthPRO® Heritage shares this **Communication ToolKit** created by public relations specialists with deep experience in the healthcare industry: **Jarrad, Inc.** Included in the **Communication ToolKit** is the following:

- Guidance for training of your frontline staff and designated spokesperson(s)
- Recommended language for media statements, talking points, memos, and Frequently Asked Questions (FAQs)
- Direction for implementing escalation processes

Whether a community has chosen to close down to all admissions -- or new and returning patients are being accepted – SNF providers must inspire confidence amongst their community's stakeholders with clearly defined messaging. Ultimately, a provider's ability to communicate important changes in policies, procedures and preparedness plans will be key to building/maintaining network relationships over time.

Depending on your community's response scenario (which may change), talking points must be clearly and thoroughly communicated as follows:

Your Current COVID-19 Response Scenario	Strategy & Talking Points Delivered to Multiple Stakeholders	Optimize All Communication Platforms
Preparation for COVID-19	Caregivers State & Local Officials Residents Hospital Partners/Payers Downstream Partners: Home Health, Senior Living Communities, Primary Care Physicians	Virtual Hospital Meetings; Social Media; Website Review with each resident Collaboration with payers & case managers
Active COVID -19 Outbreak Cases		Notification to state & federal as indicated; Memos & regular updates for families/residents; Virtual Town Hall meetings
Becoming a COVID-19 Response Site		Memos & regular updates to all partners; Memos & regular updates to residents/families; Virtual town hall meetings; Website and Social Media; Regular updates to clinical capabilities checklist; Collaboration with payers & case Managers
Closing to NEW Admissions		Notifications via memo to residents/families RE: what this may mean if a resident is discharged; Communication to downstream hospitals and payers & partners
Closing to NEW & Re-admissions		
Enhanced Trainings + Changes in Clinical Capabilities & Competencies	Hospital Partners/Payers Downstream Partners: Home Health, Senior Living Communities, Primary Care Physicians	Website updates; Payer & hospital meetings &/or memos with updated clinical capabilities listing; Social Media

A Unique Strategy for TODAY & Beyond! Downstream Partners As Referral Sources

Amidst the COVID-19 pandemic, multiple opportunities exist for savvy SNF providers to consider the 'Big Picture' and focus on one of the important overall goals for the PAC industry: To provide the right care, at the right time, and at the right place.

SNFs focused on solutions and strategies to flatten the curve, prevent surge capacity at hospitals and consider downstream providers will be seen as regional leaders with a progressive approach to care delivery and long-term partnerships.

In fact, the time is now amidst the COVID-19 crisis for post-acute providers to think outside the box. Consider the opportunity to leverage CMS's extension of 1135 Blanket Waiver (that waives the 3-day hospital stay and 60-day wellness break requirements) during the declared COVID-19 public health emergency.

With the waiver in place at least through July 25, 2020, post-acute providers are in a unique position to communicate with industry partners (and to the Federal government) about how these waivers are in aiding to slow the transmission of the disease and improve overall population health.

Many hopeful that these waivers in place beyond July 25 (or possibly becoming a long-term solution in the post-acute spending conundrum). As such, it is imperative for forward-thinking SNFs to:

- Use the waivers proactively and responsibly to prevent hospital surges that will keep acute beds available for critically ill patients. (Note: SNF providers are encouraged to utilize the waivers not only with COVID-19 patients.)
- Break down silos by having strategic conversations with various downstream partners to educate them RE: current waivers in place surrounding the COVID-19 pandemic and how partnerships can best serve patients and collectively help "flatten the curve."

For example, home health providers will appreciate knowing that **any** patient under their care (regardless of where the patient was previous to their home health admission) can be directly admitted to a SNF as long as they meet skilled care criteria (as outlined in Ch. 8 of the Medicare Benefit Policy Manual.)

Also, freestanding AL or IL communities can benefit from SNF partnerships if they struggle to care for residents with COVID-19 or other complex medical changes. Senior living communities would appreciate being able to rely on SNF partners rather than risk having residents be admitted for a hospital stay.

Likewise, SNFs can collaborate with outpatient physician clinics to alert them to the waivers in place that will allow for patients to be directly admitted to SNF communities. With challenges surrounding well-visits and doctors trying to navigate new integration of technology (e.g.: telehealth), SNFs can provide a solution for those patients with acute exacerbations of chronic conditions, positive COVID-19 tests, change in ability to care for themselves. In many situations, it will make good sense to admit at risk patients for a short-stay in a skilled facility to prevent potential decline that could lead to a hospitalization.

Create a Niche Clinical Program to Drive Census

Many SNFs struggle with the question of whether -- by developing a clinical specialty program or niche program – they can drive admission rates. Initial steps to vetting this growth strategy involves five key factors:

- **Data & Market Analytics**
  SNF providers are often unsuccessful when they create specialty, niche programming without analyzing metrics and analyses to assess potential need, available volume. In turn, the data must be used to leverage meetings and/or ongoing dialogue with referral sources. Please see pp. 10-12 for specific tips related to mining and leveraging analytics.

- **Collaboration with Referral Source(s)**
  SNF providers must to verify whether the clinical specialty addresses a 'pain point' or unquestionably fills partners' needs. While the data serves to shape these collaborative discussions, SNFs must be certain that niche programs will be perceived as solutions by referral sources.

- **Competitive Intel**
  Be certain about what specialty programs offered or in planning by peer facilities. For example, if a competitor has market share with their own well-established CHF program, understand that offering the same niche program will require extraordinary effort and investment to create an exemplary service to steal away referrals. Consider program ideas that are not already in place within the local network and have been identified as valuable ideas by referral sources.

- **Care Design & Operations**
  Deciding to build a niche program is exciting, but requires several decisions to be made related to elements that differentiate services from competitors such as:
  - Program design
  - Processes from pre-admission to post-discharge
  - Outcomes to track, trend and assure quality

- **Be Creative & Think Outside the Box**
  While many providers recognize niche programming that covers a specific diagnostic category as a common approach, others are considering creative strategies to differentiate specialized care delivery. For example, Aetna partners have joined a "Floor to SNF" program where SNFs accept acute patients directly and easily from the Emergency Department with a fast-tracked physician assessment upon admission and a specific set of communication and process strategies. Data is collected for each post-acute provider in the program and shared with all participants monthly.

Data Collection & Analytics + Hospital & Payer Collaboration

Metrics and competitive intel will serve to jump-start discussions with potential referral sources about clinical niche programs. Four examples of common data sets are provided/discussed here.

Example 1: DRG Data

BPCI Bundle	Volume	Hospital ALOS	County ALOS	State ALOS	Hospital Average Payment	County Average Payment	State Average Payment	Hospital 30-Day RR	County 30-Day RR	State 30-Day RR	Hospital 90-Day RR	County 90-Day RR	State 90-Day RR
Simple pneumonia and respiratory infections	177	4.2	4.2	4.3	$5,455	$5,455	$7,464	12.0%	12.0%	17.9%	24.7%	24.7%	32.3%
Major joint replacement of the lower extremity	172	1.6	1.6	2.3	$10,357	$10,357	$11,347	LT11	LT11	5.8%	LT11	LT11	11.0%
Sepsis	169	4.8	4.8	5.6	$9,354	$9,354	$11,523	15.0%	15.0%	19.6%	32.1%	32.1%	34.2%
Congestive heart failure	157	3.8	3.8	4.4	$5,870	$5,870	$7,394	20.9%	20.9%	24.7%	36.4%	36.4%	43.9%
Cardiac arrhythmia	98	2.6	2.6	2.9	$3,994	$3,994	$4,813	18.7%	18.7%	16.9%	32.4%	32.4%	30.0%
Chronic obstructive pulmonary disease, bronchitis/asthma	95	3.5	3.5	3.4	$5,186	$5,186	$5,934	LT11	LT11	19.2%	24.6%	24.6%	36.7%
Stroke	88	3.0	3.0	3.7	$5,631	$5,631	$7,744	16.4%	16.4%	13.7%	27.6%	27.6%	24.2%

What to Look For:

- Data identifies top Medicare A FFS diagnostic resource groups (DRGs) discharged from a referral source and the volume
- Identify higher than average (county or state) length of stay data (that shrinks hospital margins)
- Identify 30 and 90-day readmission rates by DRG. (In this example: a slightly higher than average rate for COPD & Stroke is illustrated.)

What to Ask:

- Talk with referral sources about whether metrics indicate the need for a solution (As with the above example, "Can a COPD or a Neuro clinical program -- that

assures high quality care/competencies – be a solution for your hospital?")

Example 2: Discharge Data

Care Setting	CY2018 Volume	% To Care Setting	TTM Q3 2019 Volume	% To Care Setting
Expired	52	2%	56	2%
HH	199	7%	237	8%
Hospice	187	7%	182	6%
IP	95	3%	101	4%
Patient Home	1,532	54%	1,582	55%
SNF	**763**	**27%**	**708**	**25%**
Other	4	0%	4	0%
	2,832	100%	2,870	100%

What to Look For:

- Review discharge volume from referral sources to SNF settings versus other post-acute care settings such as home health, which in many markets is trending down.

- Identify the total Medicare A FFS volume the hospital is discharging in total. Has there been a decline there as well, which may account for the decline in referrals.

What to Ask:

- Ask referral sources about trending volume to shape discussions about expectations, needs and satisfaction.
- Ensure that if you selected as a "preferred provider" or their "#1 partner", that all case management is onboard with this directive. Do not be afraid to have this conversation with your partner.

Example 3: Discharge Volume

Sender Name	Receiver Type	Receiver Name	CY2018 Volume	TTM Q3 2019 Volume	
HOSPITAL	SNF	SNF A	254	216	-15%
HOSPITAL	SNF	SNF B	19	13	-32%

What to Look For:

- In this example, SNF A's volume decreased by 15% from calendar year 2018 (12 months rolling data) to trailing twelve months ending in Q3 of 2019.

What to Ask:

- Is volume down due to service expectations, competition, and/or a change in patient population?

Example 4: The Market-specific "Competitive Scorecard"

Please refer to pp. 18-28 for more guidance on leveraging data from competitive scorecards. In the interim, please note, a competitive scorecard is a valuable tool to best understand the global perspective of a regional marketplace inclusive of:

- Total market's share
- Areas of SNF strength compared to peer facilities to leverage in discussions with referral sources
- Areas of opportunity for performance improvement to be more competitive
- Market share trending up or down. (See page 18-28 for more details related to reviewing sample scorecards.)

A Caveat for SNFs Regarding Niche Programs

As healthcare shifts from fee for service to more of a value based care model, SNFs must continue to evolve and be competent in several ways. A niche program can serve to supercharge collaborative partnerships and provide an opportunity to fortify a long-standing partnership. However, it does not replace the need to continue to admit critical and highly acute patients with a variety of diagnoses. Transitions are shifting and will continue to do so over time in post-acute. SNF skill sets and clinical capabilities need to continue to develop and evolve.

Key Takeaways from this section:

Use data to determine the market volume/need + Collaborate with referral sources to meet that need
Use data to hone the skill sets for process and program improvement
Use data to track & trend volumes and determine whether the programs are effective
Do NOT limit opportunity to just one referral source or area of expertise
Continue to evolve

The (New) Care Transition Coordinator Role Drives Triple Aim + Network Development

Some SNF providers are operating under a new model of care delivery focused on driving optimal outcomes and patient satisfaction from pre-admission to post-discharge. This Safe Transitions or Transitional Care Management Model is intended to better align with value-based care and to reduce cost,

A Care Transition Coordinator (CTC) facilitates the patient's transition from the acute care hospital discharge, throughout the SNF stay and during the patient's discharge to the next level of care (i.e.: home, senior living, long-term care, or home health).

Serving as a liaison to assist patients and family members to bridge levels of care, a CTC provides information, guidance and support to achieve optimal outcomes, assure patient/referral source satisfaction, enhance communication between the care team and patient, assure proper resources are in place, as well as reduce burden on IDT staff.

Moreover, the CTC can be extremely effective in maintaining consistent collaborative discussions with payers and referral sources and facilitating processes that lead to reduced rehospitalization rates, reduced length of stay, improved outcome scores and reduced cost. As such, investing in a CTC can be a smart strategy for SNFs focused on optimizing collaborative partnerships to drive census.

Basic requisites for the Care Transition Coordinator role are outlined below for SNF operators interested in hiring this key member of a successful IDT. This role may be an option for success in census & network development. It is recommended that you communicate with your hospital partners and understand their process and policies for introducing SNF providers at pre-admission to their patients.

Checklist for CTC Role Responsibilities

Soft hand-off at the acute-care setting and introduction to the patient and family
Risk assessment for re-hospitalization completed and set up for the IDT at the SNF level prior to admission
48-hour meeting with CTC leading to discuss to following: o Risk and interventions needed o Care planning o Discharge planning o Needs and barriers to a successful discharge o Caregiver capability, capacity & support level
Set up and completion of Health Literacy using the Teach back method for the patient and caregiver
Pain management
Ensure risk interventions are in place and working throughout the SNF stay
Communication and regular updates to the referral source and/or payer, patient and responsible party involved
Post-discharge: o Set up PCP visit and collaboration with PCP o Medication o Home and community based services o Set up and complete follow up calls post- discharge

Agenda Template for Initial Collaborative Meeting

Welcome & Introductions
Stated Goals for Today's Meeting
Data Analysis Review
Hospital or Payer Needs Analysis
Discussion Hospital or Payer Expectations
Post-Acute Provider Expectations
Role Provider Clinical Capabilities Review
Programmatic Solution Review: Process & Outcomes Takeaways
Schedule Next Meeting

Preparation Checklist for Meetings with Payers & Hospitals

Be prepared! Prior to meetings & discussions with referral sources (hospitals, payers, downstream providers, and physician groups), it's critical to anticipate and proactively address the expectations and needs to help fortify a strong partnership. To that end, HealthPRO Heritage offers the following Preparation Checklist:

Understand relevant market data inclusive of:

- Complete a Medicare A FFS analysis to review competition's performance (i.e.: market share, length of stay, readmission rates, episodic cost and five-star quality measures, staffing and health inspection, etc.)
- Data available from Medicare Advantage, such as :
  - Current scorecards for closed SNF cases
  - Benchmarks for within your SNF
  - Competitive (blinded) scorecards
- Review areas for potential improvement within your SNF
- Data from Medicare Provider Analysis and Review (MedPAR) to identify avoidable days and specific hospital or payer level data by diagnosis (DRG).

Be prepared to proactively:

- Articulate any solid plans for improvement and add to Quality Assurance Process Improvement (QAPI) Plan;
- Highlight higher than average performance metrics;
- Describe initiatives or rationale for why metrics are positive;
- Outline additional/future plans to maintain, or continue to improve performance outcomes (because benchmarks continue to move upwards);
- Discuss processes related to admission and referrals; transitions between the SNF to/from the hospital; safe transitions from the SNF to the next level of care, etc.

Be prepared to address:

Although perhaps counterintuitive, hospitals may balk at the proposed solution for high readmission rates. In a situation where the hospital Value Based Purchasing report indicates an unfavorable readmission rate for COPD, for example, and hospital is penalized by CMS for this, a savvy SNF partners may consider propose a clinical niche program specializing in COPD to reduce unnecessary readmissions. Situations do exist, however, where hospitals benefit financially from the readmission, because the DRG revenue payment outweighs the value based purchasing penalty.

Be an advocate & let your voice be heard:

Communicate SNF expectations in order to assure a mutually beneficial, long-term partnership. While the referral source needs are a priority, SNFs must continue to negotiate in their best interests and the best interests of the patients they serve.

Built trust and credibility by sharing details related to clinical competencies, staff training and clinical programming. (Often times, hospitals or payers do not feel comfortable with SNF in particular and tend to hold onto patients longer and then discharge directly home when able.) Do what's possible to increase the comfort level for all network partners.

Best practices to assure continued effective, consistent communication are outlined here:

- Recap key takeaways and goals of each interaction
- Review data points as often as possible
- Make a list of items that need additional vetting, discovery or better solutions,
- Agree on a well-defined list for follow-ups.
- Arrange for the next meeting to progress the partnership.
- Meet at least quarterly.
- Always follow up each interaction with written communication to express gratitude, outline key takeaways and list next steps.

Data Analysis Workshop:
How to Assess & Strategize Based on Hospital Scorecard

Example 1

SNF A in column 1 is in a favorable position with their upstream provider, receiving the highest volume of Medicare A Fee For Service (FFS) post-acute referrals at 216, or 31% of the market. Worth noting: SNF A also has largest bed capacity, and thus may have greatest availability; hospital is likely aware of this.

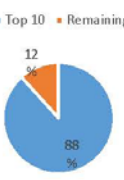
Please refer to pp. 19-22 for examples RE: developing actionable 'Work Plan' recommendations based on scorecard data interpretation. On page 28, please review list of suggested talking points with SNF A's referring hospital.

Hospital Score Card

HEALTHPRO HERITAGE

Info.	Hospital	BLANCHARD VALLEY HOSPITAL
	Data Period and Source	Advisory Board 2018 Q4 to 2019 Q3, Medicare FFS Claims Data
	Market	State of OH

Top 10 Market Competition	Rank by Hospital Volume	1	2	3	4	5	6	7	8	9	10	County* Benchmarks	Market Benchmarks
	Metrics	SNF A	SNF B	SNF C	SNF D	SNF E	SNF F	SNF G	SNF H	SNF I	SNF J		
	Admissions from Hospital	216	147	102	28	25	25	21	21	20	20		
	CMS Beds	136	120	99	114	50	128	74	72	52	20		
	Total SNF Volume %	31%	21%	14%	4%	4%	4%	3%	3%	3%	3%		
	Avg LOS	27.5	25.8	36.0	32.5	32.5	23.0	22.8	19.3	22.0	17.9	27.5	22.8
	30-Day Readmission Rate	19.4%	14.5%	Less than 11	Less than 11	Less than 11	Less than 11	Less than 11	Less than 11	Less than 11	Less than 11	15%	21%
	90-Day Readmission Rate	28.1%	33.3%	23.2%	Less than 11	Less than 11	Less than 11	Less than 11	Less than 11	Less than 11	Less than 11	30%	38%
	Avg Episodic Cost	$11,618	$10,611	$15,061	$11,167	$13,308	$9,198	$9,305	$6,974	$10,169	$7,516	$ 11,355	$ 9,710
	Notes	*"Less than 11" Values omitted per CMS' Data Use Agreement.*										*County HANCOCK	
		Facility Scores compare better or worse than market average (Green/Red).											



VBP	Rank	612	9,558	10,236	2,910	7,255	9,567	10,236	6,449	8,886	10,236
	Bonus / Penalty	2.92%	-1.91%	-1.97%	0.00%	-1.48%	-1.91%	-1.97%	-1.06%	-1.85%	-1.97%

CMS 5-Star Data	Category	SNF A	SNF B	SNF C	SNF D	SNF E	SNF F	SNF G	SNF H	SNF I	SNF J	OH State Avg	National Avg
	Overall	5	3	4	5	4	2	5	4	4	5	3.12	3.17
	Quality	5	3	5	5	5	3	5	2	5	5	3.89	3.70
	Quality-Short Stay	5	4	5	5	5	3	5	2	5	5	3.73	3.61
	Quality-Long Stay	5	2	4	5	4	2	5	2	5		3.92	3.68
	Health Inspection	3	2	3	4	3	2	4	4	3	4	2.80	2.82
	Staffing	4	4	2	3	3	3	2	3	2	4	2.46	2.91
	Average CMS Rating*	4.3	3.0	3.5	4.3	3.8	2.5	4.0	3.3	3.5	4.5		
	CMS Data File Date	*Apr-2020*	*Conditional Formatting compares Facility to State Averages*										

Average Length of Stay	
Observations	Slightly higher than competitors in market, but in line with market average
Considerations	This is tied to *Episodic Cost* and directly correlated to hospital readmission rates - if they were to trim back LOS, would this SNF be able to maintain, or improve, their hospital readmission rates? Is this Length of Stay (LOS) competitive enough to remain the #1 receiver of hospital referrals? How does this LOS compare to their Managed Care patients? LOS should not be driven by payer & needs to remain competitive enough to continue to claim space in market & networks
Work Plan Recommendations	Discovery and deep-dive of patient LOS sorted by patient type/diagnostic group Vet whether there is opportunity to implement Interdisciplinary Clinical Pathways to shorten LOS where appropriate without sacrificing care delivery &outcomes Implementation of HealthPRO-Heritage Safe Transitions program to ensure a smooth patient transition to next level of care when appropriate with emphasis on hospital readmission mitigation processes through interdisciplinary approaches to care delivery

30-Day Readmission Rate	
Observations	Despite slightly longer LOS than many others in market, 30-day readmission rate is unfavorable at 4% higher than market and 5% higher than second-highest volume SNF Not only does this impact SNF Value Based Purchasing, but this is of concern to hospital partners, as this is tied to their penalties and overall cost-management as well
Work Plan Recommendations	Implementation of Safe Transitions, with use of Discharge Readiness checklists and risk assessments Root Cause Analysis completed for each readmission to determine cause and if avoidable or unavoidable deep-dive review of downstream partnerships With an Average LOS of 27.5 days, one would suspect a lower 30 day RR- is this tied to our Home Health partners? How many Home Health partners are you currently utilizing? Suggestion would be to drill this down to 2 (possibly 3 in some markets) top providers that share your same initiatives, goals, and patient care philosophy Safe Transitions framework also contains resources on how to vet and sustain desirable Home Health partnerships Review publicly reported Home Health data at: medicare.gov/homehealthcompare Request specific data points that could be regularly shared with you from your Home Health Partners o Average turnaround time for Start of Care (SOC) o Staffing ratios of RN to LPN o Average readmission rates o Average LOS o Weekend availability for new SOC and adequate staffing for 7 day/week coverage o Ability to refer back to SNF in the instance that a patient is unable to safely remain in home

90-Day Readmission Rate	
Observations	Observation: This number is favorable compared to the market averages
Work Plan Recommendations	Instituting all 30 day readmission rate recommendations would have a significant impact on the 90 day readmission rates as well

Average Episodic Cost	
Observations	This figure is higher than the market average and as previously mentioned, can be tied to LOS, but comes directly from the claim submitted to CMS Is this because this SNF takes on a higher acuity individual? Could this be supported through PDPM CMIs and marketed to physicians and hospitals?
Work Plan Recommendations	Through above recommendations regarding LOS and readmission rates, determine if there is an opportunity to streamline care without sacrificing optimal outcomes (i.e. clinical pathways)

Value Based Purchasing Score	
Observations	SNF A has fared well in the second year of the program, with an incentive multiplier allowing them 2.92% back on their Medicare FFS revenues
Considerations	How will this SNF fare moving into year 3 & beyond of the program? Does this SNF know their benchmarks that they had to hit in order to maintain the incentive multiplier?

Star Ratings	
Observations	SNF A is in a very desirable spot with regard to CMS 5 Star Rating program
Considerations	This is something that should be marketed within their network to display the quality care being provided, particularly with regard to their nearest competitor (SNF B) There could be an opportunity to regain even greater market share with leveraging their quality measures, staffing ratio, and history of satisfactory survey results With that said, there is some opportunity to focus on where they may be able to make greatest impact with State Health Inspection results and ensure that all previously tagged items or deficiencies are on facility QAPI and are being proactively managed to mitigate any future findings HealthPRO-Heritage also offers support for Survey Preparedness and Infection Control

Data Analysis Workshop:
How to Assess & Strategize Based on Hospital Scorecard

Example 2

SNF B is also in a favorable position with their upstream provider, receiving the second greatest volume of Medicare A post-acute referrals at 147, or 21% of the market.

How can this SNF not only continue to stay in the top tier of PAC providers receiving greatest market share, but also reclaim some of the volume from SNF A?

Please refer to pp. 24-27 for examples RE: developing actionable 'Work Plan' recommendations based on scorecard data interpretation below. On page 28, please review list of suggested talking points with SNF B's referring hospital.

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HEALTHPRO HERITAGE

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	Market	State of OH											
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	CMS Beds	136	120	99	114	50	128	74	72	52	20		
	Total SNF Volume %	31%	21%	14%	4%	4%	4%	3%	3%	3%	3%		
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	30-Day Readmission Rate	19.4%	14.5%	Less than 11	Less than 11	Less than 11	Less than 11	Less than 11	Less than 11	Less than 11	Less than 11	15%	21%
	90-Day Readmission Rate	28.1%	33.3%	23.2%	Less than 11	Less than 11	Less than 11	Less than 11	Less than 11	Less than 11	Less than 11	30%	38%
	Avg Episodic Cost	$11,618	$10,611	$15,061	$11,167	$13,308	$9,198	$9,305	$6,974	$10,169	$7,516	$ 11,355	$ 9,710
	Notes	*"Less than 11" Values omitted per CMS' Data Use Agreement.*										*County HANCOCK	
		Facility Scores compare better or worse than market average (Green/Red).											
VBP	Rank	612	9,558	10,236	2,910	7,255	9,567	10,236	6,449	8,886	10,236		
	Bonus / Penalty	2.92%	-1.91%	-1.97%	0.00%	-1.48%	-1.91%	-1.97%	-1.06%	-1.85%	-1.97%		
CMS 5-Star Data	Category	SNF A	SNF B	SNF C	SNF D	SNF E	SNF F	SNF G	SNF H	SNF I	SNF J	OH State Avg	National Avg
	Overall	5	3	4	5	4	2	5	4	4	5	3.12	3.17
	Quality	5	3	5	5	5	3	5	2	5	5	3.89	3.70
	Quality-Short Stay	5	4	5	5	5	3	5	2	5	5	3.73	3.61
	Quality-Long Stay	5	2	4	5	4	2	5	2	5		3.92	3.68
	Health Inspection	3	2	3	4	3	2	4	4	3	4	2.80	2.82
	Staffing	4	4	2	3	3	3	2	3	2	4	2.46	2.91
	Average CMS Rating*	4.3	3.0	3.5	4.3	3.8	2.5	4.0	3.3	3.5	4.5		

Average Length of Stay	
Observations	Slightly lower than neighboring SNFs and county average. Is this LOS competitive enough to remain the #2 receiver of hospital referrals? How does this LOS compare to their Managed Care patients? Is there an opportunity to market this and the lower episodic cost to reclaim some of the market share from the #1 and #3 providers in market (SNF A and C)?
Work Plan Recommendations	Discovery and deep-dive of patient LOS sorted by patient type/diagnostic group Is there opportunity to implement Interdisciplinary Clinical Pathways to shorten LOS where appropriate without sacrificing care delivery and outcomes? Implementation of HealthPRO-Heritage Safe Transitions program to ensure a smooth patient transition to next level of care when appropriate with emphasis on hospital readmission mitigation processes through interdisciplinary approaches to care delivery

30-Day Readmission Rate	
Observations	Very favorable at 14.5% when compared to the #1 receiver of hospital referrals (SNF A= 19%) and also in line with market average at 15% Not only does this impact SNF Value Based Purchasing, but this is of concern to hospital partners, as this is tied to their penalties and overall cost-management as well We will discuss VBP in greater detail below, as this is an area of concern for this SNF
Work Plan Recommendations	Implementation of Safe Transitions, with use of Discharge Readiness checklists and Risk assessments, it would also be recommended to conduct the following: Root Cause Analysis completed for each readmission to determine cause and if avoidable or unavoidable Deep-dive review of downstream partnerships How many Home Health partners are you currently utilizing? Suggestion would be to drill this down to 2 (possibly 3 in some markets) top providers that share your same initiatives, goals, and patient care philosophy Safe Transitions framework also contains resources on how to vet and sustain desirable Home Health partnerships Review publicly reported Home Health data at: medicare.gov/homehealthcompare Request specific data points that could be regularly shared with you from your Home Health Partners o Average turnaround time for SOC o Staffing ratios of RN to LPN o Average readmission rates

90-Day Readmission Rate	
Observations	This number is unfavorable at 33%, being 3% higher than county average and 5% and 10% higher than SNF A and C, respectively
Work Plan Recommendations	Instituting all 30 day readmission rate recommendations would have a significant impact on the 90 day readmission rates as well, with particular focus on Home Health partnerships and an ability to participate in the continuum of care if patient's need OP services following discharge from Home Health

Average Episodic Cost	
Observations	SNF B is positioned favorably with their episodic cost $744 less than county average, and significantly less than SNF A and C
Work Plan Recommendations	This is something that the SNF can leverage in conversations with the hospital partners in area to assist with overall cost containment in post-acute setting and potentially gain additional market share from SNF A and C

Value Based Purchasing Score	
Observations	SNF B has not fared well in the second year of the program, with a multiplier < 1.0 and thus reducing their Medicare A FFS reimbursement by 1.91%.
Considerations	With a competitive 30 day readmission rate: How will this SNF fare moving into year 3 & beyond of the program? Does this SNF know their benchmarks that they had to hit in order to maintain the incentive multiplier? What is their 30 day readmission rate today and is there opportunity to implement some of the above recommendations (i.e. Root cause analysis, Safe transitions, HH partnership review) to positively impact future reimbursement through this program?

Star Ratings	
Observations	SNF B is in an unfavorable position with regard to CMS 5 Star Rating program
Considerations	RE: Quality Measures: Implement a formal process to complete Clinical Grand Rounds and ensure that all patient needs are being proactively met Review as a team which QMs impact 5 star rating For this facility, they should begin with their Long- stay Measures that impact star rating, since there is more opportunity for improvement here, as opposed to their Short-stay measures o High Risk/Unstageable Pressure Ulcer o Falls with Major Injury o Antipsychotic Meds o UTI o Catheter Insert/Left Bladder o Increased assistance with ADLs o Move independently worsens SNF B also has opportunity to focus on where they may be able to make greatest impact with State Health Inspection results and ensure that all previously tagged items or deficiencies are on facility QAPI plan and are being proactively managed to mitigate any future findings HealthPRO-Heritage also offers support for Survey Preparedness and Infection Control

Talking Points to Share with Referring Hospitals

- Begin conversation by expressing gratitude for the partnership and for having the second largest volume of their referrals

- Share objective, meaningful data that speaks to the quality care delivered:
  - LOS
  - Episodic Cost
  - Readmission Rates
  - Discharge destination: Home with home health, home with outpatient, home without services, hospice, etc.
  - Report on any specialty programs you/they participate in (BPCI-A, ACO, Specialty Niche Programs)
  - Patient outcomes
  - Star Rating with emphasis on staffing, survey, and quality measures

- Ask probing questions to determine how to expand the partnership. What would help to get more referrals in the future?

- Do they have difficulty placing a particular DRG?
  - Is their LOS too long for any specific DRGs?

- Is there anything that can be done to alleviate hospital pain points?

- What are hospital organizational goals or initiatives for the upcoming year?
  - This will provide additional insight of how to be a strategic partner downstream

- Share Clinical Capabilities and Staff Competencies surrounding patient care

- Share organizational initiatives or goals that would speak to hospital's needs and give the added confidence as a strategic partner. Include any organizational QAPI plans to improve CMS overall star rating as well.