OPTIMIZING THE VALUE OF SKILLED NURSING FACILITIES (SNFS) IN VALUE-BASED CARE:
INSIGHTS FOR HOSPITALS & HEALTH SYSTEMS

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INTRODUCTION

In an effort to increase care coordination and decrease health care costs across the care continuum, many health systems and hospitals are reconfiguring their relationship with post-acute care (PAC) providers. The momentum for change is driven in part from government-initiated efforts that hold hospitals and health systems responsible for the cost and quality of care delivered beyond the four walls of acute care. There has also been an increased interest in identifying the appropriate site of care and leveraging the benefits of each PAC setting.

Skilled Nursing Facilities (SNFs) play a critical role within the PAC environment and offer indispensable value in the care continuum. In order to better understand the role of SNFs, it is necessary to first understand the shift in payment models, the "acuity cascade" in which patients are transitioned more quickly from higher-level, higher-cost environments into lower-level, lower-cost care settings, and the benefit of SNFs in high-value networks. It is also important to evaluate tools and programs that SNFs offer and to consider potential dollar and percentage savings if health systems can work with SNFs to reduce costs. Health systems can optimize these benefits by collaborating more closely with SNFs to implement value-based care along the PAC continuum.

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HEALTH CARE TRANSFORMATION & THE ACUITY CASCADE

SHIFT IN PAYMENT MODELS

Hospitals and health systems find themselves in a rapidly changing Medicare and commercial payment environment. They are increasingly responsible for reducing costs and meeting complex quality standards, while caring for patients and populations with unique needs. Innovative initiatives—originating from the Center for Medicaid and Medicare Innovation (CMMI) and commercial payer early-adopters—are shifting how health systems approach revenue, risk, and quality incentives. Such programs include:

- Hospital-based value purchasing (HBVP);
- Hospital Readmissions Reduction Program (HRRP);
- Accountable Care Organization (ACO) models such as the Medicare Shared Savings Program and Next Generation ACO Model;
- Episode-based payment initiatives including the Bundled Payment for Care Improvement (BPCI) Initiative,

Table 1: Medicare Programs Affecting Hospital Revenue

	MEDICARE PROGRAM	% OF REVENUE RISK/ OPPORTUNITY	BEGIN	REVENUE AFFECTED	DIFFUSION
VALUE-BASED PURCHASING PROGRAMS	Hospital Acquired Conditions (HAC)	+0%/-6–8%	2008	Hospital DRGs from IPPS. Just downside risk, no upside	Nationwide
	Hospital Readmissions Reduction Program (HRRP)	+0%/-6–8%	2012		
	Hospital-Based Value Purchasing (HBVP)	+0%/-6–8%	2013		
HYBRID	Comprehensive Primary Care Plus (CPC+)	Partial FFS w/PBIP	2017	Primary Care Medicare Professional Fees	5,000 practices 14 regions
BUNDLES	Comprehensive Joint Replacement (CJR)	+/- 20%	2016	Hospital Medicare LEJR Revenue	67 MSAs*
	Bundled Payment for Care Improvement (BPCI)	+/- 20%	2013	Medicare revenue from up to 48 episodes	1500+ practices
	Oncology Care Management (OCM)	+/- 4%	2018	Medicare Chemotherapy Revenue	196 practices
LEGISLATION	Medicare Access & CHIP Reauthorization Act (MACRA)	+/- 4–9%	2017	Medicare Part B payment adjustment	Nationwide

Various payment models that incent collaboration and quality-based metrics.

*Metro Statistical Areas (MSAs)

Comprehensive Care for Joint Replacement (CJR) Model, and Oncology Care Model (OCM);

- Primary Care Transformation Models such as Comprehensive Primary Care Plus (CPC+); and
- New and emerging initiatives including the Surgical Hip and Femur Fracture Treatment (SHFFT) Model, and Cardiac Episode Models for CABG, AMI and Cardiac Rehabilitation.

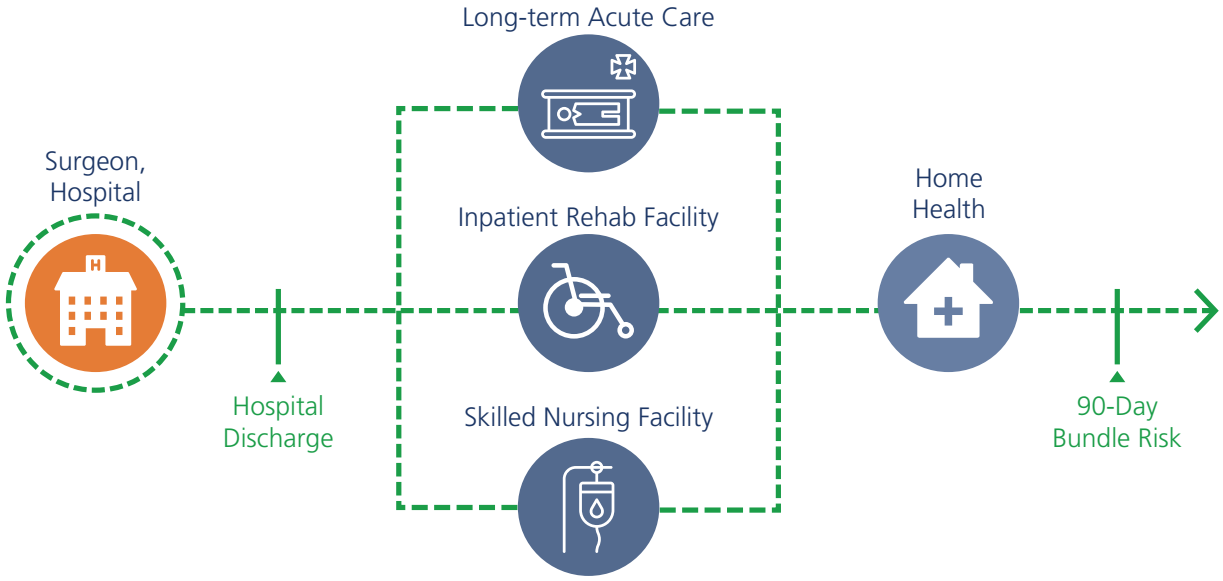
Additionally, the Medicare Access & CHIP Reauthorization Act (MACRA) ties clinician Medicare Part B payments to a value-based model.

Each payment model incents collaboration and quality-based metrics that possess varying up and downside revenue risk/reward potential. The Medicare Programs Affecting Hospital Revenue chart (below) organizes representative payment models into four groups and lists the incentives, timeline, and impact area.

Under these programs, hospitals and health systems are feeling pressure to reduce costs. Traditional hospital and physician revenue streams include ER and observation stays, procedural/surgical interventions, ICU and critical care provisions, and diagnostics. Many of these value-based payment models encourage hospitals and health systems to reduce traditional revenue streams in an effort to discourage low-value treatments.

THE ACUITY CASCADE & THE SNF VALUE PROPOSITION

One method hospitals use to reduce cost is to discharge patients more quickly, a reaction to the hospital DRG-based payment system. The resulting acuity cascade, in which patients are discharged quickly, can be a two-



In many value-based payment models, hospitals and health systems are at the center of financial responsibility for the patient's total cost of care or entire episode of care.

edged sword for hospitals. They are also responsible for the patient's outcome throughout the care cycle, instead of solely focusing on patient discharge plans. This compounded cost *and* care burden has caused hospitals and health systems to leverage downstream PAC providers, including SNFs, to provide high-value care.

As hospitals seek to discharge patients quickly while ensuring these patients continue to receive appropriate care, PAC providers assume more clinical risk as higher-acuity patients are transitioned sooner. Consequently, hospitals and health systems have started partnering with SNFs and other PAC providers to align, innovate, and effectively leverage each other—striving to achieve the triple aim in a high-stakes care environment.

Hospitals and health systems have taken different approaches to improve outcomes and decrease costs by leveraging partnerships with SNFs. However, another approach health systems have taken to decrease costs has been to skip SNF and other PAC providers altogether, discharging patients directly home or into ambulatory care settings. While this approach may reduce cost in the short-term, it can have a long-term effect on quality outcomes for patients that need more advanced care. The National Investment Center for Seniors Housing & Care (NIC) reported that SNF occupancy decreased from 85.5 percent in late 2012 to 82.9 percent in early 2016, with Medicare occupancy decreasing from 16.6 percent in early 2013 to 13.8 percent in early 2016.[1] Skipping SNFs may be appropriate for some patients, but can have dire consequences for high-acuity patients with complex needs.

A more effective, holistic approach is to work with SNFs and other PAC providers to examine the needs of a patient and leverage the right site of care. One patient may be able to leave the hospital and function independently to continue their care plan. Another patient may need additional nutritional, rehabilitative, or pharmacological support through a SNF or other PAC provider. By entering into collaborative relationships, health systems and SNFs can work together to make appropriate site-of-care decisions, synchronize treatment plans, and reduce costs.

SNF occupancy decreased from **85.5%** in late 2012 to **82.9%** in early 2016.

Features of SNFs that Can Improve Patient Quality

Therapy

Specialized Clinical Services

Medication Management

Social Support

Nutrition

ROLES & VALUE OF SNFS IN HIGH-VALUE NETWORKS

Collaborating with SNFs can help hospitals and health systems both **increase quality** as well as **improve the patient experience**. Each area is explored below.

SNFS CAN IMPROVE QUALITY OF CARE

SNFs can offer advanced and valuable in-house services to improve the quality of care and patient outcomes throughout the episode. SNF transitional care partnerships typically leverage these features:

Therapy

Gains patients make directly after hospitalization can have a longitudinal effect. Therapeutic resources available in SNFs—including physical therapists (PTs), occupational therapists (OTs), and speech-language pathologists (SLPs)—help patients return home with maximum function. These therapy benefits reduce the likelihood of readmission or clinical decline after discharge.

Features typical to SNFs utilizing advanced therapy programs include:

- In-house, employed therapy team members
- Day of admission evaluation and treatment
- Evidence-based therapy programs that maximize industry advancements and technology
- Intensive therapy as an alternative to higher-cost inpatient rehabilitation
- Electronic documentation, analytics, and evidence-based functional improvement measures (e.g. CARE Item Sets, FIM, LiveSafe)
- Structured gym environment, maximizing length of stay for improved function
- Coordinated handoff between hospital and SNF, synchronizing treatment plans
- Specialized training of PT/OT/SLPs in disease- and diagnosis-specific care pathways
- Deliberate coordination after the SNF stay, including therapy service home evaluation, and follow-on care providers (e.g. outpatient therapy, home health, palliative care services, family support, or ambulatory care management)
- Coordination for durable medical equipment, home adaptations, and equipment, including caregiver education
- Post-discharge episodic care services and episode management (e.g., follow-up phone calls, PCP and specialist engagement, pharmacy fill synchronization)

SNF therapy programs have historically maximized the length of stay to return the patient to full health and function. As health systems and SNFs work more collaboratively, they can leverage follow-on levels of care to transfer patients to the most appropriate, cost-effective site of care. This means efficiently managing the SNF length of stay and closely coordinating with outpatient and home health therapists to smoothly transition and continue the patient's progress.

Specialized Clinical Services

The acceleration of patient transitioning from higher-level, higher-cost environments into lower-level, lower-cost care settings creates an environment in which the recipient facility must shoulder the burden of additional ancillary, length of stay, cost of care, and clinical service provision.

This acuity cascade has created a clinical evolution in the SNF setting. With patients transitioning to SNFs following abbreviated hospital stays, many SNFs have developed advanced clinical specialties to care for a wide-range of patient needs. Hospitals can depend on these advanced clinical services when discharging high-acuity patients. By coordinating care between the hospital and SNF, these patients can continue to progress. Typical services include:

- IV Administration
- Complex wound care with on-site wound care providers and teams
- Vent/trach management and care, with a focus on weaning
- Specialized therapy programs (e.g. neuro-stroke, cardiac recovery, behavioral, lymphedema, evidence-based and advanced technologies)
- In-house dialysis
- Attending pulmonologists, intensivists, and extensivists specialized in SNF care
- Bronchoscopy, blood transfusion, and high-acuity observation
- Readmission prevention protocols, preventive and proactive change of condition management, and rapid response processes

Medication Management

A lack of consistency in medication management and medication reconciliation across care settings can significantly impact patient safety and patient care. Hospitals and health systems can coordinate with SNFs to manage medication to amplify patient gains, reduce episode costs, and reduce relapses (especially readmission). Involving all applicable clinicians in medication management helps stabilize the patient safely.

Features typical of SNFs with advanced medication management programs include:

- Oversight by a licensed pharmacist or Pharm D, improving safety especially during transfer between facilities[2]
- Medication reconciliation during hospital discharge, SNF admission, and SNF discharge
- Assessments:
  a. A pharmacy assessment reconciles the patient's pre-hospital medication regimen with the hospital and SNF regimen. Adjustments decrease risks of medication interactions, contraindications, and polypharmacy
  b. Clinicians conduct frequent pain assessments for rehabilitation patients, with patient complaints of pain being reported to a physician
- Medications administered by licensed clinicians
- Patient refusals are noted and reported to the physician and pharmacist
- Medication synchronization with therapy (physical, occupational) sessions

Many SNFs have formed community and pharmacy partnerships, and they work with fulfillment pharmacies to ensure the patient discharges with the necessary medications and prescriptions, avoiding the need to pick up medications after discharge. Additionally, SNFs with advanced medication reconciliation practices typically synchronize medication fill/refill with the patient's insurance and pharmacy. This coordination helps increase medication compliance by reducing the patient/family burden.

Social Supports

SNFs also typically have strong social support models that leverage family, community, and agency resources to continue their recovery. These resources can help connect patients with education and services they need to adhere to treatment plans, reduce hospital readmissions and continue progressing.

Features typical of SNFs with advanced social support programs include:

- Liaisons for patient and family/caregiver education prior to SNF admission who proactively address care considerations, clinical and psychosocial needs, and facilitate a smooth transition to SNF from the acute care setting, community, or primary care office.
- Oversight by a licensed clinical social worker who completes an initial psychosocial assessment, facilitates discussions about advance directives and goals, educates family/caregivers and staff, facilitates groups, identifies

social and emotional needs, connects with community programs post-discharge, and acts as a patient advocate.

- Development—and continued monitoring—of a comprehensive care plan with input from medical and nursing providers, therapy, case managers, family/caregivers, and other members of the interdisciplinary care team.
- Activities directors and/or recreational therapists who design programs that encourage socialization, provide entertainment, and improve quality of life and daily living skills.
- Chaplains provide spiritual counsel and comfort.

These social support tools provide a holistic approach to healing. Health systems can work with SNFs to enable patients and caregivers and adhere to treatment plans by providing the social support they need. Having the right supports arranged before, during, and after transition to home is paramount to becoming and staying well.

Nutrition

Recovery from a condition, infection, clinical decline, wound, or surgical intervention requires a deliberate nutrition plan. Surgery, anesthesia, and surgical wounds require appropriate caloric intake and protein to heal. SNF nutritional programs maximize clinical progress.

Typical features include:

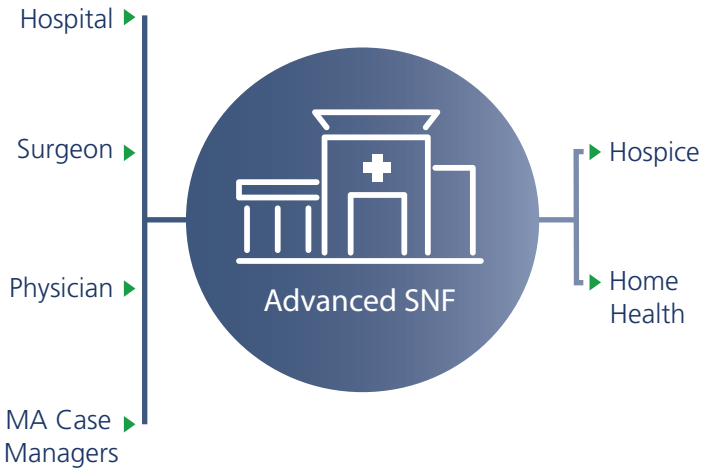
- Dietary programs and menus overseen by a registered dietician (RD) with specific diet considerations
- Assessments:
  a. Nutritional assessment conducted and adjusted according to patient preferences, medications, and risk of aspiration
  b. A comprehensive assessment upon admit and at regular intervals, reporting patient appetite and weight changes
- Calorie and menu intake monitored and reported to the director of nursing, therapists, and RD
- Weekly weights taken and reported to the physician and RD
- Specialized retraining, including adaptive utensil modifications and specific swallowing treatments for dysphagia
- Patient monitoring for dietary/fluid inputs and outputs as well as key clinical signs such as nausea, vomiting, diarrhea, or constipation

> "The body requires extra nutrients to heal, so proper nutrition can mean the difference between quickly bouncing back and a lengthy recovery."
>
> —Tina Ruggiero, M.S., R.D., L.D.[3]

As a continuum partner, SNFs can improve quality of care in an increasingly complex environment. These features of SNFs (therapy, specialized clinical services, medication management, social supports, and nutrition) improve patient outcomes and help transition patients safely home, while reducing the risk of hospital readmissions.

SNFS CAN IMPROVE A PATIENT'S EXPERIENCE AND CARE COORDINATION

High-quality care coordination programs can improve clinical quality and patient experience. SNFs that engage in value-based arrangements typically coordinate care with both upstream and downstream providers in the care continuum.



SNFs act as a "quarterback," coordinating with upstream organizations and home health and hospice providers.

SNFs often serve as a quarterback, taking accountability for PAC coordination during and after the SNF stay. SNF clinical capabilities combined with managed care experience through Medicare Advantage (MA) and other commercial managed care plans provide a strong platform for effectively participating in alternative payment models.

For example, BPCI Model 3 through CMMI targets PAC providers, incentivizing health systems to coordinate care throughout the episode of care. As of January 2017, there were 758 Model 3 participants,[4] signaling that many PAC providers are interested in engaging in value-based payments that incentivize coordination across the care continuum.

Roles that SNFs can play in improving patient experience and coordination include:

A. Upstream Care Coordination

- Surgeons/Physicians:
  a. Provide pre-surgery patient education, "pre-habilitation," and other efforts to prevent hospital readmission risk-factors
  b. Follow the surgeon's orders for surgical incision-site skin care and post-operative protocols
- Hospitals:
  a. Provide pre-discharge patient and caregiver education and coordinate with the hospital
  b. Communicate outcomes—favorable and unfavorable—to hospital case management
  c. Use health system technology and systems, such as access to the hospital's EHR, care coordination platforms, and other information tools
  d. Co-develop care pathways that translate between levels of care and provider groups
  e. Establish consistent prescription medication formularies, patient education modules, and care pathways
- Coordinate care with bundled payment awardee conveners (groups that help hospitals involved in bundled payments), PAC management groups (organizations that manage post-acute networks), or Medicare Advantage (MA) case managers:
  a. Work closely with market representatives of awardee conveners and PAC management groups
  b. Utilize data provided by the conveners and MA plans both for patient-level utilization and for facility-level quality improvement

B. Downstream Care Coordination

- Coordinate care pathways with home health (HH) and hospice providers:
  a. Communicate with HH therapists and nursing teams shortly after SNF admission
  b. Set appropriate expectations for length of stay and intensity of services with patients/families
  c. Efficiently optimize patient for the next level of care
  d. Establish preferred, strategic, and quality-based home health and hospice provider partnerships based on transparency and quality performance

WORKING WITH SNFS TO REDUCE COST

Hospitals and health systems can also collaborate with SNFs to reduce episode costs across the continuum of care. Five percent of Medicare beneficiaries account for almost 50 percent of all spending.[5] A potential area in which health systems can work with SNFs to reduce costs—rather than skipping the SNF all together—are patients with the highest costs.

WORKING WITH SNFS TO REDUCE COSTS ON HIGH-NEEDS PATIENTS

The analysis below considers national 2015 SNF facility Medicare all-condition costs compared to all-condition costs in three low-utilization regions (Maricopa County, AZ; San Diego County, CA; the Wasatch Front)* and three high-utilization regions (New Jersey, Indiana, and Maryland).

Patients with the highest needs often require the rich resources of a SNF, but they also end up utilizing a substantial proportion of costs. Health systems working with SNFs to save on these high-cost patients—even by

*Wasatch Front is an area in Utah comprising Salt Lake, Davis, Utah, and Weber Counties.

REGION	TOTAL PATIENTS	CUT OFF FOR 90TH PERCENTILE OF 2015 COST	PATIENTS ABOVE 90TH PERCENTILE	1% SAVINGS		5% SAVINGS		10% SAVINGS	
				Total	Per Patient	Total	Per Patient	Total	Per Patient
National	**1,843,084**	**$45,075**	**184,309**	**$106 mil**	**$579**	**$533 mil.**	**$2,894**	**$1.07 bil.**	**$2,894**
Maricopa County, AZ	12,167	$42,456	1,217	$400,419	$554	$2 mil.	$2,777	$4 mil.	$5,554
San Diego County, CA	11,492	$30,564	1,150	$525,180	$432	$2.6 mil.	$2,158	$5.2 mil.	$4,315
Wasatch Front	7,208	$45,338	721	$655,173	$569	$3.3 mil	$2,849	$6.6 mil	$5,697
New Jersey	78,590	$43,611	7,859	$4,072,744	$567	$20,363,719	$2,839	$40,727,439	$5,678
Indiana	52,202	$49,613	5,221	$3,134,463	$600	$15,672,317	$3,002	$31,344,634	$6,004
Maryland	45,130	$41,444	4,513	$2,420,300	$536	$12,101,502	$2,681	$24,203,003	$5,363

By working with SNFs to reduce the spend on patients with the highest spend— even by small amounts—health systems can see drastic savings system wide.

small amounts—can potentially save significant costs, while still providing SNF advanced care options. Consider the spending on patients above the 90th percentile in the Wasatch Front in 2015, a total of 721 patients which each cost over $45,338 per patient. A 1 percent reduction in spend would have saved $655,173 in total (an average of $567 per patient); $3.3 million savings (an average of $2,849 per patient) for a 5 percent spend reduction. At 10 percent savings, the total increases to $6.6 million ($5,697 per patient).

In high SNF utilization areas, the total savings could have been even more dramatic. In New Jersey, 7,859 patients accounted for the top 10 percent of cost (over $43,611 per patient). A 1 percent cost reduction on these high-cost patients could have saved $4,072,744 overall ($567 per patient). At 5 percent and 10 percent, the overall savings would have been $20,363,719 and $40,727,439, respectively.

By working with—instead of skipping—SNFs, health systems can potentially reduce overall costs while capitalizing on the advantages that SNFs offer high-acuity patients.

PRACTICAL STRATEGIES TO DECREASE EPISODE COSTS

There are many practical ways SNFs can help reduce episode costs along the care continuum. As hospitals and health systems collaborate with SNFs, they can take advantage of the SNF's ability to provide the appropriate site of care to optimize the spend. Some of these methods are listed below.

a. Optimize the Right Site of Care

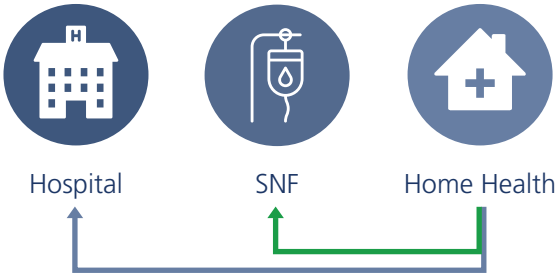
SNFs that have forged continuum partnerships can help health systems efficiently allocate episode costs. Each site of post-acute care has its own unique benefits for a patient's recovery, and each of these sites carry their own costs (as seen in Average Medicare Fee-For Service (FFS) Payment Per Day and Episode). By coordinating

Average Medicare Fee-For Service (FFS) Payment Per Day and Episode[6]

ACUTE CARE HOSPITALS	LTAC	IRF	SNF	HHA
$2,457 – 3,406 per day	$1,512 per day	$1,415 per day	$450 per day	$2,674 x 1.9 episodes = $5,081 per patient

There are significant differences in per day and per episode costs. Hospitals and health systems can coordinate with SNFs and other PAC providers to establish the most appropriate site of care.

If a patient needs non-emergent or low emergency triage, the SNF can serve as the readmission site of care rather than the hospital.



Because a SNF can triage a patient, risk-bearing entities should consider having an attributed patient go from HH to SNF, rather than readmitting to the hospital.

and integrating—rather than competing and providing siloed care—SNFs can help health systems reduce overall spend by helping patients recover at the most appropriate location.

Consider, for example, that a SNF with advanced care options could serve as a readmission site for home health agencies and PCPs. Hospitals increasingly feel pressure to de-escalate observation stay costs, reduce emergency department utilization, and decrease length of stay.

A SNF can also serve as a direct-admit point for ACOs. For patients that can be served by SNF resources, SNFs can operate as a cost-effective alternative admission site instead of a hospital. Hospitals who pursue this route must consider the three-day stay rule and ensure that the patient is attributed under the appropriate waiver.[7] Patients covered under a Medicare Replacement Plan (i.e. Medicare Advantage or Managed Care Plan), however, can be transitioned to SNF without a three-day qualifying stay or waiver.

b. Work with SNFs to Reconcile Care Plans and Medication Regimens During Transitions

One qualitative study created a description framework for understanding care transitions, interviewing patients who readmitted and their providers. Unsurprisingly, patients and their providers overwhelming reported throughout 43 interviews and four focus groups that inadequate communication and collaboration amongst the care team was the root cause for preventable readmissions. The most effective care—which this framework labels as a "Patient Care Circle"— involves a collaborative team that integrates multi-disciplinary care addressing medications, psycho-social factors, illness, and health systems navigation and management.[8] By collaborating with SNFs, hospitals and health systems can work together to create an integrated care plan to transition the most vulnerable patients between sites of care.

An especially important aspect of a care plan especially vulnerable during transitions is medication regimens. A Stratis Health study on medication reconciliation between hospitals and SNFs found that approximately half of hospital-related medication errors and 20 percent of adverse drug events resulted from poor communication at transitions.[9] Another study estimated that 60 percent of post-discharge adverse drug events could be prevented or improved by better intervention.[10] By consistently and clearly communicating the medication regimen with SNFs, health systems can reduce unnecessary cost associated with medication reconciliation.

The Stratis Health study, for example, estimated the cost of reconciling medication lists with missing indications and/or diagnosis at a total of 9.75 hours and $289.21. However, by better coordinating medications between the hospital and SNF, these costs could be reduced to one hour and $35.41 (ibid).

PRACTICAL STRATEGIES TO OPTIMIZE SNFS AS COLLABORATIVE PARTNERS

Hospitals and health systems that engage SNFs in mutually-benefitting partnerships are more likely to see aligned quality improvement incentives, an improved and coordinated patient experience, and a reduction in spend. However, creating this kind of network can be difficult, given the complexity of PAC and the fundamental shift from volume toward value.

The practical strategies below list ways hospitals and health systems can optimize partnerships with SNFs.

1. CREATE EQUITABLE PARTNERSHIPS

Background

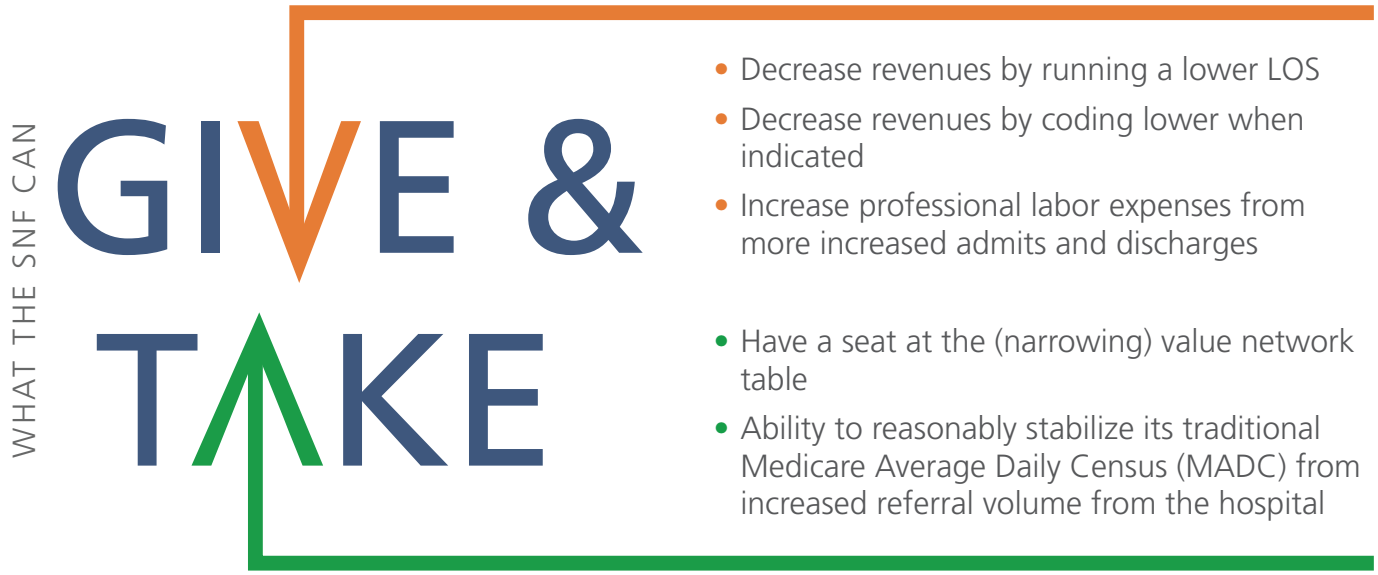
One way health systems can reduce spend is by decreasing a patient's length of stay (LOS) and services they provide (and then bill); however, decreasing LOS and services is complicated. According to the Medicare Payment Advisory Commission March 2017 Report, SNFs operate at a 1.8 percent profit margin, so lowering the LOS and decreasing coding may not initially seem viable for a SNF.[6] Concurrently, patients and their caregivers often prefer the maximum allowed SNF days under their benefit.

For example, a post cardiovascular accident (stroke) patient with hemisphere paralysis could prefer to receive maximum support—including physical, occupational, and speech therapy—for as long as possible as they return to function. As the patient continues to receive these benefits, the facility can continue to code for these higher levels of therapy and nursing services.

STRATEGIES

Health systems can align efforts with SNFs by creating a give-and-take relationship. For example, health systems and hospitals can create collaborative relationships with SNFs and develop consistent referral patterns. So while those SNFs work to decrease LOS—and the associated costs—they can receive more referral volume to maintain financial viability.

Hospitals can also create gainsharing arrangements in bundled payments to create equitable alignments and incentives.



Hospitals and health systems can work with SNFs to create equitable partnerships to align incentives.

2. ANALYZE ALL SNF QUALITY DATA POSSIBLE (NOT JUST 5-STAR RATINGS)

Background

CMS' Nursing Home Compare five-star ratings are the most readily and publicly-available metric that evaluates SNFs, and they can help health systems evaluate SNFs. But this metric is flawed and should be used as part of a broader strategy of evaluation. Some weaknesses are:

- Banded Ratings: Many user-generated review websites allow unlimited products to have a five-star rating as long as enough consumers rate them as such. CMS, however, rates facilities on a curve, limiting five-star SNF providers to only 10 percent. Thus, the distribution across the bands may artificially reflect quality disparities, and the raw score difference between a four- and five-star facility may be very small.

- Subjectivity of State Surveys: The five-star quality rating is partially determined by a SNF's survey history, but states vary significantly in how many deficiencies and penalties their surveyors impose. A recent study published in the Journal for Healthcare Quality, the official publication for the National Association for Healthcare Quality (NAHQ), critiqued the variation across states.[11] While Nevada's surveys did not indicate that any SNFs were deficiency-free, Virginia's surveys passed off 33.5 percent of their SNFs as deficiency free. This drastic difference, the publication argues, is less likely reflects quality differences between Nevada and Virginia SNFs and more likely indicates that the metrics are measured inconsistently.

- Artificially Inflated Ratings: Focusing solely on five-star ratings incents SNFs to artificially inflate ratings by avoiding high-acuity patients. For example, SNFs concerned with keeping a higher rating may be tempted to refuse patients with combative behaviors, wandering risk, or those needing psychotropic medications. However, if SNFs only admit alert, low-acuity patients, health systems can't safely discharge high-needs patients to SNFs with advanced care options.

Strategies

★★★☆☆

Contextualize five-star metrics as a subset of a broader assessment of SNF quality.

Issue clear and specific requests for proposals so that SNF operators have defined reportable outcomes, obtained from validated data sources and defined consistently. Such validated data sources and quality indicators can be obtained via CASPER reports, PEPPER Reports, PECOS reports, and EMR/MDS Dataset-based extractions. A health system or hospital may also consider using a PAC data analytics company or bundle awardee convener with experience in PAC management to assess SNF quality.

CMS's 5-star rating methodology is banded on a curve, rather than reflecting raw scores. This may artificially skew perceptions of quality differences.

Average Deficiencies per Nursing Home Survey & Percent of SNFs with Deficiency-Free Surveys.[12]

AVERAGE DEFICIENCIES PER NURSING HOME SURVEY	
Vermont	California
2.9	11.2

PERCENT OF SNFS WITH DEFICIENCY-FREE SURVEYS	
Nevada	Virginia
0%	33.5%

States vary significantly in how many deficiencies and penalties their surveyors impose during their reviews of SNFs.

3. ALLOW APPROPRIATE READMISSIONS

Background

Since CMS implemented the Hospital Readmissions Reduction Program in 2014, the hospital industry has increasingly focused on reducing hospital readmissions.

Hospitals now face penalties of up to 3 percent Medicare revenue, and in 2017 CMS will withhold $528 million in reimbursements to 2,597 hospitals for 30-day readmissions.[13]

However, not all readmissions are bad readmissions. Recent studies on readmissions indicate a correlation between low readmission rates with higher mortality, noting that CMS financial penalties for readmissions are 10 times greater than financial penalties for patient deaths. These studies conclude that simply reducing readmissions does not necessarily increase quality.[14, 15, 16, 17]

Strategies

Instead of solely focusing on reducing readmissions, hospitals and health systems can employ a more holistic discharge and readmission strategy, using SNFs as a readmission point (as described above) and coordinating with SNFs to collaborate on discharge and readmission standards. This strategy can lower avoidable readmissions and facilitate safe and appropriate readmissions when appropriate. Optimal SNFs will have the clinical systems, acumen, and scale to deal with complex medical needs upon hospital discharge, and they will have evidence-based readmission prevention strategies in place.

4. EMBED HOSPITALISTS/PHYSICIAN RESOURCES INTO SNF PARTNER FACILITIES

Background

Embedding hospitalists, physicians, or mid-level practitioners at a PAC facility can integrate care and align interests between hospitals and SNFs.

Strategies

In order to integrate and align care, hospitals can embed specialty resources as attending or consulting providers at SNF partners. This can help increase clinical continuity. In a recent study analyzing readmission rates for patients discharged from the Cleveland Clinic, SNFs in which hospital-related providers began visiting patients experienced decreased readmission rates.[18] SNFs can pay hospital physicians a medical directorship or quality assurance fee for discreet activities in the SNF, in addition to the fees for seeing patients.

Consider these best practice examples:

1. In 2015, the hospitalist group at Palomar Medical Center (Escondido, CA) began an outreach process with twelve SNFs, assigning a hospitalist physician to each facility. Results after one year showed the 30-day hospital readmission rate from those SNFs dropped from 9 percent to 1 percent.[19]

2. The presence of hospitalists in SNFs is growing. According to the Society of Hospital Medicine, as many as 30 percent of adult hospital medicine groups provide physician care in SNFs, with large management groups expanding in this area.[20]

CONCLUSION

Post-acute care is the new frontier of opportunity for hospitals, health systems, and risk-bearing entities engaged in value-based payments and quality of care improvement programs. Working with SNFs can help these organization reduce costs while maximizing patient care. As health systems partner with SNFs, they can more effectively coordinate across the care continuum. True collaboration—rather than simply skipping SNF care—can align interests between the SNF and the health system, delivering high-quality care while optimizing episode costs.

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