WHITE PAPER

Towards Value-Based Discharge Planning

By Maureen E. McClusky, FACHE

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This whitepaper discusses the regulatory pressures that are driving changes in hospital discharge planning processes and how leading health systems are responding.

THE IMPORTANCE OF SNF QUALITY

40% of Medicare patients discharged from hospitals require post-acute care for their continuing recovery. Skilled nursing facilities (SNFs), for example, provide rehabilitation services such as physical and occupational therapy in addition to more complex acute and chronic medical care for their residents.

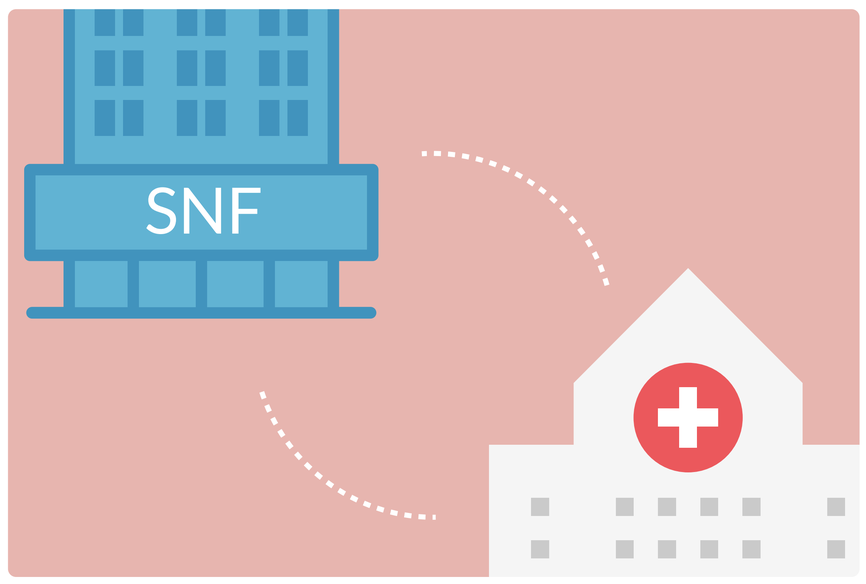
Pressure on hospitals to decrease length of stay has resulted in higher acuity patients discharged from hospitals and entering SNF care. Not all SNFs, however, possess the capabilities and resources to manage these medically complex patients. SNFs vary widely in size, staffing levels, clinical capabilities, and overall quality of care provided.

This variation has important implications for health care outcomes and spending as patients who receive care in higher-quality SNFs are less likely to be re-hospitalized within 30 days.[1]

As health systems are held accountable for post-acute outcomes under new payment models like accountable care organizations and bundled payments, they must consider SNF quality when discharging patients.

PARTNERING WITH HIGH QUALITY SKILLED NURSING FACILITIES

To succeed under value-based care, forward-thinking health systems are partnering with SNFs to improve quality and lower costs. A study including over 2.8 million patients, 15,000 SNFs and 4,500 hospitals found that patients discharged to SNFs with strong linkages to hospitals experienced lower re-hospitalization rates. [2]



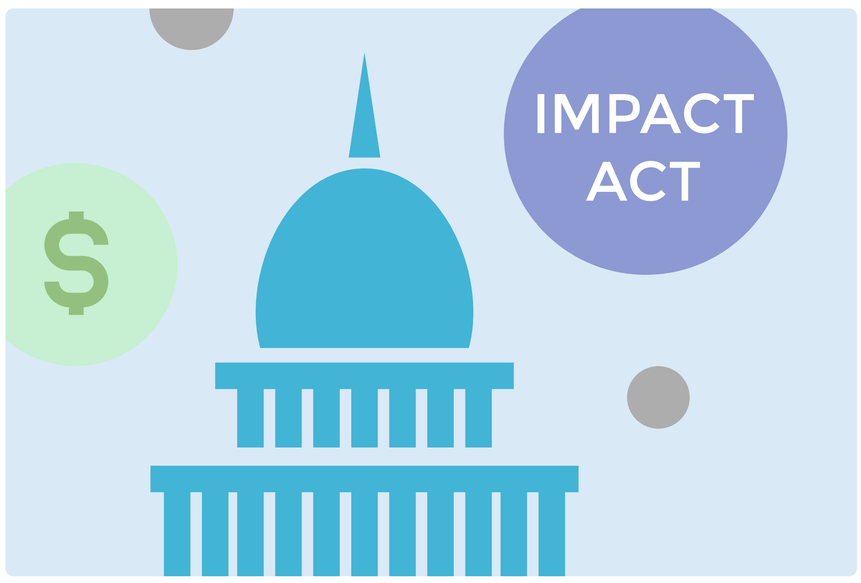
Many leading health systems such as North Shore-LIJ Health System (NY), the Cleveland Clinic (OH), and Partners HealthCare (MA), have begun to develop a continuing care network - a group of SNFs that collaborate with hospitals to better coordinate care, follow standardized care protocols, and maintain high quality standards.

These health systems are already guiding patients to high value providers, and early results point to improved post-acute outcomes such a reduction in SNF readmissions and length of stay. These outcomes have also been validated in [3] studies which demonstrate that hospitals with tighter SNF referral networks exhibit lower rates of post-acute spending. As value based payment continues to take hold, preferred provider programs are expected to become the norm rather than the exception.

PATIENT CHOICE

Whether or not a health system elects to develop a continuing care network, patients and their families still make the ultimate decision about where to receive care. Medicare regulation requires that patients be provided with a list of all available facilities and that "the hospital must not specify or otherwise limit the qualified providers that are available to the patient."[4]

This rule originated as an anti-kickback measure to prevent hospitals from recommending SNFs in which they had a financial interest. The unintended consequence, however, is a perception among discharge planners that they cannot provide any information to patients beyond a basic list of facilities. Patients and families are thus left to make decisions without much more information than a list of SNFs with addresses and phone numbers. The result is that patients often choose the SNF that is closest to their home, which may not be the facility of highest quality or best-suited for their needs.



Under the IMPACT Act, guidelines for educating patients about post-acute options are finally being articulated and codified. The newest discharge planning proposed rules focus on enabling patients to choose high quality post-acute providers. Under the new rules, hospitals would be required to share data on quality and resource measures about post-acute provider. The intent is to increase patient participation and reduce readmissions from post-acute providers.[5]

IMPROVING THE DISCHARGE PROCESS

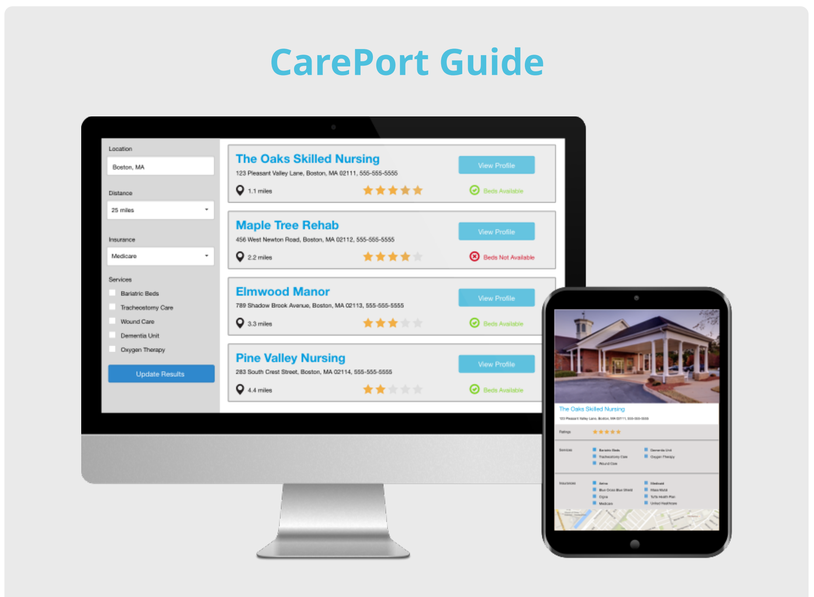
Hospitals can help patients make better decisions about post-acute care by developing a more structured discharge process and incorporating tools to educate patients.

Collect information on providers. To properly assess SNF suitability, information on quality of care, clinical capabilities, and insurance eligibility is needed. Quality scores can be obtained from public sources such as Medicare's Nursing Home Compare, which publishes star ratings for facilities based on staffing levels, patient outcomes, and health inspections. Unfortunately the Medicare rating has come under scrutiny recently and there are concerns about its reliability.[6] Some state agencies also publish scorecards for SNFs based on periodic inspections. Other information can be collected through surveys or interviews with SNFs. This information should be kept up-to-date and reviewed for accuracy.

Assess SNFs based on:

- Federal and State Quality Scores
- Insurance Eligibility
- Clinical Capabilities
- Surveys and on-site interviews

Incorporate educational tools. Paper lists have been the traditional tool used to educate patients about post-hospital providers. To guide patients towards higher quality or continuing care network providers, these lists can be tiered based on objective quality metrics, attending physicians, and geographic proximity. Commercial tools are also available that can help generate dynamic lists depending on the patient's insurance and clinical needs. For example, the Cleveland Clinic uses CarePort, a patient-centered tool that incorporates photos, virtual tours, and quality scores to help patients select providers prior to discharge.



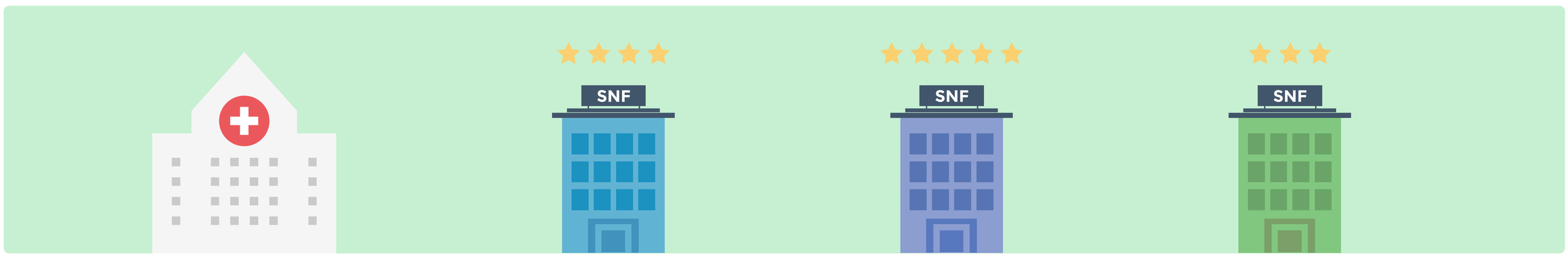
According to Dr. Eiran Gorodeski who leads the Center for Connected Care at the Cleveland Clinic, "We are giving patients all the information they need to make an informed decision that best suits their needs and preferences." Patient-centered tools enable patients to select providers based on quality rather than simply geography, which leads to improved post-acute outcomes and higher patient satisfaction.

> *"We are giving patients all the information they need to make an informed decision that best suits their needs and preferences."*
>
> Dr. Eiran Gorodeski, Cleveland Clinic

Standardize the discharge process. A new focus on discharging patients to high-quality providers will require changes in discharge planning culture and workflows. Educating the discharge team about the hospital's goals is a critical first step to securing higher quality placements for patients. Discharge planning should begin early during the hospital stay to leave enough time for patients and families to learn about their SNF options. To alleviate discharge planners' concerns about steering patients, they should be provided with scripts and handouts that have been approved by the hospital legal department. Finally, discharge planners should help patients access the hospital's educational tools for post-hospital care.

CONCLUSION

When patients receive care from higher quality SNFs, they are less likely to experience adverse health outcomes. Under the Impact Act, hospitals may be mandated to educate patients about their care options using objective quality data. Increasing referrals to high-quality providers has significant potential for outcomes improvement including readmission rate reduction and cost savings.



ABOUT THE AUTHOR

Maureen E. McClusky, FACHE is the Senior Vice President of Post-Acute/Long Term Care at NYC Health + Hospitals, where she is responsible for formulating strategies to reduce costs and drive better health outcomes across the system's five post-acute facilities. She has over 20 years of experience working in a variety of hospital, community-based and post-acute healthcare settings. Previously, she was Executive Director for ArchCare's largest specialty post-acute facility in East Harlem and oversaw skilled nursing facility operations for Northwell Health, St. Mary's Healthcare System for Children, and Bergen Regional Medical Center. She has a BA from SUNY and a MA from NYU School of Health, Nursing and Arts Professions.

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