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White paper

SNF collaboratives:

Challenges associated with partner selection, and how to define and track quality

The rise of "payviders", the growth of Medicare Advantage, and the growing prevalence of value-based arrangements have brought increased attention to post-acute care settings, and it is increasingly important that patients receive high-quality care as efficiently as possible. There is tremendous variance in quality across the healthcare industry, and the transition to post-acute care is a more complex process than simply sending patients to a highly-rated skilled nursing facility (SNF).

To illustrate the nuance and complexity involved in the SNF partnership process, a CarePort analysis demonstrates the limitations of the Centers for Medicare & Medicaid Services (CMS) Five-Star Quality Rating System in identifying high-quality providers. The analysis explored the variance in rates for "successful discharge to the community" by comparing the 25th percentile providers to the 75th percentile providers within each county. The average differences across all counties examined was 17 percentage points, suggesting the existence of variances in the quality of care provided.

A well-selected and measured SNF collaborative is critical to a health system's ability to ensure high-quality care for its patients. A collaborative is comprised of preferred SNF providers to which acute providers send their patients. Collaboration between the acute provider and the SNF is essential to achieving better care coordination through streamlined transitions from the hospital to the SNF, as well as enhancing communication among the patient's providers. This partnership should be a two-way street: not only is the SNF sharing data with the provider, but the provider is also sharing data with the SNF. Think of the members of a collaborative as business partners who have a proven track record of high-quality care and positive patient outcomes based on shared goals and measurements.

Challenges in SNF partner selection

There is significant variance in the quality of care that SNFs provide. Even in a small market, these discrepancies in quality of care can be rather large. Understanding which SNFs to partner with – and what data to measure – presents its challenges.

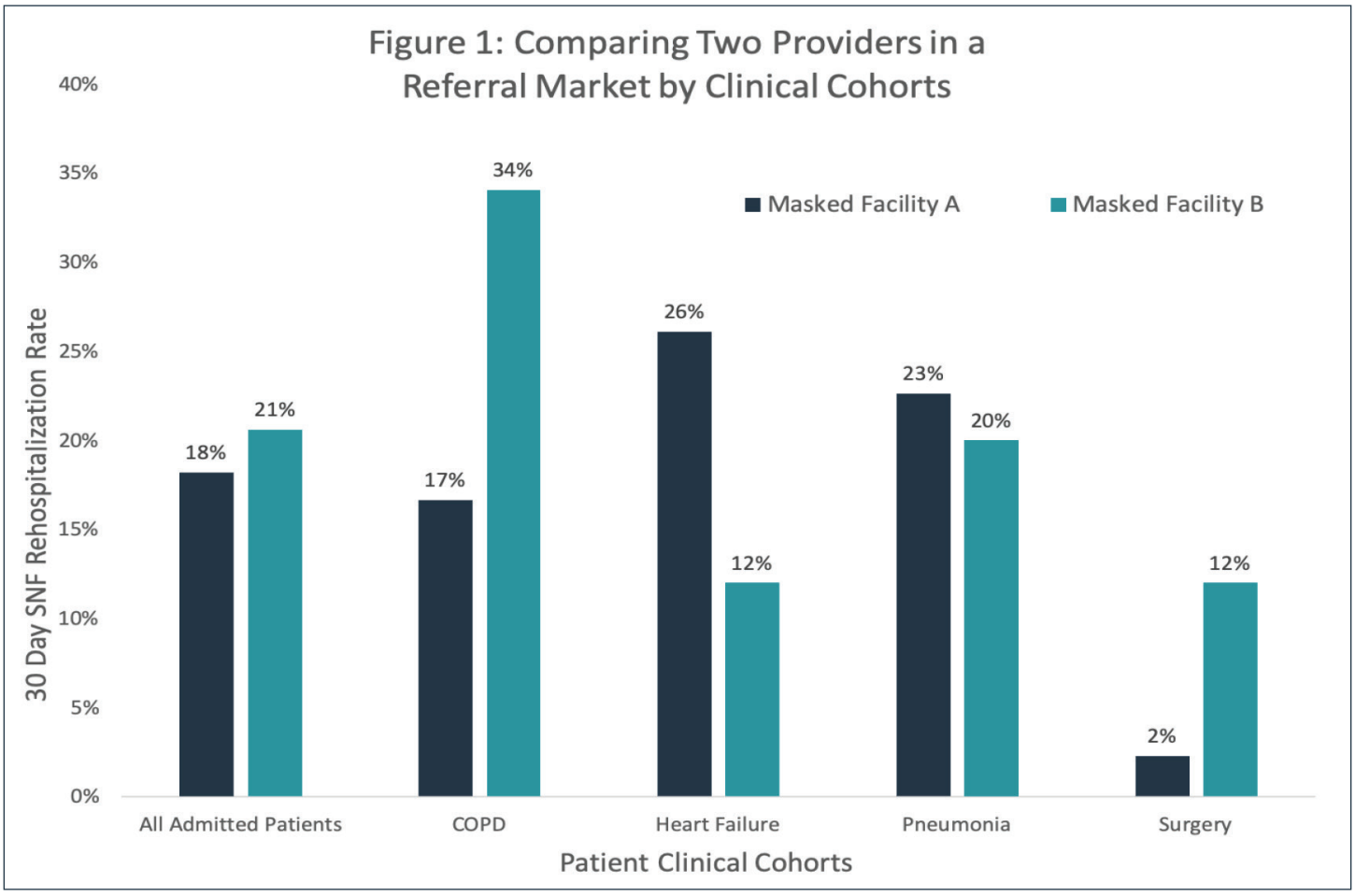
Outlined below are four obstacles frequently encountered when forming a SNF collaborative and addressing quality variance in the industry.

1. Data collection

Collecting data from SNFs can be time-consuming and expensive, particularly when it is a manual process. Further, if the data collected is not extremely well-standardized, it may not be useful for comparing quality amongst the collaborative. Data collection also puts significant burden on SNFs, which should be focused on caring for patients – not spending hours querying their EMR data.

2. SNF specialization

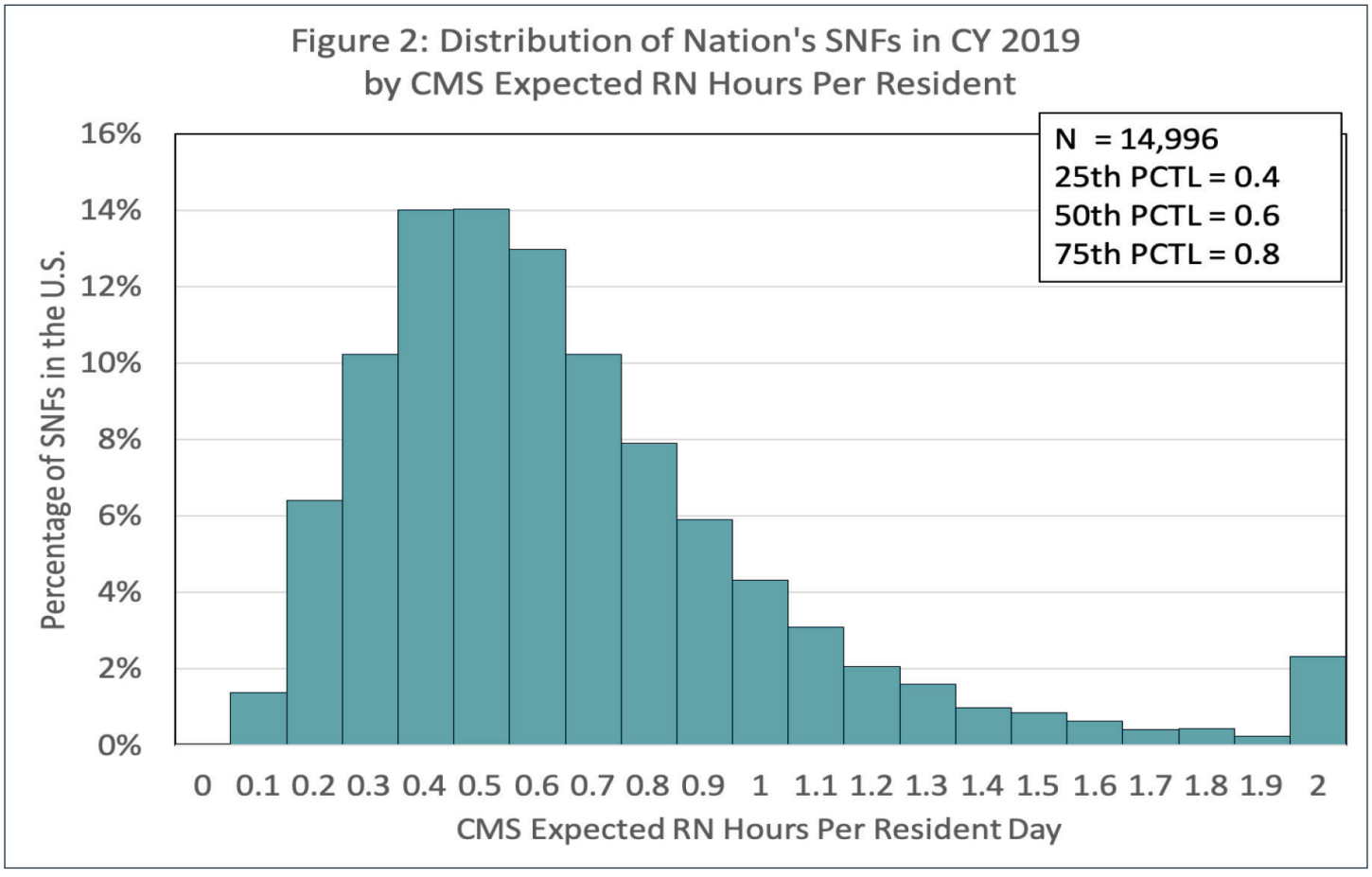
CarePort analysis shows that even after a health system has identified a post-acute provider that, on average, provides efficient and effective care for all of its patients, important differences remain in how they perform for specific clinical cohorts of patients. Figure 1 (below) reports the clinical cohort-specific readmission rates for two providers in the same hospital referral region. While Facility A appears to outperform Facility B in terms of overall readmission rate, Facility B significantly outperforms Facility A for the clinical cohorts of pneumonia and heart failure. A health system that can track these differences in quality between clinical cohorts will not only send their patients to the best SNFs in the market, but also the best SNFs for patients' unique needs.



3. Difference in acuity

Within the same market, the type of patients that SNFs care for can vary greatly from one SNF to the next. When comparing simple observed measures between providers, differences could be due to the quality of care provided or the acuity of the patients cared for at that SNF. All meaningful measures of quality should be risk-adjusted to account for those differences in acuity, which is why CarePort has developed a custom network management dashboard to assist providers with these analytics.

One measure that nicely illustrates the difference in patient acuity is the CMS expected registered nurse (RN) hours per resident day (HPRD) metric, which is used as part of the Five-Star rating on Care Compare. The measure represents the expected RN hours required to care for a SNF's patient population based off of their clinical care needs as reported by the Minimum Data Set. The distribution of U.S. SNFs by this measure (Figure 2, below) demonstrates just how different clinical care needs can be amongst SNF patients, as over 12 percent of SNFs have an expected RN HPRD of greater than one hour per patient day and 18 percent of SNFs have an expected RN HPRD of less than 20 minutes per patient day.



4. Outdated public data

The Five-Star rating is an important and readily available metric that helps health systems identify and exclude poor performers from their post-acute network. One drawback of the stars program, however, is that its data is heavily weighted toward the custodial population cared for by SNFs. The focus on long-stay measures is not relevant to health systems that are seeking placement for short-stay SNF patients. Also, many of the most valuable measures are based on only Medicare fee-for-service (FFS) claims data, which can lag behind by a year or more.

Defining and tracking quality with a SNF collaborative

Because acute providers are held responsible for patient outcomes post-discharge, it is critical to not only gain visibility into this end of the continuum but to also get in the habit of continually assessing the quality of care delivered to patients in post-acute care settings. To achieve optimal results with a SNF collaborative, hospitals and health systems should consider the following when determining how to define and track quality of care.

1. Small set of measures

Define a finite number of measures on which the SNF collaborative plans to focus. Other measures may remain in the dashboard, but the collaborative cannot improve upon every measure at once. If providers ask their post-acute partners to focus on a large set of measures, they are setting unrealistic expectations.

2. Real-time measures

On average, SNFs see a six percent change in their readmission measures — positive or negative — over the course of one year. This illustrates how quickly quality can change — and how drastically, for some providers. Using a measure that is one to two years old will not suffice. While it is tempting to use claims data for these analyses, health systems that do so will always find themselves behind the curve due to the lag time in receiving the data. To understand current patterns, providers should invest in tools, such as those offered in CarePort's suite of solutions, that are powered by real-time data and are specifically designed to track post-acute utilization and outcomes.

3. Measures already important to SNF partners

CMS is already focused on several areas of quality improvement in the SNF industry through Value-Based Purchasing, the Quality Reporting Program, and the Five-Star Quality Rating System. Each of these programs incorporate a version of 30-day readmission tracking. Tracking measures such as readmission rates for patients should align with quality improvement efforts, and it should not be difficult for SNFs to prioritize this measure because it is already a critical measure that they monitor. Though there are numerous hospitalization measures to choose from, it is in the collaborative's best interest to focus those that are mutually beneficial.

4. Fair measures

It is critical that the measures selected to track a SNF collaborative are truly measuring quality and that there is buy-in on these measures from SNF partners. The chosen measures should not be confounded by the acuity of the patients cared for by the post-acute provider and should adequately exclude patients that are not appropriate for measurement. For example, comparing discharge to community rates of two providers is only meaningful after accurately accounting for the differences in acuity between the provider populations.

It is important to select the correct risk-adjusted measurements, otherwise providers will ultimately just track the post-acute facility that has more acute patients. Also, health systems should confirm that they have included the right exclusions. For example, if measuring the efficiency of a provider's care by examining their average length of stay, providers must first exclude those patients that were readmitted or died in the facility, otherwise a post-acute facility that has several readmissions in the first week following arrival at the SNF will appear to have lower length of stay.

5. Measures are shareable

Once measures are finalized, providers may want to develop a scorecard for these measures and establish a regular cadence for deploying and reviewing it with post-acute partners. Using shared systems that measure in the same way, and examine the same measures, helps this process. Measures should be easily communicable and frequently shared within the network to ensure everyone is focused on the same objectives. Transparency and aligned priorities between collaborative members ultimately help guarantee a more optimal and safe experience for patients.

Critical to patients' positive outcomes, providers must ensure they have the right partners in place to carry out post-acute care transitions. However, the work does not end there. Once formed, the SNF collaborative must determine the appropriate measures through which to track quality.

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CarePort is the leading care coordination network with thousands of providers connected across the U.S. The end-to-end platform bridges acute and post-acute EHR data, providing visibility into the entire patient journey for providers, physicians, payers, and ACOs. With CarePort, healthcare professionals can efficiently and effectively coordinate patient care to better track and manage patients as they move through the continuum. CarePort helps providers meet and comply with the patient event notification Condition of Participation, as part of the CMS Interoperability and Patient Access final rule, and the IMPACT Act. Read more about CarePort on careporthealth.com, Twitter and LinkedIn.

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