




Time to Recharge Referral Relationships!

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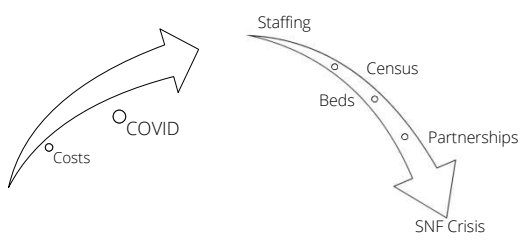
OBJECTIVES

- Participants will understand what data referral networks value and how to leverage that data to increase census.
- Participants will understand what referral partners value in a SNF and how they can better appeal to current and potential partners.
- Participants will understand how to set partnership goals and evaluate partnership equity.




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2020-2022 REFERRAL RELATIONSHIPS



The diagram illustrates the impact of COVID on referral relationships. An upward-pointing arrow labeled 'COVID' is associated with 'Costs'. A downward-pointing arrow labeled 'SNF Crisis' is associated with 'Staffing', 'Census', 'Beds', and 'Partnerships'.



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The Era of Value-Based Care

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DEFINITION AND VALUE

Value-Based Care


- Ties reimbursement to results of the care provided not quantity of services
- Holds providers accountable through financial incentives
- Maintain highest level of wellness, decreases costs, improves outcomes

Three Pillars of VBC

EQUITY

QUALITY

COSTS



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SNF VALUE-BASED PURCHASING PROGRAM

FY 2024
All-Cause Unplanned Readmissions

FY 2026
SNF HAI with Hospitalization
Total Nurse Staffing Hours/Res Day

FY 2027
Discharge to Community


<https://www.cms.gov/files/document/fy-2023-snf-vbp-fact-sheet.pdf>




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HOSPITAL VBP PROGRAM WITH SNF SUPPORT

<p>Hospital Readmission Reduction Program HRRP</p> <ul style="list-style-type: none"> • AMI • COPD • Heart Failure • Pneumonia • CABG • THA/TKA <p>Need strong SNF partners to mitigate risks of readmission</p>	<p>Bundled Payments BPCI-Advanced</p> <ul style="list-style-type: none"> • Voluntary model • Extended through 2025 • Model Year 6 (2023) change in pricing methodology • Added new diagnosis – MJRUE <ul style="list-style-type: none"> – Multi-setting includes outpatient now <p>CMS Fact Sheet https://www.cms.gov/media/document/bpci-model-overview-fact-sheet-my6</p>
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ACCOUNTABLE CARE ORGANIZATIONS

- Medicare Shared Saving Programs
- Alternate payment model
- Agreements with CMS
- ACO's are one example
- Can share in financial reward
- But risk of loss as well


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I-SNP OPTION?

- Institutional Special Needs Plan
- Type of Medicare Advantage plan
- Value-based model
- Restrictions to enrollment
- Residents receive added care benefits
- COVID derailed emergence somewhat
- Success depends on the volume of residents needed to remain viable and management


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PREFERRED PROVIDER

- Ties to value-based care
- Allows acute care to work more closely with SNF on care
- Results in decreased 30-day readmissions
- Collaborative care is better care!
- Most health systems have application/evaluation process
- Narrowing networks pre-COVID
- Scrutiny that led to change

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WHAT DO YOU WANT TO TACKLE

Primary Considerations

- Is my organization taking on episodic or population health risk?
- Is caring for a specific patient population key to my organization's strategy?
- Does my organization own or have a joint venture with any post-acute providers?
- How much financial investment and human capital commitment is my organization willing to put into partnership?


(Getting the Most out of the Hospital-Post-Care Partnership, The Advisory Board, April 2023)

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IDENTIFY YOUR LEVEL OF COMMITMENT

	Least commitment	Most commitment
Description	Joint quality improvement • Information exchange initiatives • Data tracking programs • Affiliation agreements • Preferred provider networks	Strategic contracting • Pay-for-performance contracting • Episodic/total cost contracting • Direct service purchasing
Pros	• No financial investment required • Ability to partner with multiple providers under one partnership umbrella	• Post-acute asset operation • Staffing contracts • Managed services agreements • Joint ventures/full ownership • More control over results due to financial investment • Direct control over partnership assets
Cons	• Results dependent on partners' willingness to participate and collaborate	• High level of financial investment • High amount of effort to put in place and maintain

(Getting the Most out of the Hospital-Post-Care Partnership, The Advisory Board, April 2023)

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APPEALING TO NETWORKS

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WHAT DO NETWORKS VALUE in SNFs?

2019	2019	2019	2019
Mitigates Hospital Readmissions	Capitates Costs	Navigating Misaligned Incentives	Bed Availability
2022	2022	2022	2022



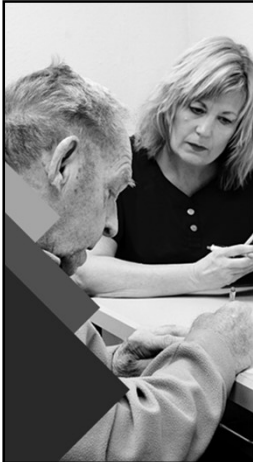
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WHAT VALUE DO YOU BRING?

- Decrease costs?
- Increase outcomes/quality?
- Reduce readmissions
- Increase resident satisfaction
- Enhanced communication

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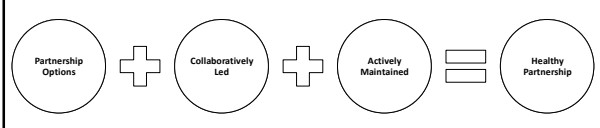


NETWORK MISCONCEPTIONS


1. Hospitals are in the driver's seat
2. Preferred Provider status is the only way to align across the continuum
3. Once established, network partnerships are self-sustaining

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ADVISORY BOARD'S PERCEPTION



Partnership Options + Collaboratively Led + Actively Maintained = Healthy Partnership

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RESIDENTS AT THE HEART OF VALUE

Patient Experience – *“The sum of all interactions, shaped by an organization’s culture, that influences patient perceptions, across the continuum of care” -The Beryl Institute 2021*

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VALUE TO RESIDENTS = VALUE TO NETWORK

- Environment/hospitality
- Culture & leadership
- Quality outcomes and clinical excellence
- Patient/Caregiver communication & engagement
- Staff engagement
- Technology & innovation
- Safety is #1
- Meaningful communication
- Know your demographic- Baby Boomers
- Continued use of Telehealth
- Explore technology
- Boutique/Concierge experience
- Satisfaction surveys

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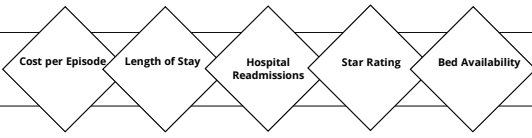
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LEVERAGING PERFORMANCE DATA


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LEVERAGING TOP 5 DATA POINTS



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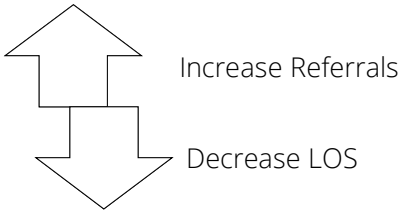


COST PER EPISODE

- Capitate costs across the episode
- Network savings should flow to SNFs
- Decrease ED visits and readmissions
- Capitate length of stay


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LENGTH OF STAY



Increase Referrals

Decrease LOS

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HOSPITAL READMISSION RATE

- What protocols
- What programs
- What HRR tools
- Does data indicate progress


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STAR RATING

- Network partners and other referrals sources judge you by this
- Potential residents and family use Care Compare frequently
- Partner with Therapy

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BED AVAILABILITY



Pre-COVID
SNF use - less
SNF costs - less

2020 -Current
SNF use - High
SNF costs - Elevated

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DATA SLUMP?

- Show past trends
- Show recent gains
- Demonstrate plan for improvement

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FOCUS ON PARTNERSHIP GOALS & ACCOUNTABILITY

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PARTNERSHIP PARAMETERS for SUCCESS

1. Setting fair and equitable goals
2. Holding all parties accountable
3. Evaluating partnership strength and cohesiveness

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FAIR & EQUITABLE GOALS

- Pre-Covid data points still a focus
- Determine shared goals
- Navigate misaligned incentives

Table 1. Measures of Success

CMS Star Rating (must be > 3%)
<ul style="list-style-type: none"> • Overall • Quality measures
HCOIS (OIG) Data
<ul style="list-style-type: none"> • Readmission rate to hospital during SNF stay • Readmission rate to hospital after SNF stay • Overall SNF readmission rate to hospital
CMS Star Rating
<ul style="list-style-type: none"> • Percentage of short-stay residents who were rehospitalized after a nursing home admission • Percentage of short-stay residents who have had an outpatient emergency department visit • Percentage of short-stay residents who were successfully discharged to the community
SNF Total Cost of Care
<ul style="list-style-type: none"> • Average SNF stay cost • SNF total cost of care

(Annals of Long-Term Care, How to Be Included in a Health System's Preferred SNF Network)

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HOLDING ALL PARTIES ACCOUNTABLE

- Identify accountability measures
- Engender accountability
- Regular partnership meetings

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EVALUATING THE PARTNERSHIP

- Strength
- Cohesiveness
- Educate physicians and discharge planners

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STRATEGIC APPLICATION

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PARTNERSHIP STRATEGY


1. Develop the leadership team that will drive the partnership
2. Identify the type that best aligns with your organization
3. Seek out or re-engage acute partners
4. Hold frequent meetings with agendas that give SNFs a voice
5. Ensure network utilization
6. Frequently re-evaluate goals and brainstorm

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Thank you!



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