Navigating the Effectiveness of Skilled Nursing Facilities: Five Factors to Consider When Selecting Your Post-Acute Care Partner
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Introduction

The healthcare industry is in the midst of a transformational era as providers seek to succeed under new payment models, and payers continue to provide incentives to improve care coordination by managing transitions in care and reductions in readmissions. For example, the Centers for Medicare & Medicaid Services’ (“CMS”) Bundled Payment for Care Improvement Initiative (“BPCI”) further expands the boundaries of clinical and financial accountability for patients by including post-acute care provider participation in Model 2, in which episodes of care will include the inpatient stay in the acute care hospital plus all related services during the episode, for up to 48 different clinical conditions. Furthermore, accountable care organizations and other organizations at risk with health plans are exploring post-acute strategies to effectively manage patients who transition from acute to post-acute care settings. While care model redesigns are occurring to support population health across the continuum, here the focus is on the operational issues to consider when evaluating potential relationships. As hospitals are incentivized to work with post-acute care providers, hospital leaders are asking the big question, “How do we find the best post-acute care partner?”

Skilled nursing facilities (“SNFs”) are a logical post-acute care partner for hospitals since they provide healthcare services to patients who require ongoing inpatient medical care but no longer need the intensity of services provided by an acute care hospital. Given the potential financial incentives, hospitals must carefully evaluate five key areas when considering a SNF as a partner for episode of care management: 1) organization and structure of the medical staff, 2) operational readiness to manage episodes of care, 3) patient and family experience, 4) care transitions, and 5) adoption of information technology (“IT”) and telemedicine. Each of these key areas will be discussed in the following sections.
Organization and Structure of the Medical Staff

The hospital and skilled nursing facility must jointly align with physicians and advanced practice clinicians (“APCs”) to successfully manage episodes of care across the continuum, since these providers will actively participate in the design, implementation, and execution of new care delivery models that focus on quality outcomes, care coordination, and cost savings, while reducing variations in clinical practice. As such, it is critical that providers between the two types of organizations understand the complex care needs of fragile patient populations and deploy an interdisciplinary approach that involves both patients and their families.

Skilled nursing facilities are typically staffed by community-based physicians through an open or closed medical staff model, or by using SNFists. The role of the SNFist (e.g., nursing home physician specialist or long-term care specialist) has increasingly emerged as a way to improve quality of care provided to SNF patients, and use of SNFists has several advantages. Since these providers may be physically based in the skilled nursing facility, they can be responsible for:

• The provision of physician services and coordination of care transitions
• Ensuring that patients are moving from the acute care setting to the SNF to home at the appropriate time and with the appropriate support
• Coordinating care transitions with primary care physicians

Conversely, in the open staff model, the amount of time a physician can spend with a SNF patient is variable due to care delivery responsibilities in other facilities. To address these challenges, as an example, Banner Health, one of the largest, nonprofit healthcare systems in the country, recently introduced a new physician role called the Transitionalist, in order to proactively manage the continuum of care for patients who are potentially high risk for a hospital readmission, or who may need SNF or home health services. Patients have direct access to the Transitionalist, and the physician can alter care plans when medically necessary to avoid unnecessary emergency department (“ED”) utilization or hospital readmissions. As hospitals continue to take on more financial risk, this role has the potential to reduce unnecessary utilization and costs during a given episode of care.

Operational Readiness Assessment

Hospitals should evaluate the operations and performance of potential SNF partners to determine their ability and readiness to manage episodes of care. Factors that should be evaluated include: financial performance, clinical and quality outcomes, medication reconciliation process, the care model and clinical protocols, staffing, and recent facility inspections and penalties. SNF-specific outcomes and performance data is available through a variety of publically reported and proprietary resources. The table on the following page provides an example of these resources and a description of the data that is reported by each.
In addition to reviewing facility-specific performance reports, hospitals should evaluate a skilled nursing facilities’ medication reconciliation process during its operational readiness assessment. Medication reconciliation is a formal process that is used to compare a patient’s current medications with the list that is available in the medical record. While the majority of drug-related errors occur on the inpatient setting, there are also many errors in both the long-term care and ambulatory practice settings. And, while medication errors occur in each care setting, the most common site of errors in medication reconciliation is between care settings, during handoffs, and transitions. To manage the complexity of the pharmaceutical interventions, many SNFs are moving to in-house pharmacy review and automated dispensing systems with unit dose packets of the appropriate medications for each patient.

When evaluating the operations of a potential SNF partner for episode of care management, hospitals should consider the following key questions in order to complete a comprehensive review of the facility’s operational status:

- What is the scope of services provided (e.g., complex intravenous medication, total parenteral nutrition?)

<table>
<thead>
<tr>
<th>Resource</th>
<th>Metric</th>
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<tr>
<td><strong>CMS’ Nursing Home Compare</strong></td>
<td>- Five-Star Quality Ratings of overall and individual star performance on health inspections, quality measures, and hours of care provided per resident by staff performing clinical care tasks</td>
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<tr>
<td>(publically reported database accessible at <a href="http://www.medicare.gov/nursinghome">http://www.medicare.gov/nursinghome</a> compare)</td>
<td>- Health inspections results and complaints, including detailed information about deficiencies found during the three most recent state inspections and recent complaint investigations</td>
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<td>- Clinical staffing information about the number of registered nurses, licensed practical nurses (“LPNs”) or vocational nurses, physical therapists, and nursing assistants in each facility</td>
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<td>- Quality measures that describe the quality of care in the facility, including percent of residents with pressure sores, percent of residents with urinary incontinence, among others</td>
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<td></td>
<td>- Penalties against a nursing home</td>
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| Definitive Healthcare Database          | - Finance and operations: revenues, expenses and budget; income and Earnings Before Interest, Taxes, Depreciation, and Amortization; assets, debt, and ratios; length-of-stay (“LOS”); average daily census; discharges; total charges  |
| (proprietary database, user subscription required) | - Quality: falls, pain level, physical restraints, pressure ulcers, urinary tract infections, vaccinations (e.g., influenza, pneumococcal), weight loss  |
|                                        | - Staffing: employed full time employees; Registered Nurse hours per resident per day; LPN hours per resident per day; total licensed nursing staff hours per resident per day; Certified Nursing Assistant staffing hours per resident per day  |
• Does the SNF accept admissions 24 hours a day and direct admissions from the ED or home?
• What is the process to conduct functional assessments?
• Are patient safety huddles conducted daily?
• What is the frequency of interdisciplinary rounds?
• Is there an active falls prevention and pressure ulcer program in place?
• What is the discharge planning process to return the patient to their home environment?
• What is the readmission rate to the hospital and back to the SNF?
• How is patient education about disease process and plan of care conducted?
• Is there a registered nurse in the facility 24 hours a day?
• What is the retention rate of nursing staff?
• How does staff receive continuing education?
• What is the pharmacist’s level of involvement in care rounds and pharmaceutical review?
• How are medication errors and adverse events reported and addressed?
• Where are lab draws and radiology exams completed, and what is the turnaround time for physician reporting?

Patient Engagement and Experience

Research has proven that patients actively involved in the decision-making of their healthcare tend to have better outcomes. As a result, many healthcare organizations have placed a heavy emphasis on patient education and encouraging the patient and family to be more active participants in the decision-making process. This strategy requires a refreshed perspective from clinicians that positions the patient as a partner in their plan of care and ensures that the patient’s preferences are understood and honored. Health coaching programs support patient engagement by deploying a variety of techniques aimed at behavior changes and include the stages of change, motivational interviewing, self-management techniques, positive psychology, and social cognitive theory.

Skilled nursing facilities may develop specialty niches such as ventilator, palliative care, bariatric, and geropsych units to differentiate themselves in the marketplace as well as to provide post-acute specialty care services needed to more effectively manage specific episodes of care and complete a comprehensive continuum of care with a hospital partner. Today, SNFs are being designed with more private rooms clustered in smaller units that appear less institutional and are providing better dietary, social, and therapeutic services.
Further, since SNF patients frequently experience loneliness and feelings of disconnect from the outside world, many facilities are providing patients with computers and other remote devices that allow them to stay connected. Additionally, SNFs in North Carolina have introduced a software application called “It’s Never 2 Late”, which has the ability to update content based on cognitive/brain fitness, patient education, virtual travel, and games. This is an example of adopting technology to enrich the patient experience during convalescence.

The National Research Corporation reports that the Nursing Home Consumer Assessment of Healthcare Providers and Systems is the largest private database of patient experience and employee engagement for skilled nursing facilities. Though not currently mandatory for Medicare-certified nursing homes, the Agency for Healthcare Research and Quality has endorsed the survey, and it is anticipated that CMS will soon mandate it.

Care Transitions

The CMS Hospital Readmissions Reduction Program levels penalties against hospitals with “excessive readmissions” after risk adjustments have been applied. The penalties apply to all Medicare payments, not just payments associated with excessive readmissions. In 2015, hospitals with higher than expected 30-day readmission rates will incur penalties of 3 percent against their total Medicare payments. When considering a SNF as a potential partner to manage episodes of care, hospital readmissions are particularly risky given that SNF patients are medically complex and are frequently readmitted. CMS, through its Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents, recently evaluated Medicare-Medicaid enrollees in nursing facilities, and their findings suggest that approximately 45 percent of that patient population’s hospital admissions could have been avoided. When quantified, this represents approximately 314,000 potentially avoidable inpatient hospitalizations, and $2.6 billion in Medicare expenditures in 2005 alone. These readmissions are expensive and disruptive to a fragile patient’s care plan and often leave patients vulnerable to risks associated with hospitalization and transitions in care.

In response to these trends, several organizations are designing transition innovation initiatives to reduce avoidable readmissions for SNF patients. The management of the SNFs should be aware of these programs and actively engage in the support of patient care transitions. Examples of initiatives that hospitals and other healthcare organizations are implementing to prevent avoidable admissions and improve the quality of care for the patient are described on the following page.
• CarePlus, formerly known as Evercare, uses nurse practitioners to provide increased clinical care and intensive management of chronic conditions. They also provide additional payments to SNFs to offset the costs of additional staff needed to care for higher acuity patients.

• Interventions to Reduce Acute Care Transfers is a CMS quality improvement and information exchange program that focuses on early identification, assessment, communication, and documentation of acute changes in the SNF patient’s clinical condition. It includes clinical and educational tools and strategies for use in every day practice in long-term care facilities.

• In the Care Transitions Program®, a nurse or nurse practitioner serves as a Transition Coach. This individual conducts a home visit within 72 hours of discharge and speaks with patients by phone on post-discharge days 2, 7, and 14. During these encounters, the Transition Coach prepares the patient for upcoming appointments with healthcare providers. The four main components of the Care Transitions Program® are: medication self-management, patient-centered record (“PCR”), follow-up with the physician, and knowledge of warning signs and symptoms and how to respond to them.

• The Transitional Care Model provides pre-and post-discharge coordination of care for high-risk, elderly patients with chronic illnesses. The core components include consistency of providers across the entire episode of care with the Transitional Care Nurse serving as the primary coordinator of care, regular home visits with available, ongoing telephonic support (24 hours per day, seven days per week) for an average follow-up of two months post-discharge. The model emphasizes the early identification and response to healthcare risks and symptoms, avoidance of adverse events that could lead to readmissions, and active engagement of patients, and families and caregivers in all aspects of the patient’s care, including health education and support.

• CMS is operating a Nursing Home Value-based Purchasing Demonstration Project in Arizona, New York, and Wisconsin to improve the quality of care for SNF patients. Skilled nursing facilities participating in the program receive annual payment awards based on performance levels or improvements across four sets of performance measures, of which potentially avoidable hospitalizations are one of the measures.

Evaluation of the SNFs program for managing transitions into and out of the facility, as well as their actual data should be considered prior to any partnership with a health system.

Application of Information Technology and Telemedicine:

CMS’ Electronic Health Record (“EHR”) Incentive Programs were authorized by the Health Information Technology for Economic and Clinical Health Act of 2009. Under this program, acute care hospitals that demonstrate “meaningful use” of EHRs are eligible to receive incentive payments. However, skilled nursing
facilities are not eligible to participate in the incentive programs and will not be subject to penalties. Consequently, SNF adoption of EHRs is relatively low; based upon research, only 43 percent of SNFs have implemented an EHR\(^1\) and several barriers to implementation continue to exist, including:

- Large amount of capital required to implement combined with an absence of meaningful use incentives to do so
- Workforce limitations due to the staffing resources required to implement and maintain an EHR
- Business and cultural factors, given that SNFs often undergo frequent changes of ownership and are commonly low-tech, paper-based organizations

As healthcare reform continues to focus on strengthening care coordination between the acute and post-acute clinical arenas, the need to effectively capture, use, and exchange information in a timely manner across the continuum is critical as patients transition from SNFs to acute care facilities and/or emergency care facilities several times each year. Additionally, EHR implementation in a SNF provides a powerful opportunity for a hospital partner to manage episodes of care and impact care quality, since providers will have real-time data that will provide information needed to proactively adjust patient care plans when needed.

In addition to the EHR, remote medical technology is becoming a popular, cost-effective tool for care management. The Commonwealth Fund recently sponsored a research study to determine the efficacy of telemedicine in SNFs for afterhours care. This technology has the ability to reduce hospital readmissions and improve overall patient health because it provides physicians and APCs with the ability to evaluate a patient’s status in the SNF via a two-way video, there minimizing patient wait times by providing the right care at the right time. This research study concluded that patient hospitalization rates declined among SNFs that had deployed telemedicine services, with an average reduction of 11.3 percent in hospitalizations for those SNFs that were considered to be “more engaged.”

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\(^1\)Stage 1 meaningful use ("MU") medication reconciliation requirements are putting pressure on health care systems for better access to patient information. MU stage 2 has requirements for interoperability of EHRs (i.e. interoperable exchange of summary care records), therefore minimizing a SNF’s apprehension that they could possibly be installing an EHR that won’t work with all of their referral hospitals’ IT systems. Also, the Stage 2 requirements for written transition of care summaries will put more pressure on SNFs to have an EHR that accepts these summaries electronically. Stage 3 is considering one possible requirement to include longitudinal care plans, putting more pressure on SNFs.
Summary

As opportunities arise for hospitals and health systems to partner with post-acute venues, these five factors are essential to ensure that the patient’s care is continuous and coordinated. Given the potential financial incentives under this initiative, hospitals must complete a comprehensive assessment of a SNF when evaluating a potential partner for episode of care management in the post-acute care clinical arena. Additional discussions with SNF administration and medical staff will assist to determine cultural fit, long-term strategic plans, and a “go or no-go” decision related to strategic alliances.
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