

Viewing post-acute care in a new light: Strategies to drive value

Executive summary

"Post-acute care looks like an archipelago of little islands with no bridges. Consumers are at a loss about which island to approach, with poor transportation and communication options."—Physician executive

Today's health care leaders are juggling the demands and opportunities of a transforming market: New entrants are disrupting the status quo and traditional players are reinventing themselves. Payment and care models are changing. Organizations are searching for ways to innovate for cost and quality improvement. This last point certainly rings true for post-acute care, as health systems and health plans begin to view this industry segment in a new light—as one that can deliver more value and opportunities to their organization.

Consider the impact on Medicare, for example. More than one in five Medicare patients discharged from a hospital receives post-acute care.¹ Moreover, the total impact of post-acute services on readmissions, ER visits, outcomes, and overall spending far exceeds the direct cost of post-acute care services. Because value-based payment models increasingly focus on costs and outcomes occurring inside and outside hospital walls, now is the time to rethink post-acute care strategies to drive value. Market pressures—including the expansion of bundled payment programs, the Medicare Access and CHIP Reauthorization Act's (MACRA) incentives for providers to join risk-bearing payment models, and readmissions penalties—further reinforce the need for organizations to take a new look at post-acute care.

To understand the industry's post-acute care strategies, the Deloitte Center for Health Solutions interviewed 36 executives from 27 organizations, including health systems, health plans, post-acute care companies, and professional associations. Their insights provide a useful roadmap for organizations as they look to boost post-acute care value.

The interviewed health systems agree that partnerships and quality initiatives are important elements of a post-acute care strategy:

- **Partnering is preferred over owning.** Partnering with post-acute providers brings expertise, scale, and speed-to-market that health systems typically cannot achieve on their own. Relationships can take different forms, such as joint ventures (JVs), leasing beds, and preferred referral networks.
- **Identifying the right partners is important.** Many post-acute providers are keen to innovate and collaborate for performance improvement. Some leading traits of potential post-acute partners include a commitment to value-based care, the ability and willingness to analyze their data to guide improvement, as well as geographic coverage and scale.
- **Specific quality initiatives are the next step.** Clinical improvement efforts for post-acute care often focus on care transitions, augmenting clinical staffing, broadening the medical director role, reducing readmissions, developing patient-centered models, and enhancing clinical staff education. A few leading organizations are beginning to develop evidence-based care pathways specific to post-acute care.

Most health systems' initial clinical improvement efforts have focused on quality: They reviewed data on readmissions, acute care and post-acute care length of stay (LOS), and discussed performance with their top post-acute referral destinations. Several of the health systems have seen results from these discussions alone, including:

- Reduction in LOS at post-acute settings;
- Lower readmissions, particularly those in Medicare Accountable Care Organizations (ACOs);
- Improved utilization by shifting appropriate patients from a skilled nursing facility (SNF) to home health; and,
- Sustained performance on patient experience measures.

Some interviewed health plans are active in post-acute care, but this is not the norm. Most health plans we spoke with believe that their medical management approaches are reasonably effective at controlling costs and quality for their Medicare Advantage populations and any further responsibility for improving post-acute care cost and quality falls to health systems. Other health plans take a more active role in post-acute care performance by developing new clinical models and analytics-driven decision-making tools.

Interviewed health systems and health plans see and understand that post-acute care belongs in their long-term strategy. The question, therefore, is not whether to work with it, but how.

The question is not whether to work with post-acute care, but how.

Post-acute care, “the stepchild of the industry”

“In the old days, when we discharged patients from the hospital, you had this: ‘Good bye and good luck. Nice knowing you. Hope everything is great. Drop us a postcard sometime.’ The future is that we are still responsible for that patient. Whether you own the facility, operate it, or not, you are now financially accountable.”
—Health system executive

Post-acute care can offer significant potential for savings and quality improvements. Readmissions within 30 days can reach as high as 22 percent from some post-acute care facilities (compared to the national average readmissions rate of 17 percent).² Also, nearly three-quarters of all Medicare spending variation can be traced to post-acute care.³

So what is post-acute care? The name applies to a continuum of services that complement the care delivered after an acute episode, illness, or injury. Patients who are no longer in critical condition but still need care and monitoring are traditionally discharged to a post-acute care setting, which include home health agencies, SNFs, inpatient rehabilitation facilities (IRF), and long-term acute care hospitals (LTACH). (See Appendix A for definitions.)

Typically, the goal of post-acute care is to improve patient functional status and outcomes (e.g., returning to a daily activity that the patient participated in before an illness or injury).

In spite of its very large and complex role in health care, many patients and their families have never heard of post-acute care until they need it. Many hospitals and physicians have only a rudimentary understanding of post-acute care services and give little thought to where their patients are heading after discharge, as long as it does not extend the acute LOS. Payers, including Medicare, Medicaid, and commercial health plans, generally take little notice of the differences in services across post-acute providers and service lines.⁴ Many of the executives interviewed for this study describe the post-acute care landscape as “fragmented and siloed.”

Although successful population health strategies call for involving the entire continuum of care—all of the health care providers who take care of the patient, not just the acute health system and physicians—until recently, there has been little effort to engage post-acute care providers in improving population health.

As the industry looks to better integrate post-acute care, the Deloitte Center for Health Solutions sought to understand what health care organizations are doing to accomplish this goal. To inform our research, we interviewed 36 executives from 27 organizations in fall 2016 (see below and Appendix B for methodology details).

The emerging importance of post-acute care

"It's clear that we have an opportunity in terms of quality and cost [with post-acute care]. It's clear that we are not transitioning patients out of acute well."
—Health system executive

"What is accepted in post-acute care would be considered catastrophic if that level of variability existed in hospitals or physician offices."—Post-acute care executive

Post-acute care is an important component of the health care industry for many reasons; one being its relative size and total impact on the broader health care market (see Figure 1 on the following page).



About this study

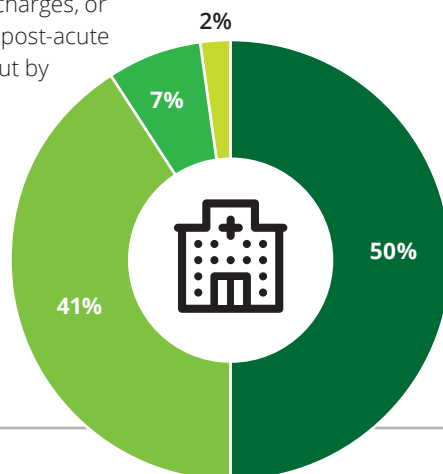
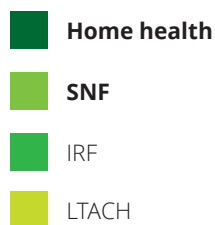
To understand post-acute care strategies, the Deloitte Center for Health Solutions interviewed 36 executives from 27 health care industry organizations in late fall 2016. The executives were from a diverse range of organizations representing several industry segments:

- 10 large and mid-sized health systems
- Seven national and regional health plans
- Five post-acute companies
- Five professional associations representing post-acute providers

Health systems and health plans shared information about their post-acute care strategies, approaches, best practices, and challenges. Post-acute providers and professional associations described how they collaborate around value-based care and improve their own performance.

Figure 1. Size and impact of post-acute care

Over 22 percent of all hospital discharges, or nearly eight million patients, used post-acute care services in 2013.⁵ The breakout by post-acute setting is:⁶



Medicare spends nearly \$60 billion per year on post-acute services, or 12 percent of its annual expenditure.⁷

Nearly all of the interviewed executives cite the fragmented state of post-acute care. With fragmentation comes variability, which can mean wide differences in cost, utilization, and quality.

Variation in post-acute care accounts for 73 percent of variation in total Medicare spending, making it the single-greatest driver of spending variation.⁸

Top-performing SNFs have an average Medicare length-of-stay of less than 24 days, but low-performing SNFs have an average of more than 34 days. The variation in length-of-stay equates to a **\$4,000-per-admission difference.**⁹

Quality performance on **discharge to community, new pressure sore development, and readmissions significantly varies between low- and top-performing SNFs.** For instance, the 25th percentile of SNFs has a 7.8 percent rate of potentially avoidable readmissions. In contrast, the 75th percentile has a 13.6 percent rate.¹⁰

SNFs re-hospitalize 22.8 percent of their patients within 30 days.¹¹

Future vision for post-acute care: An integral part of the care continuum

"Get your post-acute care partners involved in the full spectrum of care. Because together you're responsible for the care of your patients."

—Health system physician executive

"I do not believe the goals of ACA can be achieved without a strong post-acute care industry."

—Post-acute care executive

While many industry stakeholders believe that care will continue to shift from hospitals to other settings, particularly the home,¹² all types of post-acute services are expected to play a role in the future of health care (see Figure 2). Home health, in particular, is poised for new market opportunities powered by emerging technologies, monitoring services, and patient preference to remain at home.¹³ The interviewed executives agree that many patients will still need SNF, IRF, and LTACH care due to demographic trends, increasing complexity and severity of patients' conditions, and patients' social circumstances (such as elderly patients with no spouse or family to assist them at home).

Many respondents believe that post-acute care is an integral component of an aligned and coordinated continuum of care, essential to achieving the Triple Aim. Some post-acute care providers themselves are implementing new ideas and programs to better position their organizations for the future.

Figure 2. Interviewed executives' rationale to focus on post-acute care

**Push for value:**

- Value-based payment models (e.g., bundles) increasingly cover the entire continuum of care, not just primary and acute care.
- MACRA will likely increase adoption of risk-bearing payment models.
- High variability in post-acute care cost and quality drives focus for improvement opportunities.¹⁴
- Readmissions from post-acute settings are common and considered a “low-hanging-fruit” for improvement.

**Utilization realities:**

- Aging demographics and burgeoning chronic disease will increase demand for post-acute services in some markets. Moreover, high-acuity patients are leaving the acute hospital earlier and require more complicated post-discharge care. *“Patients in SNF today—these used to be hospital patients when I was in residency training.”—Post-acute care physician executive*
- SNFs are overused. LOS at SNFs that maximizes reimbursement rather than addresses medical necessity “cannot be tolerated much longer;” strategies to shift patients away from SNFs are of interest to payers and some health systems.
- Home health is a highly cost-effective site of care and consumers find it attractive.

**Capturing market opportunities:**

- Most health systems have limited understanding of and relationships with post-acute providers and can benefit from closer alignment with them.
- Health systems refer to multiple post-acute providers (upwards of 30 in some cases).
- A fragmented and siloed post-acute marketplace presents opportunities for consolidation and scale, which can lead to operational efficiencies.

**Moral imperative:**

Ultimately, improving population health, quality, and patient experience of post-acute care is the “right thing to do.”

What are health systems' post-acute care strategies?

"Find out who are your [post-acute care] partners. Start to get to know them. Know them really well."
—Health system executive

"The average physician probably cannot tell you with a good deal of accuracy the differences between IRF, SNF, assisted living, home health, or hospice... Not to speak negatively of my physician colleagues; I don't think I understand those differences very well."
—Health system physician executive

All of the interviewed executives agree they need to develop an understanding and focus on post-acute care to support future value-based care and population health efforts. Some feel that they have a "leg up" because of their participation in the Medicare Bundled Payments for Care Improvement Initiative (BPCI). Others admit to competing priorities that prevent them from fully focusing on post-acute care. Many organizations are advancing post-acute care initiatives such as collaborative relationships through preferred referral networks, analyzing quality data, and leveraging technology. A handful have made considerable progress.

While each market has different factors to consider, the interviewed executives provide a useful roadmap for health systems determining their post-acute care strategy, boiling it down to these steps:

1. Determine whether to own or partner. This includes understanding the post-acute care marketplace, current partners and services.
2. Identify attractive partners.
3. Develop specific tactics to carry out performance improvement.

Should health systems own or partner for post-acute care?

"We used to own SNFs... now we say 'Gee, should we get back in that business ourselves or look for a partner?'"
—Health system executive

"We run hundreds of SNFs and we are good at it. Hospitals trying to run a SNF don't have a point of reference or economies of scale to make it better."
—Post-acute care executive

The vast majority of health system interviewees say they prefer to partner rather than own or buy a post-acute care provider, as a partnership can provide cost-effective access to a breadth of post-acute care expertise. A few who express interest in owning post-acute care assets are only interested in home health or a SNF in unique circumstances. Almost none show interest in owning IRF or LTACH services due to their unique operational expertise, specialized services, and smaller volumes. Those executives who engaged in the process of determining whether to own or partner say they gained valuable insights about post-acute services, current partners, and broader needs.

The interviewed executives identify several considerations for owning versus partnering:

- Speed-to-market
- Capital requirements
- Focus on the core business
- Technology integration
- Financial and quality alignment
- Scale



Own: For those with legacy assets or interest in bearing full financial risk

Generally, health systems are interested in post-acute care ownership only under unique circumstances. Interviewees with legacy post-acute assets or a commitment to population health and bearing full financial risk feel most compelled to own post-acute care. They are large integrated delivery systems with a broad patient population, considerable geographic footprint, a provider-sponsored health plan, and investments in bearing full financial risk. These health systems also typically have the capital and resources required to own post-acute care facilities.

The rest acknowledge that they lack the core competencies and expertise to successfully operate a post-acute care facility; not to mention the substantial capital and scale requirements. Furthermore, reimbursement for post-acute services is low, particularly SNF and home health, making these portfolio additions hard to justify.

Home health is the only post-acute care service line worth owning, according to the interviewees. Low capital requirements make home health attractive, along with its ability to provide care efficiently, better manage transitions, supplement primary and urgent care, and meet patient preferences for care in the home. As bundled payment models become more common, post-acute care ownership, especially home health, may become more attractive.

The most compelling benefits of a post-acute care partnership are access to expertise, scale, speed-to-market, and low capital outlays.



Partner: Preferred approach to gain expertise, scale, and speed-to-market

The majority of the interviewed executives find partnering with post-acute care providers much more attractive and realistic than outright ownership, but say partnering needs to have the right participants, structure, data, incentives, and goals. The most compelling benefits of a partnership are access to expertise, scale, speed-to-market, and low capital outlays.

A partnership allows participants to focus on their core businesses and competencies while benefiting from each other's specialized operational and clinical expertise. By drawing on the resources of more than one organization, a partnership may implement innovative ideas and programs more quickly and with greater flexibility. Finally, the regulatory requirements of operating a post-acute care facility can be quite nuanced and difficult to navigate. Partnerships, therefore, may be a faster and more affordable option for most health systems. For their part, post-acute care participants in a partnership benefit from the shared resources of the larger health system, capturing large patient volumes and developing experience in value-based care programs.

In some circumstances, even some of the larger post-acute care providers may opt for partnering with other post-acute care providers. Kindred, for example, recently announced that it will pursue opportunities to partner with leading SNF providers while divesting its SNF business.¹⁵

Interviewed executives admit to challenges in collaborating with some post-acute providers. Among these are absent or incompatible electronic medical record (EMR) systems, lack of data and analytics capabilities, poor communication, and misaligned incentives. Still, they feel that selecting the right type of partnership and the right partners would enable them to resolve these issues over time.

Partnership types

“You don’t have to own the planet. You just have to work with partners.”—Health plan care delivery model executive

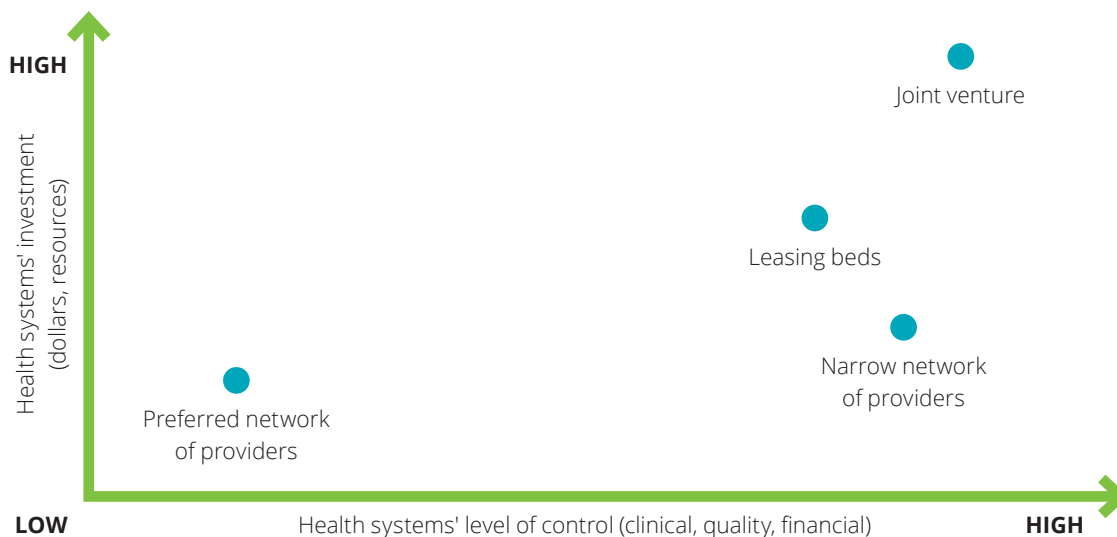
Status quo is the reality for most health systems. Many acknowledge that they are “behind” and should focus on post-acute care, but competing priorities related to broader value-based care strategies overshadow this task. Bucking this trend, several health systems are experimenting with value-based care and developing post-acute care strategies. Most began with a focus on quality—reviewing data on readmissions and LOS (acute and post-acute care) and discussing performance with their high-volume post-acute referral destinations.

Several health systems have seen results from these discussions, including:

- Reduction in LOS at post-acute settings;
- Lower readmissions, particularly those in Medicare ACOs, consistent with recently reported results;¹⁶
- Improved utilization by shifting appropriate patients from SNF to home health; and,
- Sustained performance on patient experience measures.

Our research identified a broad range of potential partnership approaches. The preferred partnership type depends upon the maturity of an organization’s post-acute care strategy, level of investments (people, capital, technology, and/or data), and desired level of control and collaboration. Some favor a portfolio approach that allows for different partnership types for different post-acute service lines (home health versus SNF), different patient populations, and specific service regions.

Figure 3. Partnership models between health systems and post-acute providers



Source: Deloitte Center for Health Solutions analysis

Joint venture (JV). This partnership type typically occurs between a health system and a larger post-acute care operator that has the capital and expertise to make such a relationship attractive. Some interviewed executives consider this approach to be most promising because it ensures commitment from both parties, can be relatively quick to launch, and enables significant levels of control. A JV can be for home health, SNF, IRF, or LTACH services, under the health system's brand or a joint brand. Both partners invest capital and have joint ownership. The post-acute partner typically contributes operational and clinical expertise, including staffing. The health system provides referrals, contributes to performance improvement efforts, and shares financial risk. A JV can be attractive in markets where health systems identify sufficient post-acute care demand. While a JV has many benefits, the deal's structure—including clearly defining financial obligations, performance goals, and partners' roles—is important.

Leasing beds. This approach seems most common in markets where there are capacity constraints with SNFs or few “high-quality” post-acute care options. Health systems can lease anywhere from 10-20 beds in post-acute facilities to guarantee access for their patients, better control clinical care, and have greater oversight of costs and quality. Health systems still developing their post-acute care strategies often find this approach attractive, as it allows them to offer post-acute care in their system without investing major capital.

Preferred network for referrals. This is the most common model we found for health systems that have just started to define their post-acute care strategies. In this model, health systems collaborate informally with a select group of home health, IRF, SNF, and LTACH providers in their geography as part of a preferred network.

Many of these collaborations tend to start with the health systems' most frequent post-acute referral destinations. Many interviewees admit they did not use data to identify partners; instead, they began the collaboration with any willing post-acute provider. Partners meet regularly, share data, discuss specific outlier cases, collaborate on initiatives to improve cost and quality, and attempt to steer a majority of their referrals to participating post-acute providers.

Preferred network partners use multiple approaches to improve clinical quality. Some are able to share and access each other's EMR systems for improved communication of clinical information and care transitions. Others have physicians and advanced practice nurses (APNs) round at both the acute and post-acute sites for improved medical management. Some perform remote monitoring of patients at post-acute care facilities to identify early medical event triggers or warnings. A few use data to identify clinical topics (e.g., fall prevention and pressure sores) for post-acute care clinical staff continuing education.

So far, few health systems have fully adopted a narrow network approach, but the interviewed executives expect this to change as experience accumulates and health systems bear more risk. Both sides of this partnership view the approach as “learning.” While currently there are no financial incentives to ensure alignment, many feel that the relationships are collaborative in nature and a step towards future financial alignment through value-based contracts.

Many of these collaborations tend to start with the health systems' most frequent post-acute referral destinations.

Identifying post-acute partners: Data-driven approaches are rare

*“Put your thumb to the wind and see what is best.”
—Health plan executive*

“We wish we could say that we have sophisticated dashboards and data analyses.”—Health system executive

Market conditions can affect the extent to which developing a narrow network is possible. In some markets, health systems refer to a large number of post-acute providers (so they can selectively create a preferred network), while other markets have a shortage of post-acute care beds. That said, all of the executives agree that it is important for health systems to start the process of identifying partners.

Though not used by all, data can be a critical component of partnership discussions, with LOS and readmissions data the most important and obtainable, according to the interviewed executives. Some analyze the data by specific post-acute provider and condition to identify better performers and to pinpoint opportunities for improvement. Even still, available data for determining the best post-acute partners is often limited or unavailable, and what is there, including Medicare Star Ratings, tends to be dated or not reflect most relevant services. A few use conveners, organizations that provide technical assistance for bundled payments, to obtain data and analytics. Our interviewees say that few health plans share post-acute care performance data with health systems.

The following sources can be useful for evaluating post-acute care providers' quality and identifying opportunities for alignment through value-based care incentives:

- **CMS claims data:** Access to this data is only available through participation in CMS alternative payment programs (such as MSSP, BPCI, CJR, etc.).
- **Health systems' own data:** Some analyze the source of their acute hospital's readmissions by specific post-acute facility, condition, or physician.
- **Self-reported data from post-acute providers:** Some post-acute providers are able to assemble and share their own data (manually or electronically) on readmissions and LOS, with detailed breakout by patient type and condition.
- **Qualitative clinician feedback on their experience with a facility:** Organizations often obtain informal feedback from their staff (discharge planners, case managers, nurses, and physicians) on their experience with a post-acute facility.
- **Medicare Star ratings:** Despite their limitations (dated and focused on the long-term care services of a SNF), many organizations use Star ratings because they are publicly available and will likely continue to evolve.
- **Commercial claims data:** Some health systems use data from their own provider-sponsored plan or from other commercial health plans, when available, on a post-acute provider's cost and quality.

Interviewed executives largely agree on criteria that make a post-acute provider attractive for collaboration:

- Shared vision and philosophy: Forward-looking leaders who embrace value-based care. *“There are quite a few [post-acute leaders] who are still stuck in the old world and don’t recognize the changes.”*
—Health system executive
- Data-savvy: Post-acute providers who are willing to share their own data and comparisons to peers.
- Geographic coverage and scale: Broad geographic coverage that aligns with the health system service area and an ability to meet the system’s needs.

Clinical and financial alignment is important

Many interviewed executives view their post-acute care partnerships as an evolution. They started by partnering with anyone willing to work with them, then progressed to collaborating on cost and quality improvement. Some are now narrowing their list of partners. A few are even considering financial risk-bearing models.

Financial alignment often is a logical next step for a collaborative partnership. JVs offer strong financial incentives for both organizations, but such arrangements tend to be less common than the other partnership types described earlier. Moreover, alternative reimbursement models, such as those that allow for shared savings around quality or total cost of care, still comprise just a small fraction of total revenue.¹⁷ The lack of meaningful financial incentives in post-acute care for value-based innovation is a barrier for many.

Most interviewed health system executives agree that once value-based contract revenue increased, they would involve their top post-acute care partners in those contracts, with both upside- and downside risk. While admitting that this is not likely for a few more years, most hope that post-acute partners will benefit from the relationship through increased referral volume, data support, and continuing clinical education for their staff.

Post-acute providers’ strategies: Focus on value-based care, quality, innovation

“This is the single best opportunity for post-acute care to elevate our status as a partner to hospitals and doctors that has ever existed. But it comes with huge risk and threats.”—Post-acute executive

Many of today’s post-acute care executives recognize that they have an opportunity to capitalize on current market trends to transform their business and meet health system, payer, and consumer expectations. Some post-acute providers participate in value-based payment models and many are changing their clinical and staffing models to improve quality.

Embracing value-based payment models: Many of the larger post-acute care providers say they recognized early that risk-bearing payment models would become an important part of post-acute care reimbursement, and worked to embrace those models. This includes participating in BPCI and value-based contracts with commercial plans.

Changing clinical and staffing models: Some home health agencies are recreating the SNF stay at home by increasing the number and intensity of nursing or physical therapy visits: instead of the typical twice-weekly home visits, they are offering daily visits for a two-week period to avoid and replace the SNF stay. Additional approaches are detailed in the next section “Strategies for clinical improvement.”

The few health plans that employ physicians are developing new care models while others are leveraging their case management expertise and wealth of data and analytics to determine cost-effective care paths.

Below are specific examples of how post-acute care operators are adding value in the changing health care marketplace.

Brooks Rehabilitation in the Jacksonville, FL area offers a continuum of post-acute care offerings under one umbrella, including SNF, IRF, and home health.¹⁸

Brooks can provide the most appropriate setting based on a patient's needs because they have the entire post-acute care continuum. Brooks also leverages telehealth technology to connect patients and clinicians for transitions to different sites of care. Before a patient transfers from an acute care hospital, SNF, or IRF to another level of care or home care, clinicians from each site join the patient in a secure web-enabled video chat.

Covenant Care, a national chain with 52 SNFs, four assisted living centers, home health, and other long-term care services,¹⁹ created a "cluster" strategy in certain markets where it has several facilities. Inside these clusters, Covenant Care manages volume and referrals across the facilities. It also adds new clinical programs to some of the facilities and makes them available to the entire market cluster. This has proved to be a more efficient strategy for them than adding programs to individual facilities. Covenant Care currently has more than 500 BPCI Model 3 bundles as the Episode Initiator. As part of this initiative, the facility with the top outcomes for the patient's DRG is prioritized as the discharge destination.

Genesis HealthCare is one of the largest SNF chains in the nation, with 500 facilities.²⁰ It employs and contracts with over 500 physicians, nurse practitioners, and physician assistants. The goal of this medical staff model is to ensure that patients receive consistent, high-quality care across the post-acute spectrum. This has enabled Genesis' strategy of embracing value-based and risk-based contracts.

HCR ManorCare, one of the largest post-acute care chains with 255 SNFs nationally,²¹ created the MedBridge certification program, which rates its facilities on 38 criteria, such as customer service, number of on-staff clinicians, and length of stay. HCR ManorCare shares this information externally and delivers detailed data to its referral sources. The organization sees it as a way to educate consumers, acute-care providers, and payers about the quality criteria relevant to short-term Medicare patients.

Kindred is the largest post-acute chain in the country based on revenue,²² with home health, SNF, IRF, LTACH, and outpatient rehabilitation services located throughout the US. It partners with health systems in multiple markets through joint ventures. Kindred also has established a contact center for post-acute care referrals to assist consumers as well as hospital discharge planners seeking the right place for their patients. Kindred expanded services to include after-care calls to discharged patients. Seventy registered nurses at the contact center handle over 50,000 calls a month. Kindred's referral recommendations are data-driven, drawing upon clinical and claims information from their own facilities, CMS, hospitals, and private health plans. Kindred nurses recommend the right facility for a specific patient, even if the facility is not one of its own.

Partners HealthCare at Home, the home health services of Partners HealthCare, is testing the feasibility of bringing inpatient-level care to the homes of patients with serious conditions, such as pneumonia and certain types of heart disease. In another program, nurse practitioners travel to a patient's home when an urgent care-level need arises.

Strategies for clinical improvement

“Transitions—you’ve got to work on transitions. That’s where the opportunity is.”—Health system executive

“The biggest opportunity in post-acute is collaboration across the levels of care.”—Health system executive

Once a health system has assembled a favored group of post-acute providers through ownership or partnership, often the next step is to develop strategies to improve post-acute care performance. While acknowledging that major challenges exist—such as the lack of interoperable EMRs and breakdowns in communication—interviewed executives suggest a number of approaches and focus areas to improve post-acute care performance.

- **Clinical improvement.** Many organizations focus on improving the clinical quality of post-acute services.
 - *“The future of post-acute is not physicians, it is advanced practice nurses,”—Health system executive.* Numerous interviewees consider **APNs an attractive alternate to lead care** versus physicians, saying that APNs appear more interested in post-acute care, engaging with patients and families, and working in team-based settings. Some SNF operators say they are replacing licensed practical nurses with APNs to strengthen medical management. Health system strategies include sending their clinicians to care for their patients at post-acute facilities to supplement the facility’s staffing. This can improve clinical decision-making and reduce readmissions and other complications.
 - Many executives noted positive results from **expanding the role of the medical director** to round more frequently at SNFs, be more involved in clinical oversight for home health, lead clinical improvement initiatives for the facility, and communicate more with acute clinical teams.
 - **Medication management**, particularly medication reconciliation at each point in care transition, is a high priority for those interviewed. Other efforts may include revisiting pain control approaches so that the patient is able to participate in rehabilitation earlier.

- **Reducing readmissions** is another focus area. Initiatives include jointly analyzing data on patient conditions more prone to readmissions; leveraging technology to monitor high-risk patients during their post-acute stay; and increasing physician or APN on-site medical management of high-risk patients (e.g., reducing the time between admission to post-acute care and being seen by a physician or APN).
- Some health systems are offering additional **continuing education and training** for clinical staff at post-acute care facilities, recognizing that these clinicians have fewer opportunities and resources to receive it. A handful of health systems develop new clinical education programs on topics that their post-acute care partners request. Others develop content tied to quality focus areas, such as falls. Some may require post-acute care clinician participation, *“as part of a remediation plan to get [their post-acute care partners] back in line with quality criteria,”—Health system executive.*
- **Evidence-based care pathways.** We found that few health systems have sophisticated approaches to post-acute care discharge planning or care pathways. Developing robust clinical pathways requires comprehensive claims data (from CMS and private payers) and clinical data from hospitals and post-acute providers, which can be rarely available. Evidence-based care pathways should take into account patient clinical and nonclinical circumstances (obesity, homelessness, behavioral health needs), geographic proximity, and the clinical competence of a market’s post-acute providers (e.g., some may have stronger CHF versus orthopedic capabilities). Health systems can work with a third-party vendor (such as a convener) for discharge planning, pathways, and network development. (See sidebar on Memorial Hermann’s user-friendly online discharge planning tool for an example of care pathways.)

- **Care coordination.** Improving care transitions between acute- and post-acute providers focuses on enabling better hand-offs, using analytics-based care pathways, and leveraging home health for pre- and post-discharge. In many effective programs, transition planning begins with hospital admission—sometimes even sooner. This can improve care coordination and operational efficiency by enabling post-acute care partners to accurately estimate patient volume, stock medications, obtain pre-authorizations, and match staff capabilities with patient needs.
- **Patient-centered care.** Improving communication is often a primary focus for patient-centered care. Some health systems are giving the post-acute facility access to the patient's entire medical record and history, not just the limited information shared in the past. Others are building technology platforms that streamline communication.

Health plans' perspectives on improving post-acute care

"Interestingly, ACOs and bundles are trying to do what health plans have been doing for years. The game in health care is... what is the most appropriate setting and appropriate LOS for every patient? Health plans are good at making that call because they have been collecting and studying that data for a while."

—Post-acute care executive

Most health plan interviewees say their medical management approaches are reasonably effective at controlling costs and quality for their Medicare Advantage (MA) populations (see sidebar); however, the high level of variability in post-acute care use and quality remains on their radar screen. Many health plans continue to invest in case and utilization management, readmissions reduction efforts, value-based care contracts that include the full continuum of care, and initiatives to better coordinate care for patients pre- and post-discharge. Many health plans also express interest in leveraging home health in all of their lines of business to help members avoid more expensive care settings, such as the ER or hospital.

Medicare Advantage vs. Medicare fee-for-service post-acute care utilization

Medicare Advantage (MA) enrollees are less likely to be admitted to IRFs and have shorter stays at SNFs compared with fee-for-service (FFS) Medicare enrollees.²³ Researchers analyzed discharge data for patients hospitalized for joint replacement, stroke, and heart failure. They found that MA enrollees also are less likely to be readmitted to the hospital within 30 or 90 days and more likely to return to the community after being discharged from post-acute care.

Among the findings:²⁴

- MA enrollees discharged after joint replacements are two percentage points more likely to be admitted to a SNF, but stay 3.2 fewer days than FFS Medicare patients, on average.
- Patterns of differences in the use of post-acute care facilities between MA enrollees hospitalized for a stroke are similar to those of joint-replacement patients.
- MA enrollees with heart failure are less likely to be admitted to a SNF compared with FFS enrollees.
- FFS Medicare could save \$1,455 per joint replacement, \$2,397 per stroke, and \$1,143 per heart failure episode if it had the same post-acute care use and readmissions rates as MA.

Health plans' approach to post-acute care falls into two camps:

- **Traditional:** These health plans prefer to steer patients to low-cost settings and try to achieve this through benefit design, medical management, and value-based incentives so the responsibility for performance improvement falls on the care delivery system.
- **Hands-on:** These health plans take ownership of post-acute care cost and quality by developing new clinical models and supporting data analytics tools.

Many of the health plans in the traditional camp are developing strategies that incorporate post-acute care to target high-risk (high-cost) members. The few health plans that employ physicians are developing new care models while others are leveraging their case management expertise and wealth of data and analytics to determine cost-effective care paths:

- CareMore Health System, a vertically integrated care delivery organization owned by Anthem, relies upon an "Extensivist" model in which its employed Extensivist clinicians round on CareMore members in all settings, including the hospital, SNF, and home. This model eliminates breakdowns in care transitions as patients move across settings since the same care team follows and treats the patient until the episode is resolved and the patient is fully recovered and transferred back into the community under the care of a CareMore primary care physician.
- Aetna's "AetnaCare" program uses analytics to drive longitudinal evidence-based care maps for medically complex patients. The focus is on creating an ecosystem of health care solutions, including post-acute care, around each individual, beginning in the home.

It is worth noting that the full benefits of sophisticated medical management may not be realized until incentives are fully aligned. Many medical management approaches—such as pre-authorizations for SNF, ER diversion programs, or strict guidelines on LOS—quickly reach their limits within the constraints of traditional reimbursement methodologies due to competing stakeholder financial interests. Implementing value-based contracts that include the full continuum of care and place accountability for the total cost of care on the providers may be one option.

Yet, in order to assume risk for total cost of care, health systems may need additional supporting resources and capabilities, such as care pathways that combine case management and network development solutions. A number of health plans have the data and care management experience in post-acute care to create the building blocks for such care pathways.

The few health plans that employ physicians are developing new care models while others are leveraging their case management expertise and wealth of data and analytics to determine cost-effective care paths.

Technology can fuel post-acute care innovation

Technology can support post-acute care innovation in clinical areas, care transitions, referrals, and patient engagement. For example, several interviewed organizations offer remote monitoring in SNF or home health settings to support clinical improvements.

- Two organizations are piloting technology that enables remote monitoring of patient vital signs. A physician executive explains the concept behind this pilot: *"You have very close observation in a hospital. Now that the patient is in a post-acute facility, the only time we know when the patient is crashing is when they actually crash. With this technology, the vital signs are sent to our nurse practitioners several times a day so they can look for changes in respiratory rate, hypotension, or tachycardia. We watch and try to predict before they crash and proactively try to solve those problems so they don't get worse and require a hospital visit."*—Health system executive
- In home health care, remote monitoring supplements home visits, allowing for an intense level of care. A respondent describes an ER diversion program: *"A patient presents to the ER and if he or she meets certain criteria, that patient can be sent home to receive*

hospital-level care at home. This is like advanced home health, physician-led, but includes home health nurses and intense remote monitoring."—Post-acute executive

Some organizations are developing solutions to fill gaps in their EMRs or care management tools.

- Brooks Rehabilitation developed software that lets its frontline clinicians "track patients as they move through the bundle." This tool supports Brooks' strategy, participation, and results in BPCI.²⁵
- Brooks Rehabilitation also uses technology to improve patient experience and facilitate care transitions via real-time virtual handoffs. While still at the hospital or SNF, the patient, nurse, and physical therapist talk via "HIPAA-compliant Skype" with the nursing and therapy staff at the setting to which the patient is getting discharged, whether it be SNF or home health. This helps educate patients and families about what to expect and ease their anxiety about the transition.

A few health systems use electronic referral systems to communicate patients' clinical status and needs to post-acute providers. (See sidebar.)

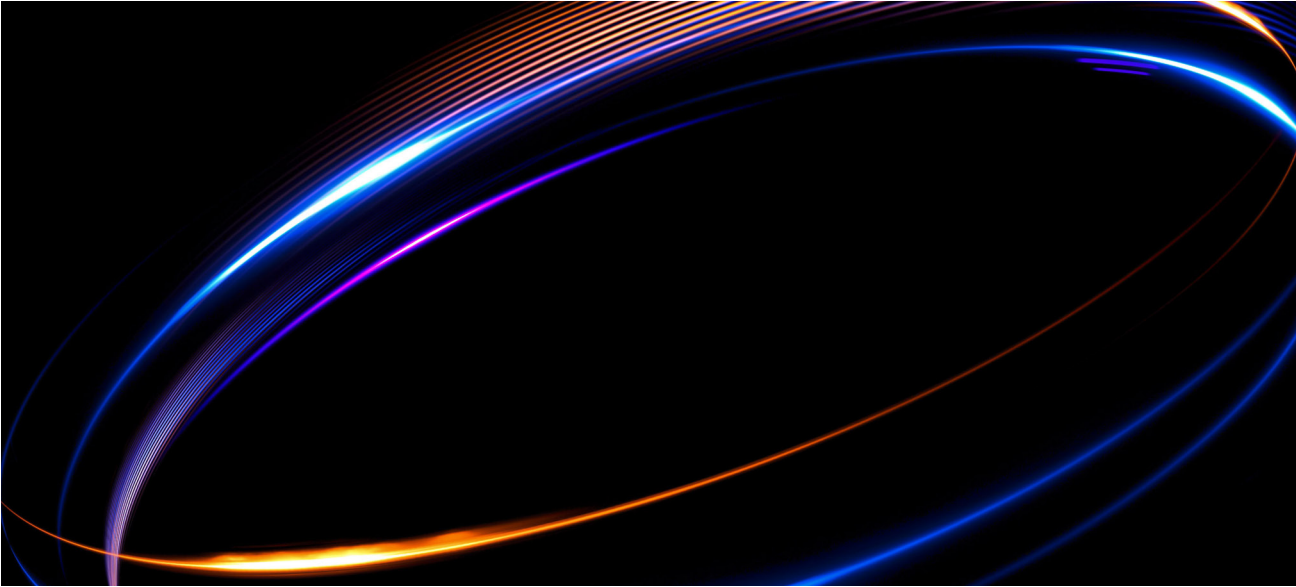
"Travelocity-like" discharge planning tool

Memorial Hermann, a large integrated health system, knew that hand-offs are a risky part of patient care. The organization wanted its patients who needed post-acute care to get a facility that could handle their level of acuity, would accept their insurance, and had experience with patients of a similar demographic. Data-miners had the answer.

By matching the capabilities of a post-acute care provider's facility with a patient's clinical needs, Memorial Hermann could improve care transitions and reduce risks, such as medication errors and readmissions. Memorial Hermann combined its clinical and claims data with publicly available data and self-reported quality metrics from its post-acute care partners, and made it accessible through a "Travelocity-like" software system for its discharge planners.

The referral tool is supplemented by an app loaded on Memorial Hermann's physicians' smartphones. The app lets a discharging physician exchange secure messages with an admitting clinician at a post-acute facility; this is an improvement over the old system in which the hospital clinician would call the post-acute facility, leave a message, and hope to be available when the callback came.

The referral tool also enables temporary suspension of referrals to post-acute facilities with unresolved quality issues: "In the past, we sent out a memo to referring clinicians. Now, we have a programmer 'put them on probation.'"



Mobile applications for patients are a common technology used in home health. One organization developed two smartphone apps for broader use:

- *“We developed an app that lets patients and families see real-time functional improvements. If you get them addicted, they want more communications; they want to see progress.”—Post-acute executive.* The app provides an opportunity for better self-care. Patients and their families can take the app home or to an outpatient setting and continue that care with the mobile app’s help.
- *“We developed a ‘rehab relay’—an app that notifies doctors, ‘You haven’t approved this order for 24 hours.’ This is a big deal because reimbursement is not there for that patient unless a physician approves the order.”—Post-acute executive*
- Some home health programs either lend mobile devices to patients or load the apps on patients’ own devices. Patients are then able to communicate with their care team through secure messaging or Skype-like interfaces, and receive “pushed” content (video, reminders, checklists) appropriate for their condition.

As in other health care areas, lack of interoperability presents barriers to post-acute care on multiple levels, especially for care transitions and communications. Some organizations have developed add-on systems to facilitate electronic referrals and clinical communication or have an amalgamation of tools to help with discrete tasks such as referrals, SNF eligibility verification, or prior authorizations.

Lack of interoperability presents barriers to post-acute care on multiple levels, especially for care transitions and communications.

Conclusion

Some health systems and health plans have mature post-acute care strategies, while others are still developing their approach. Even with challenges and constraints emanating from the current reimbursement structure, all interviewed executives believe that a robust post-acute care strategy is critical for implementing value-based care and population health.

Collectively, interviewees recommend a roadmap for

health systems to begin developing a post-acute care strategy (see the checklist on the following page).

Health systems and health plans have many priorities and initiatives to focus on as the industry continues its transition to patient-centered, value-based care models. Now is the time for organizations to consider existing and new strategies around post-acute care and focus their efforts to drive value.

Change the lens on post-acute care

"It makes us bemoan the fact that post-acute care is in our title. In reality, we are not just about post-acute care."—Post-acute executive

ER diversion programs: Instead of being admitted to the hospital from the ER, the patient is treated and monitored in a home health or SNF setting.

Primary care enhancement: Primary care is supplemented by home health visits and remote monitoring via telehealth, targeting high-risk patients (recently discharged, with multiple ER visits, or patients who are disabled or have limited mobility).

Hospital at Home: Treatment and care are delivered in the home instead of the hospital. This includes using sophisticated medical equipment, nurse home visits, and telehealth for physician visits and remote monitoring.

Hospital at SNF: Instead of a hospital stay, a patient who is not medically stable enough or does not have the necessary support at home for Hospital at Home is admitted to a SNF for treatment.

Checklist for developing a post-acute care strategy



1. Decide whether to own or to partner. Unless a health system already owns significant post-acute care assets, partnering may be a preferred option.



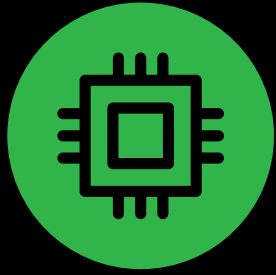
2. Identify post-acute care partners that share a vision and commitment to quality.



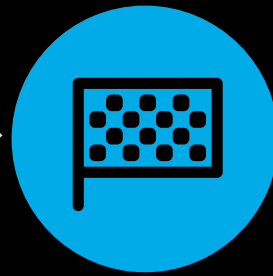
3. Get to know post-acute care partners' operational and clinical leaders.



4. Designate a champion for the initiatives. Executives in quality, nursing, case management, and clinical affairs may be appropriate choices to lead initiatives.



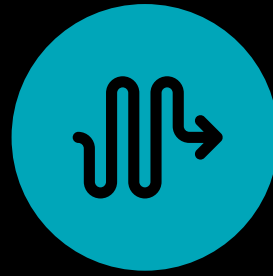
5. Leverage technology, including analytics, for identifying attractive partners and implementing improvement opportunities.



6. Decide where to begin improving performance. Typical targets include care coordination, clinical enhancements, and patient-centered care models.



7. Develop readily achievable goals. Many agreed that focusing on SNF LOS and readmissions is a good place to start.

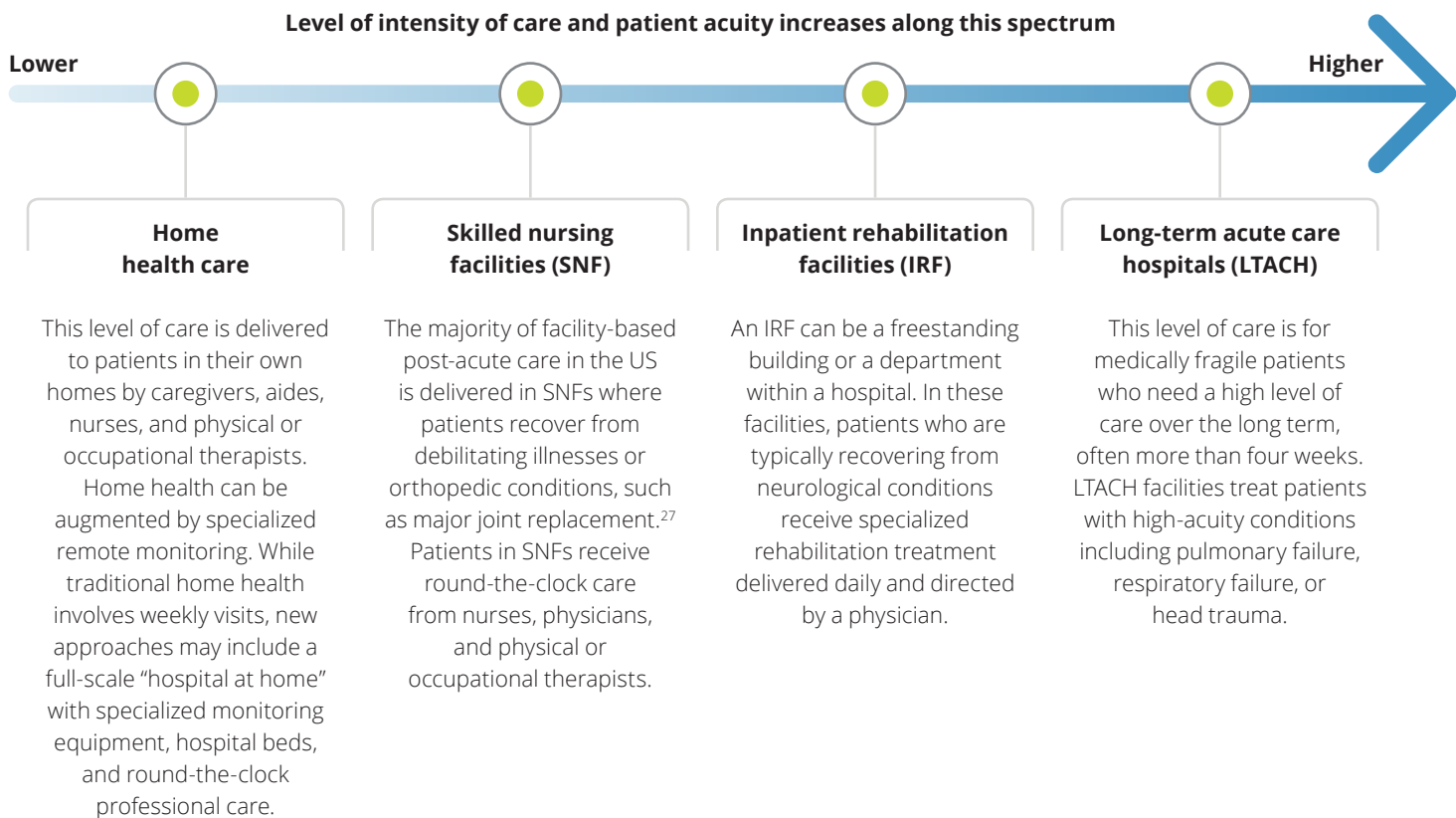


8. Implement evidence-based care pathways. Some experienced post-acute care providers have developed care pathways or clinical frameworks that can serve as a foundation for this effort (e.g., VNAA Blueprint for Best Practices in Home Health, Hospice and Palliative Care). Conveners, health plans, and large post-acute care chains are developing solutions.



9. Borrow from the health plan playbook: Consider alternative post-acute care uses that prevent hospital utilization (e.g., ER diversion programs, primary care enhancements, "hospital at home" or "hospital at SNF" concepts).

Appendix A: Post-acute care settings



Source: Deloitte Center for Health Solutions analysis

Appendix B. Research methodology

In late 2016, the Deloitte Center for Health Solutions spoke with 36 executives from 27 organizations in a series of semi-structured interviews. The executives were from a wide range of organizations from several industry segments:

- 10 large and mid-sized health systems
- Seven national and regional health plans
- Five post-acute care companies
- Five professional associations representing post-acute providers

All interviewed executives held senior-level leadership positions within their organizations, with titles ranging from Director to Senior Vice Presidents and Executive Vice Presidents to C-suite and equivalent. The executives also represented a range of functions, including, medical affairs, nursing, physician leadership, quality, finance, strategy, and operations.

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Acknowledgments

The authors would also like to thank Mitch Morris, Greg Scott, Mike Van Den Eynde, Jeff Ford, John Kutz, Bill Laughlin, Amy Goodman, Samantha Gordon, Lauren Wallace, Christina DeSimone, Mohinder Suttrave, and the many others who contributed their ideas and insights to this project.

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