

1) Building a best in class skilled nursing facility network

Atrius Health

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WINNING
ENTRY

PROJECT DESCRIPTION

In 2012, a physician-led Pioneer Accountable Care Organization (“ACO”) recognized an opportunity to better serve patients requiring care in skilled nursing facilities after a hospital stay. The organization began building a preferred network of skilled nursing facilities (“SNF”) and providers to improve collaboration between facility staff, attending teams and patients’ primary care physicians to help patients recover and return home sooner, improve care coordination between the SNF and the primary care provider and reduce unnecessary hospital readmissions. The organization established key factors for evaluating potential preferred skilled nursing facility partners:

- Location of care in proximity to the organization’s practices and patients’ homes.
- High facility ratings, including the Centers for Medicare and Medicaid Services Star Ratings, Massachusetts Department of Public Health inspection, and patient satisfaction surveys.
- Cleanliness, friendly staff and accommodation of special diets for patients as well as facility amenities that appeal to patients such as internet and television.
- Staff willingness to collaborate in an active relationship to define care standards and metrics with a shared commitment to consistently meeting those goals.
- Standard model of operation providing high quality care at a cost-effective value for the ACO’s patients.
- A set of SNF Facility and SNF Provider expectations were created and distributed to participating facilities and other Pioneer ACOs in Boston.

Outreach and evaluation efforts were extensive and involved contacting and/or visiting more than 100 skilled nursing facilities in the Greater Boston area where the ACO’s patients had received care in the past. After completing these evaluations, it selected about 50 skilled nursing facilities as part of its preferred network.

Since its formation, patients and providers have many advantages in choosing a skilled nursing facility within the network. Patients receive care from the organization’s physicians, advance practice clinicians, or affiliated physicians in one of the preferred facilities and one of the organization’s affiliated Nurse Case/Care Managers oversee patient care during the stay.

Care is streamlined with access to patients’ electronic medical records, supporting communication of patient health status and prescribed medications to their primary care providers. Information about immunizations, fall risk and any Advance Care Planning documents procured during the skilled nursing facility stay are also shared. In addition, primary care physicians are notified upon patient discharge in order to ensure timely follow up once the patient arrives home. Discharge summaries from the SNF provider are either directly entered in the electronic health record or are faxed to the primary care provider ensuring continuity of care.

As a result, the organization has reduced hospital readmissions, recovery periods in the facilities, and costs while creating a more collaborative care model. Furthermore, this effort enabled the ACO to achieve the triple aim goals of improving patient experience, quality of care, and lower costs.

OUTCOMES ACHIEVED

- Average readmission from the skilled nursing facilities back to the hospital decreased from 12.6% in 2012 to 9.6% in 2014 among Pioneer Accountable Care Organization aligned beneficiaries, while Medicare Advantage enrollees improved from 10.5% in 2012 to 8.6% in 2014, saving half a million dollars while avoiding the deconditioning for patients and chaos for families that usually accompanies avoidable readmissions.
- Average length of SNF stays decreased from 21.5 days in 2012 to 19.6 days for patients aligned to the Pioneer ACO in 2014, and from 14.9 days to 14.1 days for those enrolled in Medicare Advantage Plans. This resulted in two million dollars in savings and patients recovering sooner and returning home.

LESSONS LEARNED

- In developing a preferred network of skilled nursing facilities, organizations can implement a more coordinated care experience with improved outcomes for Medicare patients recovering from a hospital stay.
- Improved communication between staff at preferred skilled nursing facilities and the organization’s medical care teams allow for more timely notifications about a patient’s medical conditions as well as follow ups with patients following discharge.
- Use of the Medicare three-day rule waiver, which allows patients to be admitted to a skilled nursing facility without a 3-day hospital stay, has helped avoid unnecessary hospital admissions, improve access to the right level of care, and improve patient satisfaction.