# "Must Do" Service Line Strategies in Q1 2014

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The rapid evolution of the healthcare industry is about to thrust upon hospital and health system board members a new set of vocabulary, performance oversight responsibilities, and resource allocation decisions specific to post-acute care.

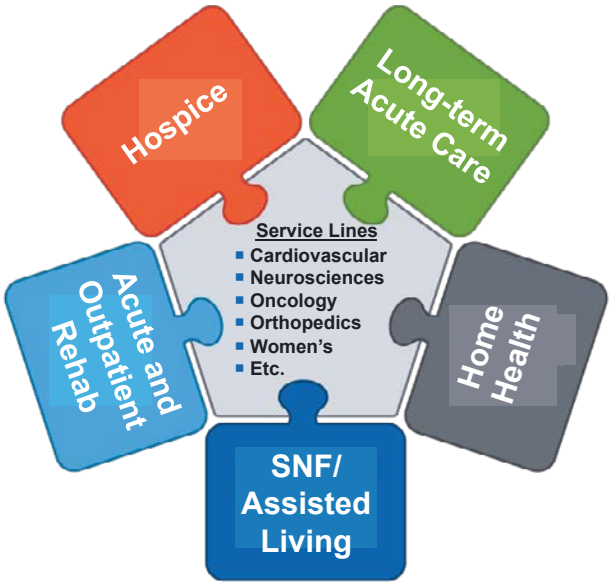
For this reason, it is crucial that board members have an understanding of how post-acute care will be integrated with the strategic and operational initiatives of the hospital's clinical service lines. It is also important that board members ensure their management team is effective in the formation of post-acute care strategic partnerships and proactive in taking steps that will result in an operationally and financially successful relationship. This special section provides a framework for understanding these issues and assessing the progress of the management team.

Hospital and physician service line leaders are hard at work on clinical integration and operations improvement, yet few have made sufficient progress on a critical component in the value-based purchasing environment—developing a robust strategy for the post-acute care elements supporting those services, which include skilled nursing facilities (SNFs), long-term acute-care hospitals, home health, hospice, and acute rehabilitation (see **Exhibit 1**). Given the implementation of federal- and state-operated health insurance exchanges, the pending expansion of bundled payment (including post-acute care models), penalties for readmissions, and other payment reform initiatives, it is no longer possible to ignore the role of a post-acute strategy without suffering significant quality, financial performance, and patient experience consequences.

The three most frequently cited reasons for the limited focus by hospital and health system leaders (including the board and management team) on the post-acute elements of a service line are: 1) other initiatives have higher priority (physician integration, cost reduction, investment in EMR); 2) the hospital or health system may not own post-acute services nor have strategic partners; and 3) post-acute providers may lack the capabilities needed to collaborate with the organization in effectively managing care across the continuum. To ensure success in 2014 and beyond, the management team should develop a robust post-acute care strategy, approved by the board, and give hospital and physician service line leaders three to six months to complete two broad steps:

1. Establish selected post-acute care elements for their service lines via strategic partnerships rather than building or buying those resources.
2. Proactively take expertise and resources out to post-acute partners and enable them to be integrated with the acute components of the service line and effective in care coordination and management.

**Exhibit 1. Service Lines at the Core of Post-Acute Support**




## Selecting Post-Acute Strategic Partners

When considering the formation of strategic partnerships, it is tempting to quickly jump to consideration of structures, deal terms, and enhancements to operational processes. While these are significant tasks that will have a role in implementing a partnership, the success of the partnership(s) is often determined by four precursor tasks. First, determine the objectives of establishing a post-acute care partnership supporting one or more service lines. While this task is led by the management team, the board should review the objectives and associated resource allocation to validate that they are consistent with the organization's overall strategic and operational plans.

Second, identify the type of post-acute partner(s) (e.g., SNF, home health) that will meet the specific patient care management needs of the service line. It is unlikely that the service line will require partners in the full continuum of potential post-acute services. The type of partner is generally determined by the management team with input from the dyad leadership (administrative and medical staff leaders) of the service line or a service line steering committee, as well as the hospital's chief medical officer. Often the quality committee of the board will review and approve the type of partner.

Third, identify the nature of the criteria to be used to evaluate potential partners. Finally, establish an objective process for applying the criteria so that the best candidates are rapidly separated from the rest, creating focus for the succeeding activities. Use of a weighted scorecard is one effective

technique for achieving this, but care must be taken to avoid unintended biases and other pitfalls.

There are 10 categories of criteria useful in the initial stage of evaluating the operational experience of potential partners:

1. **Performance on Institute for Healthcare Improvement (IHI) Triple Aim™ principles[1] (pay for value):** the post-acute organization's track record in quality (i.e., clinical competency, outcomes), cost, and patient experience (ambiance of the care delivery site, responsiveness of staff to patient/caregiver needs, satisfaction, etc.). Inherent in this qualification is the ability to track and benchmark data that demonstrate performance and the alignment of economic incentives to reinforce these parameters.
2. **Readmission rate and other clinical indicators:** the track record of the post-acute care organization in the readmission of patients to acute-care facilities, length-of-stay relative to benchmarks specific to a particular clinical conduction, and other indicators.
3. **Healthcare reform readiness:** the degree of integration of the post-acute care organization's clinical care team and processes into a cohesive structure; use of a coordinated, formal care management process (led by on-site hospitalists, SNFists, etc.); ongoing commitment to and processes supporting performance improvement; use of evidence-based care protocols; and information technology infrastructure (existence of and potential for connectivity between the acute and post-acute providers specific to EMR, computerized physician order entry [CPOE], and picture archiving and communications systems [PACS]) inclusive of linkages between the physicians and the hospital. These factors reveal the degree to which the acute-care hospital will have to augment the post-acute care entity's infrastructure and care management resources.
4. **Clinical skills:** the extent to which the post-acute care entity's care delivery staff is composed of registered nurses (versus licensed vocational nurses), registered therapists (versus techs), etc.

**Exhibit 2. Post-Acute Care Provider Strategic Partner Evaluation Tool℠**

| | Criterion to Evaluate the Post-Acute Partner Candidate | Evaluation (Circle One) (In Comparison to Other Providers) | | |
|---|---|---|---|---|
| 1 | **Performance on quality:** clinical competency, outcomes | Lower | Comparable | Higher |
| 2 | **Performance on cost** | Higher | Comparable | Lower |
| 3 | **Performance on patient experience** (satisfaction) | Lower | Comparable | Higher |
| 4 | **Readmission rate and other clinical indicators** | Higher | Comparable | Lower |
| 5 | **Healthcare reform readiness** | Lower | Comparable | Higher |
| 6 | **Clinical skills** | Lower | Comparable | Higher |
| 7 | **"Fit" with your organization's service line** | Low | Moderate | High |
| 8 | **Partner's leadership:** ability to execute and manage the integration | Lower | Comparable | Higher |
| 9 | **Synergy** | Lower | Comparable | Higher |
| 10 | **Long-term viability** | Lower | Comparable | Higher |
| 11 | **Accessibility** (location) | Lower | Comparable | Higher |
| 12 | **Accessibility** (scheduling) | Higher | Comparable | Lower |
| 13 | **Ease of forming the partnership** | Lower | Comparable | Higher |

*Source:* The Camden Group.

5. **"Fit" with your organization's service line:** culture, mission, vision, core values, integrity, focus on patient-centered care, patient safety, and the ability of the post-acute organization to make a positive contribution to the value of the service line brand of the acute-care organization.
6. **Partner's leadership:** the stability of the post-acute organization's leadership team; ability of the administrative and clinical leadership of the post-acute entity to implement a shared (with the acute-care hospital) plan of action and adjust the role descriptions, performance evaluation mechanisms, and incentive mechanisms for the staff to achieve accountability.
7. **Synergy:** the degree to which the partner's breadth of services will satisfy service line operational, financial, and/or strategic "gaps" and critical success factors, and appeal to referring physicians, payers, and patients.
8. **Long-term viability:** the post-acute care organization's financial position (operating and cash-flow position, debt capacity); ownership structure; regulatory status (licensure, accreditation); critical mass and stability of clinical staff; and condition of physical plant/resources.
9. **Accessibility:** the ability to admit/transfer patients to post-acute care services 24 hours a day, seven days a week; limited/no wait time to achieve patient transfer from the acute to the

1 The simultaneous pursuit of better care for individuals, better health for populations, and lower per capita costs. See www.ihi.org/tripleaim for more information.

post-acute setting; proximity of the location of the post-acute care organization to the service line's area of greatest patient density, thereby limiting patient commute time; ease of street access and parking; and lack of barriers to entry based on payer contracts.

10. **Ease of forming the partnership:** level of interest on the part of the post-acute organization; the organization's track record of completing prior affiliations, alliances, and partnerships; the relative complexity of the relationship to be created; the time needed to complete due diligence; and the extent of barriers, if any.

These criteria can be converted into a scorecard-style evaluation tool as demonstrated in **Exhibit 2**. The dyad leaders of the service line would apply the tool to assess several alternative entities within a particular mode of post-acute care (e.g., SNFs). Then they would compare the completed rankings for each candidate and identify the "best" one or two candidates. At this point, a more comprehensive due diligence assessment should be performed on the remaining partner candidates.

The board and management team should scrutinize the actions of clinical service line leaders to ensure that they are forming strategic partnerships with post-acute providers, have an appropriate list of criteria for screening prospective partners, and are implementing an objective decision-making process supported by a weighted scorecard or similar mechanism.

## Enabling the Success of the Post-Acute Partnership

In an ideal circumstance, the strategic partner(s) will have the resources, capabilities, and competencies enabling it to rapidly integrate with the acute-care service line's care coordination and management processes. More typically, within the post-acute entity, clinical integration and care management are at very early stages of evolution. This situation should be treated as a catalyst to proactively extend the expertise and resources that have been developed within the acute-care setting to the post-acute partner(s). Whether your organization is at either of these extremes or at a point in between, we recommend five specific action steps to implement before the end of the first quarter of 2014:

1. **Care redesign:** The service line dyad leaders should extend service line care redesign activities from the acute setting to the post-acute care partner(s). If the hospital's service line has established the infrastructure for bundled payment, broaden the responsibility of the associated committees addressing care redesign, continuous quality improvement and quality assurance, and information technology to include the post-acute partner(s). If bundled payment has not been implemented, the service line's hospitalists and care managers should work proactively with the post-acute care facility's clinical staff to determine those care delivery steps that will be retained and enhanced and those that will be eliminated to increase care efficiency and throughput. Lean, Six Sigma, and related tools can be effective in achieving that end.
2. **Care coordination and management:** The acute-care service line hospitalists and care managers should work proactively with the partner's clinical staff to establish service line-specific evidence-based protocols for the post-acute portion of care and develop a structured care coordination and management process within the partner's organization. To support and reinforce a standardized process, they should round at the post-acute facility and train the clinical staff of the partner to target reduced clinical resource consumption, minimized acute-care readmissions, and increased timely transition of patients from the post-acute facility to community-based outpatient services and home care. Acute-care hospital patient navigators should be assigned to guide and support patients who are transferred from an acute to a post-acute setting. Finally, acute-care service line dyad leaders should work with the post-acute care facility's clinical staff to establish care management metrics specific to quality, cost, and patient experience, and a benchmarking process reinforced by incentives. Consider utilizing data available via CMS's Web sites, Home Health Compare and Skilled Nursing Facility Compare,[2] and proprietary data sets specific to other post-acute care services to benchmark quality performance. In addition, consider utilizing the CMS Hospital Consumer Assessment of Healthcare Providers and Systems Survey (HCAHPS), the Home Health Care Consumer Assessment of Healthcare Providers and Systems Survey tool (HHCAHPS), and other resources to benchmark patient experience.

2 See www.medicare.gov/homehealthcompare and www.medicare.gov/nursinghomecompare.

3. **Patient and caregiver engagement:** Third, the dyad leaders should work with the service line's patient care navigators to extend their role to the post-acute setting and have them work proactively to engage the patients and caregivers in the post-acute care. As a starting point, the care navigators should conduct initial and ongoing coaching and education for the patients and caregivers specific to self-management, nutrition, medication management, and recognizing and responding to changes in the patient's health status. This can be supplemented by the post-acute care facility staff and online tools.
4. **Clinical information exchange:** In support of IHI's Triple Aim™ initiative and effective care management, the acute-care organization should work to enhance clinical information exchange with the post-acute partner(s). Specifically, the IT department should explore opportunities to extend the EMR to the post-acute organization directly or through a health information exchange. To the extent that the acute-care organization has an established data warehouse, it should evaluate the opportunity to link the post-acute facility with that resource. Additionally, the hospital's management team, in conjunction with its director of IT, should assess the opportunity to bring to the post-acute setting innovative applications of telehealth and related technology such as the use of remote patient monitoring (table top, wearable, ingestible, and implantable) and cell phone-based applications to enhance patient monitoring, information sharing, care coordination, and patient education.
5. **Reduce readmissions:** A proactive effort must be applied to resolve the factors most responsible for patient readmissions from post-acute facilities back to the acute-care setting. Hospital service line care managers and hospitalists should establish a thorough and clearly articulated patient transition plan. They should offer guidance to the post-acute care staff regarding the elements of a service line-specific comprehensive patient intake assessment and the formation of a multi-disciplinary care team inclusive of nutritionists, social workers, and psychologists. The acute-care pharmacists should round at the post-acute partner site to assist with medication reconciliation and management to reduce/eliminate conflicts and ensure patient adherence. Finally, the post-acute patient should receive education about their care delivery process so that they see themselves as a "partner" in the care process. Acute-care facility personnel can provide assistance in working with the post-acute care staff to remove language and literacy barriers related to educating the patients.

**Exhibit 3. Service Line Assessment Factors (Abbreviated Example)**

1. **Quality and clinical effectiveness** (e.g., degree of process variability among clinicians, effectiveness of patient transitions and care management across the continuum, readmissions rates, clinical outcomes, patient satisfaction, clinical analytics)
2. **Physician alignment/integration** (e.g., critical mass of specialists, physicians aligned financially, IT linked [EMR/aEMR, CPOE, PACS])
3. **Financial strength via operational excellence** (e.g., contribution margin, readmissions penalties, penalties for non-reporting of satisfaction metrics, right-sized staffing, right-sized clinical resources, supplies, contracting, revenue cycle management)
4. **Leadership and accountability** (e.g., cohesive program; dyad leadership; service line committee role/responsibility; prioritized goals and strategies; job descriptions, goals, compensation, and bonuses tied to performance)
5. **Market leadership position** (e.g., market share position; differentiation [on clinical outcomes, cost, patient experience]; strategic partnerships/affiliations; broad array of patient entry points and a large and effective patient referral network)
6. **System-based service line consolidation** (e.g., determination of which resources [clinical services, administrative management, clinical management] will be centralized versus decentralized)

*Source:* The Camden Group.

In addition to the five preceding action steps, the service line dyad leaders should include representatives of the post-acute care partner on the working committees addressing care redesign, performance improvement, and care management. This will contribute to enhanced integration and alignment of the organizations and maximize the value delivered.

The board and the management team should scrutinize the actions of service line dyad leaders to ensure that they are tackling each of the preceding five steps and are proactive in assisting post-acute providers to enhance their care coordination and management capabilities and integrate those features with the acute-care service line.

## Ensuring Optimal Service Line Performance

While the preceding portions of this special section have addressed the critical role of post-acute organizations in supporting a service line in a value-based purchasing and population health management environment, long-term success depends on the service line achieving optimal performance on six categories of factors that are listed in **Exhibit 3.** Each of these categories is composed of a broad list of characteristics. An assessment should be conducted by the service line dyad leaders to reveal the relative "strength" of the service line on each of the six categories of factors and the gaps that must be addressed. This will enable the service line dyad leaders and management team to pinpoint the focus of the service line's strategic plan and investment for the year ahead.

The board and the management team should scrutinize the actions of clinical service line leaders to ensure that they are proactive in conducting rigorous annual evaluations of their service line on the six categories of factors in Exhibit 3. They should be attentive to whether the resulting service line business plan and budget reflect a focus on a selected number of

critical elements rather than routinely addressing a fixed list of categories or even a broadly diffused list of initiatives.

## Examples: Bundled Payments for Care Improvement (BPCI) Model 3 Participants

Valuable lessons in the design, implementation, and operation of a service line-specific post-acute care strategy may be drawn from participants in the CMS Model 3 Bundled Payments for Care Improvement (BPCI).[3] In Model 3, payment for an episode of care (e.g., hip replacement) is bundled for both the acute-care hospital stay and post-acute care services with participating SNFs, inpatient rehabilitation facilities, long-term acute-care hospitals, and home health agencies. Examples of post-acute structures and strategies, care redesign and management methodologies, performance metrics and benchmarking, gainsharing, and other incentives supporting accountability may all be found by speaking with representatives of those participating in Model 3 BPCI and studying published documentation.

Model 3 participants are distributed across a broad geographic region and address 48 different clinical episodes of care. As such, there are a wide variety of examples organizations can examine and potentially apply to the development of their post-acute care strategy. The CMS Web site offers an interactive tool that may help identify participants in specific geographic locations and/or participants that are addressing an episode that pertains to a particular service line.[4]

## Where to Start

Environmental trends are clear and compelling; acute-care providers must act quickly to incorporate a strong post-acute strategy in their service line management. Immediate steps to accomplish this include the selection of strategic partners through the application of the 10 categories of evaluative criteria and the five proactive initiatives to extend the care coordination and management capabilities of the acute-care service line to the post-acute partner(s), as discussed above. A variety of readiness assessment tools exist to evaluate an organization's status and ability to apply the guidelines described in this article. The board should charge the executive team and service line dyad leaders to apply these criteria, establish an action plan, designate champions, and establish accountability for success.

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3 For more information, see http://1.usa.gov/I0rLUK.

4 The tool can be found at http://1.usa.gov/17faGiX.