Reducing Risks and Achieving Goals: The Critical Role of the Post-Acute Care Network Structure

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It's normal for hospital and health system executives to focus on acute and ambulatory care services. But it's no longer enough.

In the last few years, Medicare, and private insurers that are following its lead, have created an environment that requires hospitals and systems to turn their attention to what happens after hospital discharge—post-acute care (PAC)—or face serious risks. Medicare's Accountable Care Organization (ACO) program, with its emphasis on providers accepting full responsibility for provision of all services and for the total cost of care; its penalties for hospital readmission within 30 days of discharge; and its bundled payment programs that aggregate payment for all services within 90 days of hospital admission, all put acute-care entities at an increasing degree of financial risk for PAC.

The attention on PAC has revealed significant variation in PAC length of stay and resource use for patients with similar conditions at hospital discharge. It has also uncovered the potential to achieve greater cost reductions in episodes of care in the PAC than in the acute-care phase of the episode, as well as opportunities to improve patient experience. This in turn implies that it is imperative for acute-care organizations to establish a PAC strategy and play a proactive role in PAC services, improving care transitions, care management, and quality of care in PAC facilities, in order to reduce their own financial and strategic risks.

Today, it is clear that the way to have this kind of impact is through the formation of networks of PAC entities, with increased integration of acute-care and PAC entities.

It is no wonder that, according to Premier's Economic Outlook Survey, 85 percent of C-suite leaders plan to expand their partnerships with local PAC providers over the next three years. It's also not that surprising that 95 percent of those same leaders expect problems in achieving that.[1]

The foundation of a PAC strategy is the development of a network of providers that offer a continuum of post-acute care services with appropriate geographic coverage, and that ensure high-quality care and patient experience and efficient use of resources. The continuum usually comprises a combination of short-term PAC entities (home health agency [HHA], inpatient rehabilitation facility [IRF], and increasingly, home- or facility-based hospice and palliative care services), and longer-term PAC entities, including one or more skilled nursing facilities (SNFs) and, less often, a long-term acute-care hospital (LTACH).

Continuing care retirement communities (CCRCs) are generally not considered PAC entities, but hospitals and systems are increasingly incorporating them in their PAC strategy and adding them to the care delivery and management continuum.

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Key Board Takeaways

With increasing attention on post-acute care, board members should:

- Understand that a well-formulated PAC strategy is essential for hospitals/health systems active in bundled payment, accountable care, capitation, and reduction of readmission penalties.
- Ensure a PAC strategy is included in the organization's strategic plan.
- Expect management to form a PAC entity network through preferred provider relationships.
- Require PAC entity network formation to address all four forms of business risk (discussed in this article).
- Reinforce with management the need for one individual accountable for the PAC strategy, rigorous criteria for network member selection, and regular reports on PAC facility network performance.

PAC Strategies in the Market

As hospitals and systems develop PAC networks, it is crucial that they do so in a way that is consistent with three factors: their strategic objectives, the operational and financial business risks they are seeking to mitigate, and the extent to which they are willing to invest scarce capital. The latter two issues are the principle focus of this article. The strategic objectives may include (but are not limited to):

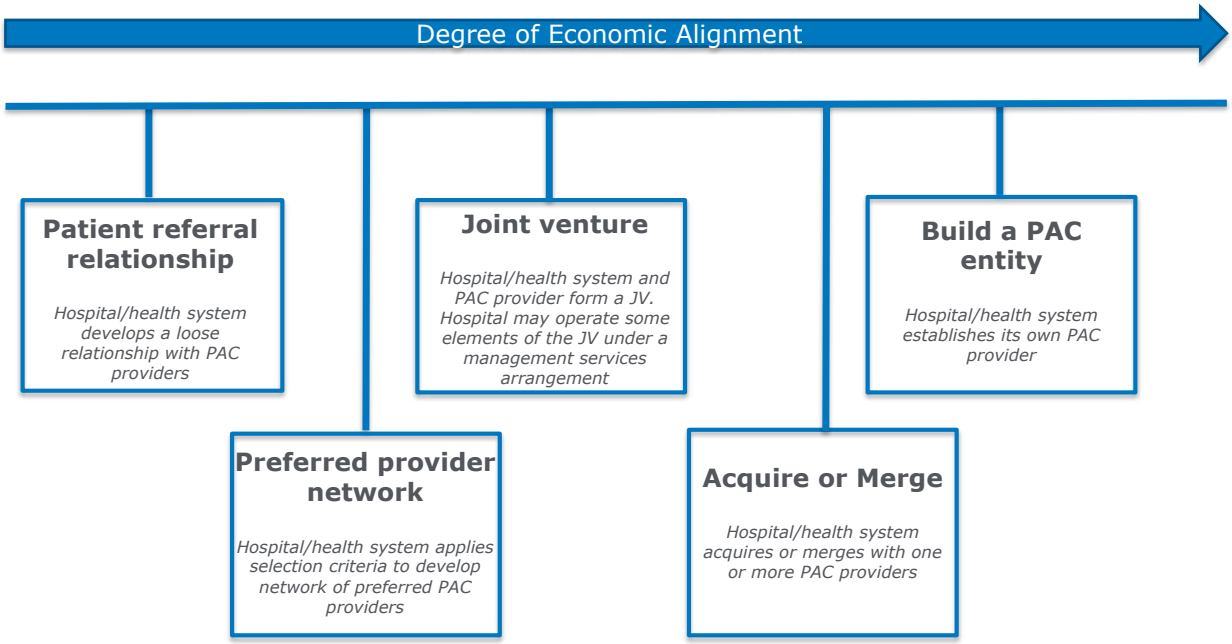
- Differentiating on value delivered
- Establishing a continuum-wide care delivery network to support implementation of an ACO, prepare for population health management, and prepare to accept greater levels of financial risk
- Positioning the organization for inclusion in the "top tier" for those health plans using tiered provider networks
- Achieving growth

Historically, the approaches used by hospitals and systems to develop their networks of PAC entities have included (see **Exhibit 1** on the next page):

- "Building" one or more PAC facilities (or continuing to operate legacy facilities)
- Buying a PAC facility or a multi-site PAC organization
- Joint venturing with one or more PAC providers
- Merging with or acquiring another acute provider that operates PAC entities (this

1 Premier, Inc., *Inpatient and Beyond: The Post-Acute Care Conundrum,* December 2016.

Exhibit 1: Methods for Developing Networks of PAC Entities



may be an "incidental" acquisition of a PAC entity)
- Establishing a preferred provider network

A review of published literature and an informal survey of nine regional health systems, conducted by the authors, indicate that *currently the most common approach to forming a PAC network is developing preferred provider networks.* Few hospitals or systems are building facilities, and selective acquisition of PAC facilities is often incidental to a merger with another acute-care organization. Under that circumstance, continued operation of those legacy facilities, whether directly or through joint venture, is common.

Many hospitals and systems have concluded that investing capital in PAC is not desirable. This reflects an understanding that PAC facilities tend to have low margins, and operating expenses and regulatory requirements are increasing while reimbursement is decreasing. At the same time, most healthcare organizations have a lengthy list of other high/higher-priority capital initiatives (e.g., IT, building a physician network, etc.).

This article is intended to help hospital and system leaders and their boards:
- Understand the motivation for developing a PAC network, with a preferred provider structure (or hybrid structure where capital costs have been minimized).
- Become familiar with how selected health systems have shaped their PAC preferred provider networks with an eye to reducing specific business risks.
- Discuss steps taken during network implementation to contribute to risk mitigation.

The Business Case for a Post-Acute Care Network

A PAC network can mitigate four business risks faced by acute-care entities: risks entailed in having insufficient PAC capacity, risks of obstacles to effective care management, risks caused by inadequate quality of post-acute care, and risks associated with management of patient transition to and from PAC.

Risk of Insufficient PAC Capacity

The most significant reason for hospitals and health systems to develop a post-acute care network is that doing so will enable them to ensure there is a sufficient supply of post-acute care beds available that they can discharge patients to when they are ready, rather than having those patients continuing to occupy acute-care beds.

Even in markets that retain a fee-for-service orientation, delayed patient transfer has several negative implications. First, it reduces patient (and family) satisfaction, in turn negatively impacting HCAHPS scores and the competitive position of the hospital. Second, the delayed discharge creates a capacity "bottleneck" that restricts other patient admissions, in general. Third, the extended length of stay of the patient not placed in a PAC entity is often excluded from reimbursement, resulting in financial losses for the hospital and a higher average cost per covered day. In markets where health plans have implemented tier provider networks, those organizations whose cost of care are high are frequently relegated to a lower tier. Patients would be subject to a higher out-of-pocket expense to use that hospital thus reducing its attractiveness and contributing to lost patient volume.

When the hospital or system is participating in a bundled payment or ACO shared savings program and is not able to transition a patient to PAC in a timely manner, there is a high likelihood that the cost of care will exceed the reimbursement with the resulting losses borne by the hospital and the physicians.

Implications: To mitigate capacity risk, the hospital/system needs to determine the number of facilities, beds, and HHAs needed, by patient acuity level, and how they should be distributed throughout the service area to ensure that there will be sufficient openings that patients can access conveniently and in a timely manner.

If the organization's regional service area is one in which there is a significant excess of post-acute care capacity at all levels, then access considerations alone could be addressed by a simple referral agreement. However, even if there is an annual average of 20 available beds among the SNFs in a given area, there will be days when there are no available beds or no beds for patients at a given level of acuity. The higher the area occupancy rate for SNFs, LTACHs, and IRFs of an acceptable quality, the more important it will be to ensure access to a defined capacity through a formal relationship. A preferred provider network can be designed to minimize capacity risk (see sidebar for more on assessing capacity risk).

Capacity Risk: Elements of Assessment

- Acute-care organization's historical trends in the volume (average and statistical distribution) of patient discharges to each type of PAC entity by type of patient condition, payer, and by location of patient home
- Acute-care organization's historical trends in the wait time to successful patient placement by patient condition, payer, and type of PAC entity
- Market capacity (occupancy—mean and distribution) for each entity, by type of PAC entity
- Willingness and ability of PAC providers to make their capacity available to hospital/system patients
- Ability of the acute-care organization to influence/control access to PAC facility capacity without formalized relationships

Risks to Care Management/Finances

Where the case managers, discharge planners, and physicians associated with an acute-care hospital are not able to have oversight on and meaningful influence over the care management at a PAC facility, three types of risk are incurred. First, the care process may be operationally inefficient and the recovery period may be extended, resulting in a high length of stay in the PAC facility and a higher than necessary cost of care. Second, the care process may fail to follow protocols, resulting in higher than necessary clinical resource use (diagnostic tests, therapeutic procedures, medications, clinical staff time, etc.). Third, patients may be readmitted from the PAC entity to an acute-care hospital resulting in Medicare penalties for the originating hospital. Each of those elements contribute to unfavorable financial performance and reduced patient and family satisfaction. Both are particularly problematic in a value-based reimbursement environment in general and for bundled payments, ACOs, and capitation in particular.

Implications: To mitigate these forms of care management risks, the acute-care organization needs a well-structured role in guiding the care delivery process in the PAC entities. In conjunction with this, one of the criteria used in evaluating and selecting PAC entities for inclusion in the network should be their willingness to have hospital physicians and case managers collaborate in the care management process.

The following specific steps are among those often taken to further reduce care management risk: hospital/system-affiliated SNF specialty physicians ("SNF-ists") act as the medical directors of the PAC entity, the care protocols specific to an acute-care episode are extended to include post-acute care and applied in the PAC setting, and the electronic medical records for a patient are linked between the acute and PAC facilities. The latter may require the hospital or system to implement a local health information exchange as a "bridge" between the PAC electronic health record (EHR) and the hospital EHR, so that patient clinical data can be shared more easily.

Risks to Quality of Care

Points of patient transition from an acute-care provider to a PAC entity often give rise to incomplete "handoffs." As a result, it is not atypical for patients to incur medication conflicts and errors during this period. Historically, as the treatment process continues, a relatively high proportion of PAC patients incur infections, falls, and other quality-of-care deficits. In the absence of a structured approach to ensuring the quality of care provided by a PAC entity, there is an increased risk that these events will not be adequately controlled.

These occurrences are unsatisfactory for the patient and also contribute to longer lengths of stay, expanded use of care resources, and potential readmissions to the acute-care facility, which, individually and collectively, increase the overall cost of care. This would be particularly problematic in the case of patients whose

care is part of a bundled payment arrangement, for patients attributed to an ACO, or where reimbursement is capitated. To the extent that the hospital or system is seen as having been responsible for the choice of PAC entity, it could also be damaging to its reputation and brand.

Implications: To mitigate these risks, agreements between the PAC preferred provider network and the hospital/system are needed to ensure that the acute-care organization has the ability to meaningfully guide and contribute to enhancing the infrastructure supporting care quality. One commonly applied approach is for the nurses and other clinicians in the acute-care organization to provide training to and assist the PAC staff to expand their clinical skills. As noted in the preceding care management section, hospitals and systems will often provide the PAC entity with access to hospital-developed, evidence-based protocols. Among an array of potential additional steps to reduce quality risk are assistance in enhancing medication management and placement of a medical director with expertise in geriatric care at the PAC organization.

Other modes of mitigating the quality risk include establishing committees within the PAC entity to coordinate development of procedures to minimize falls, infections, and errors in medication dispensing. The hospital/system generally requires the PAC network members to provide monthly quality performance reports, reserve the right to require corrective action where necessary, and to remove consistently

under-performing PAC providers from the network.

Risks to Patient Transition Management
Without a strong working relationship, it is not uncommon for a patient initially discharged from one hospital/system to a SNF, IRF, LTACH, or HHA to be sent by the PAC entity to a competing care hospital/system when additional acute care is needed. This increases the likelihood that the original acute-care provider will lose the opportunity to serve that patient and his or her family at future points in time (lost future earnings). This is particularly troublesome in an ACO, which would essentially lose an attributable life and the associated income stream.

Without a PAC network in which the acute-care and PAC entities have jointly established procedures to guide and control transfer, there is also a higher risk of patient dissatisfaction with how their transfers are handled.

Implications: One approach that hospitals and systems often take to mitigate the risk of losing patients to competitors ("leakage risk") is to proactively work with the PAC network members to establish guidelines specific to the management of patient readmissions. A second step taken by hospitals and systems is to arrange for the rotation of physicians at the PAC facility and video telehealth connectivity such that PAC facility clinical staff can seek remote observation of patients and consults with physicians to address patient care needs and eliminate unnecessary acute-care readmissions.

Consistent in the literature and interviews referenced above is the perspective that the business risks and the mitigation steps described here can be achieved through the thoughtful formation of preferred provider networks. The build, buy, and joint venture approaches are generally not necessary, thus allowing hospitals and systems to conserve scarce capital.

> The acute-care organization needs a well-structured role in guiding the care delivery process in the PAC entities. One of the criteria used in evaluating and selecting PAC entities for inclusion in the network should be their willingness to have hospital physicians and case managers collaborate in the care management process.

Additional Considerations in Shaping the PAC Network

When setting a PAC strategy and determining the optimal composition of a network of PAC providers there are at least three additional issues to be considered: circumstances in which ownership of a PAC entity makes sense, approaches a hospital/system should consider as a means of protecting itself in the event that a PAC network member becomes financially unstable or non-viable, and effectively navigating situations in which medical staff members have pre-existing well-established relationships with selected PAC entities. While one or more full articles could be devoted to these issues, the information provided below is a helpful supplement to the preceding business case discussion.

Circumstances in Which Ownership of a PAC Entity Makes Sense
Ownership of one or more PAC entities can be an important aspect of network formation and management in three situations:

1. When at an earlier point in time the hospital/system had already developed or acquired one or more PAC entities (a "legacy" PAC entity) and that entity continues to perform well and fit the broader PAC strategy.
2. When a hospital/system is evaluating the potential to merge with or acquire another acute-care provider and the potential partner's structure already includes one or more well-performing PAC entities, thereby "jumpstarting" the initial development of a PAC network or supporting expansion of an existing network.
3. When the hospital/system's PAC strategy calls for inclusion of a particular level of post-acute care (e.g., SNF, IRF, LTACH, HHA) and no providers exist in the geographic area served.

In the third example, several options are possible. The hospital or system could unilaterally develop, own, and operate the

new PAC entity. Alternatively, the acute-care provider could approach this as a joint venture, potentially with a firm that has a long, successful track record in PAC organization management.

It is notable that in the interviews referenced, every system that had acquired or already possessed such capabilities said that if they were starting from scratch, they would have focused solely on a preferred provider network rather than investing to acquire or build PAC facilities.

Proactive Protection Against Financial Weakness of a PAC Network Member

If a preferred provider within the PAC network becomes financially unstable or non-viable, it may no longer be possible to discharge patients to it. This would reduce post-acute patient care capacity, triggering each of the negative ramifications described in an earlier portion of this article. Additionally, while the PAC entity is not owned by the hospital or system and thus the acute-care provider would not necessarily suffer a direct financial impact, the circumstance could taint its image in the market and the satisfaction of its patients. For these reasons, steps should be taken to proactively shield the hospital or system from the downside risk of a financially troubled PAC network member, including:

1. Each PAC network member should be required to report its financial performance to the hospital/system on a quarterly basis. Failure to meet pre-designated metrics should trigger warning "flags" as well as the implementation of corrective action plans. Those could entail retention of third-party PAC experts to resolve the problems.
2. The hospital/system should prepare and maintain contingency plans for removing troubled network members and replacing them with other entities to retain the needed patient care capacity.
3. When selecting participants for a preferred provider network, the hospital/system should diversify the network to include members with a variety of sizes, ownership, sponsorship, and other criteria. This will serve as a hedge against unexpected developments related to capacity, payment, and the evolution of care.

When Medical Staff Members Have Pre-existing Relationships with PAC Entities

Some physicians affiliated with the hospital or system are likely to have existing economic relationships, ranging from ownership interests to paid medical directorship or coverage arrangements, with PAC organizations in the service area. If the proposed PAC network structure interferes with those economic relationships, it may create "political" risks for the hospital/system and the potential for active opposition to the network by affiliated physicians.

There is an array of potential solutions to this situation. A couple to consider include:

1. If the PAC facility involved is not critical to the network (because it is small, geographically remote, has a poor reputation, etc.) it may be possible to omit it from the network. That leaves the physician economic relationships as they are, but may not make those physicians happier if hospital discharges move away from the PAC entity with which they are affiliated.
2. The network approach can be refined to allow the hospital/system to work collaboratively with physicians that have an established working relationship with PAC organizations in the area—whether that means including those organizations in the network while preserving those economic relationships (where possible), or creating a joint venture in which those physicians can participate.

Tailoring Structure to Manage Risks and Achieve Objectives: Case Examples

The specific PAC network composition used by a hospital or system generally reflects its post-acute care patient needs, its unique PAC strategic objectives and approach to risk mitigation, as well as the nature of the inventory of PAC facilities in the market served. The examples that follow were chosen to highlight a variety of PAC network configurations that represent various combinations of the preceding factors and different regions of the U.S.

Scripps Health

Scripps Health is a health system based in San Diego, California. It has four campuses and treats more than 500,000 patients annually. The system wanted to develop a PAC network to support its strategies specific to bundled payment and ACO development, while at the same time ensuring access to sufficient PAC capacity, effective care management, and high quality.

System leadership did not consider the acquisition of PAC facilities to be the best use of its available capital. Scripps Health therefore developed a network of preferred PAC providers, including 16 SNFs out of the 90 in its service area. It entered into a series of agreements with each SNF, including a master agreement and an EMR data-sharing agreement. Scripps integrated the health system's geriatric physicians into a group and embedded a representative of the group in each SNF, enabling co-management. To facilitate monitoring of quality, a performance scorecard transparency agreement requires network members to report monthly performance on 30 quality indicators.

Dartmouth-Hitchcock Health

Dartmouth-Hitchcock is a non-profit academic health system serving New Hampshire and Vermont. The system includes the main academic medical center, an NCI-designated comprehensive cancer center, a children's hospital, four affiliated acute-care hospitals, and a series of ambulatory care centers in portions of the region served.

Dartmouth-Hitchcock's network of PAC entities includes two IRFs that were pre-existing components of hospitals that joined the system as affiliates, as well as SNF units that were pre-existing services of several of the member critical access hospitals. In addition, the health system works with many other SNFs in the region to support the geographic coverage needed. To ensure effective care management and quality, Dartmouth-Hitchcock physicians serve as medical directors in some of those SNFs.

Dartmouth-Hitchcock recently brought an HHA into its system to improve transitions to home care and to take the patient-centered medical home concept into the home of the patients served. It is hoped that this will better integrate inpatient and outpatient hospice and palliative care services.

Geisinger Health System

Geisinger Health System serves Pennsylvania and southern New Jersey with 12 hospital campuses, two research centers, and a health plan that serves more than 550,000 members.

The system developed a PAC network in order to assure adequate PAC capacity for its patients—a prime concern given the rural location of the medical center and many of the system's community hospitals. Geisinger also wanted to provide high-quality PAC for its health plan members, minimizing losses at the system level.

Geisinger's PAC network includes a combination of owned facilities, a joint venture, and a preferred provider network. The owned entities include three hospice programs and three SNFs.[2] Their IRF is a joint venture with HealthSouth,[3] which is the operating partner. Most of these owned facilities were acquired when the previously independent hospitals that operated them became part of the Geisinger system.

Geisinger maintains a preferred provider network with 15 SNFs. As a component of its ProvenHealth® medical home model, employed physicians and advanced practice clinicians participating in Geisinger's Skilled Nursing Facility Specialist program[4] have a daily presence in each of the network's SNFs, providing a degree of control over clinical quality and system efficiency.

Saint Luke's Health System

Saint Luke's Health System includes 10 acute-care hospitals in the greater Kansas City region (Missouri and Kansas). In addition, the system employs over 450 physicians and operates 13 nurse practitioner-run convenient care centers, two "big box" ambulatory care centers, and is developing seven micro-hospitals.

In developing its PAC network, Saint Luke's primary objective was to ensure the system's ability to manage patient care in support of its existing bundled payment arrangements, and in preparation for an environment expected to evolve toward population health management and toward providers taking financial risk. It also wanted to improve access to PAC beds for the patients served, while minimizing capital investment.

Saint Luke's used a formal process to develop its PAC network. It began by circulating RFPs to all of the SNFs in the region, receiving responses from 56 entities. It ultimately formed a preferred provider network with 22 SNFs. The system owns and operates its own HHA, and maintains a preferred provider relationship with four additional HHAs. The system has an affiliation agreement with one LTACH (not owned) and also sends patients to two other LTACHs with which it has no affiliation agreements. Among its hospitals there are three owned IRFs and a 12-bed hospice house, and home hospice services are provided.

Participants in the preferred provider networks entered into "evergreen" agreements with Saint Luke's with 90-day cancellation clauses. As a condition of participation, the network members must adopt the acute-care system's clinical protocols, agree to serve its patients, and report on and meet a specified array of performance criteria to remain in the network. Participation in the network may be canceled if the PAC entities fall short on performance targets and fail to complete corrective action.

HonorHealth

HonorHealth owns and operates five general acute-care hospitals in Phoenix and Scottsdale, Arizona, as well as an ACO.

Unlike the systems discussed above, HonorHealth is located in a market with a large number of SNFs and HHAs as well as three LTACHs, and some of those entities have excess capacity. While HonorHealth initiated the conversation around forming a PAC network, the PAC entities were already very interested in seeking affiliations with area hospitals and systems. Because there is competition between PAC providers, HonorHealth is positioned to be selective in developing a PAC network that can address its concerns regarding control of care management and financial risk, patient care quality, and PAC patient leakage to other acute-care facilities in the event of rehospitalization.

HonorHealth created a PAC RFP to obtain data allowing assessment of the 96 SNFs in the region. Based on this, they have begun to select a preferred provider network with two tiers. The system is applying a similar process in forming a preferred provider network with HHAs as well as its owned home health agency. HonorHealth had already established an IRF some time ago, which is operated as a joint venture.

2 Definitive Healthcare, Geisinger Health System IDN Profile.

3 For more information on Geisinger HealthSouth Rehabilitation Hospital, see www.geisinger-healthsouth.com.

4 Janet Tomcavage, "Post-Acute Continuum—Lessons Learned from Geisinger's ProvenHealth® Navigator," February 3, 2012.

Prior to developing its network of PAC entities, HonorHealth had a number of pre-existing relationships with SNFs and HHAs. Notably, the ACO was utilizing a small network of SNFs and HHAs and had already embedded transition specialists who visit the SNFs. In addition, the hospitalist groups with which the system works each had relationships where member physicians were acting as medical directors in several of the SNFs. Success in establishing the preferred provider network requires that the SNFs are utilizing physicians who are aligned with HonorHealth to maintain continuity and execute on lowering readmissions and improving transitions of care.

Ochsner Health System

Ochsner Health System includes 12 owned hospitals and 17 managed/affiliated hospitals, all serving patients across Louisiana. Ochsner's network also includes 60 community health centers that deliver primary and specialty outpatient care, and approximately 2,500 affiliated physicians.

Ochsner serves America's second most unhealthy state.[5] Despite the health challenges faced by its communities, Ochsner has accepted some level of financial risk (through full risk-based contracts and shared savings programs) for approximately one-third of its patient base. It developed a PAC network in order to support its focus on population health management and further its efforts to integrate healthcare providers across the continuum of care.

The health system's PAC network is composed of 17 SNFs in a preferred provider network, two fully owned acute rehabilitation facilities, and two joint ventures (an LTACH and an HHA) developed in partnership with the investor-owned LHC Group.

Ochsner has formal contractual relationships with the SNFs, outlining transfer protocols and establishing metrics to which affiliates are held accountable; hospitalists are provided with a directory of preferred providers. Ochsner is in the process of further developing its alignment with the preferred provider network; for example, a pilot program will provide the SNFs with access to the health system's electronic medical records for their patients. Although Ochsner does not provide medical directors to its SNF affiliates, an appointed medical director for community affairs meets with the SNFs on a bimonthly basis to address any emerging concerns regarding transitions to and from Ochsner's acute-care facilities.

Ochsner is planning to build a new IRF in a joint venture with Select Medical Corporation, a national leader in inpatient rehabilitation, which will increase their inpatient rehabilitation beds and add pediatric rehabilitation beds. This is part of a major expansion of its Jefferson Campus in which many facilities are being upgraded.

Making PAC Relationships Work to Achieve Objectives

Selecting the participants in a narrow network of PAC entities can take time. Participants that are not owned (fully or partially) need to be brought into a productive relationship with the hospital/system. Participants should be expected to agree to provisions that will allow the hospital/system sufficient involvement in the clinical operation of the entity to meet its objectives, while respecting the independence of the PAC entity.

Provisions that will facilitate achievement of these objectives include, but are not limited to, agreement on:

- A master agreement with specific performance criteria, transparent monthly reporting, requirements for corrective action plans, and the potential to remove network members that are not able to resolve performance gaps
- Protocols for transition management, medication management, clinical care, etc., to which the partners will be held accountable
- An appropriately trained physician serving as the medical director in the PAC entity, with some decision-making authority
- Provisions for tracking patients across the continuum of care, from acute care to PAC and back if appropriate, so that care management can be extended accordingly. This includes integrating EMR technology throughout the network, or linking EMRs through a local health information exchange
- Developing a cohesive team across the entities

The Role of Senior Executives and the Board

Most hospitals and health systems will be developing a PAC preferred provider network. Senior executives should play a role in setting and approving the PAC strategy and ensuring that a thorough implementation plan is developed—identifying action steps, the individual accountable for each step, start/completion dates, milestones, and progress tracking components. The executives must hold the sponsors/champions of PAC network formation accountable for rigorous analysis in selecting network participants and developing a risk mitigation plan for the network.

The board should be familiar with the issues set forth in this article and proactive in holding the executive team accountable for developing and maintaining a PAC network that effectively mitigates the risks. The board should hold the senior team to an objective assessment of its ability to address the questions and issues set forth in this article using its internal resources and expertise versus using appropriate third-party resources.

Senior executives need to provide the board with regular reports on the status of network development and performance. Most significantly, it is the board's responsibility to ensure that the PAC strategy is consistent with and supportive of the organization's overall vision and direction and that the PAC strategy strengthens its long-term financial viability.

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5 America's Health Rankings, 2016 Annual Report.