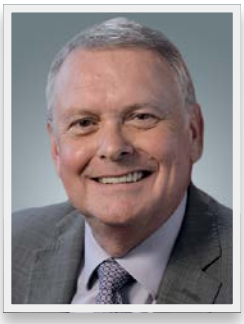
Creating a Successful Post-Acute Care Strategy to Reduce Unnecessary Utilization

By Barry P. Ronan, FACHE, Western Maryland Health System



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In 2010, as Western Maryland Health System (WMHS) embarked on a value-based care delivery journey, the board of directors recognized that such transformational change necessitated a review of our mission and vision statements, as well as our core values. It was obvious that as our care delivery model changed, our culture would, too.

The board felt that our core values of integrity, innovation, compassion, accountability, respect, and excellence still fit very well with our organization's new direction. We amended the mission statement to better reflect the patient-centered approach to care delivery in tandem with our intention to improve the health and well-being of the community. Since the value-based model cares for patients in the most appropriate setting, resulting in less acute care utilization and significantly more care delivery in pre- and post-acute settings, we changed the vision statement to reflect the need to create partnerships with other providers throughout the healthcare continuum.

The relationships between WMHS's pre-acute settings and urgent care providers, independent physician practices, ambulatory surgery centers, diagnostic centers, and in-home providers were well-established. The goal with those relationships was to solidify and enhance them, moving from relationships to working partnerships. However, relationships with post-acute care settings were more challenging for many reasons.

Strengthening Relationships with Post-Acute Care Providers

There are a dozen skilled nursing facilities (SNFs) in the area, including one of our own that regularly accepts discharges from the acute care setting. Owning one of these SNFs compounded the challenge of changing the patient care model because it added inherent competition and posed a variety of trust issues.

For example, a typical scenario at that time might include a physician with two positions: an independent practitioner, primarily, and an SNF medical director, secondarily. If an SNF resident experienced a medical difficulty, staff would make a phone call to the medical director, who would routinely send the patient to the WMHS ED for evaluation. The time of day or severity of illness was irrelevant; the normal procedure was to send the resident, by ambulance, to the hospital. Often, residents simply were dehydrated. After receiving IV fluids, they would be returned to the SNF just a few hours later. Such trips to the ED are physically and emotionally taxing on an already compromised elderly resident, not to mention costly because of the ambulance transfer and other resources dedicated to the resident's diagnosis and treatment. Under value-based care delivery and global budgeting, each ED visit constituted unnecessary utilization.

Our goal and need was to make patient-centered, value-based care the new norm. We had to move our relationship from one as a potential competitor to that of a trusted partner, acting in concert for the good of the patient.

Early in our value-based care delivery journey, we invited leadership from the SNFs to join WMHS leadership in a new venture called "Partnership to Perfection." Establishing trust was paramount to this effort. During a series of meetings, we focused on key areas beginning with education: we explained our new care delivery model and our goal to keep patients healthy and out of the hospital. Next, we asked for their assistance and support. We knew we could not achieve our goals without their cooperation. We went on to train the SNF staff on a variety of treatments that could be performed in their facilities, placed RN transitionists, or liaisons between hospitals and SNFs, in their facilities, and in some locations, replaced their medical directors with SNF specialists (similar to hospitalists, exclusively serving SNF residents). Finally, we provided education regarding the likely direction of care delivery models: that at some point in the not-too-distant future, they too would risk penalties for overutilization. WMHS leadership continue to meet with the group of SNF leaders every other month and the relationships we have established continue to mutually benefit the SNF staff and the health system.

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Key Board Takeaways

Hospital and health system boards should be aware of the deployment of the organization's post-acute care strategies to reduce unnecessary utilization. These strategies can include:

- Creating partnerships across the care continuum to better address patient needs
- Understanding the social determinants of health that may be affecting the patients served by the hospital or health system
- Developing a strategy to address patient needs
- Learning from organizations already involved with reducing utilization to discover what established strategies can be applied at your hospital/health system
- Educating the community and other providers on what you will achieve through such strategies

"Alone we can do so little; together we can do so much."

–Helen Keller

Collaborating across the Care Continuum

In addition to working with SNFs to remodel patient care, we quickly recognized that value-based, patient-centered care requires partnerships across the continuum. From physicians and pharmacies to government entities, the faith-based community, and service agencies, such as homeless shelters and senior living centers, we now collaborate with a multitude of organizations.

When working with these partners, our community health workers and patient navigators focus on addressing the social determinants of health for recently discharged patients. Interventions regularly include arranging for meals, transportation, medications, follow-up primary care physician appointments, and providing telemonitoring equipment in patients' homes. Care coordinators follow up with every discharged patient, addressing any needs that may have arisen. Care coordinators also are located in physician offices to assist patients with avoiding unnecessary readmissions. Teams of staff make an effort to see patients in locations close to where they live, including churches, community centers, shelters, and even municipal buildings. These teams arrange for follow-up appointments or find a primary care practitioner if the patient does not have one. Providing transportation for some of the most medically challenging patients has proven effective, with a direct correlation to reduced readmissions.

With the help of our partners, WMHS also has created seven community gardens throughout our service area to feed victims of food insecurity. In addition to the community garden plots, the health system maintains several plots and donates the harvest to the local food bank. Fruit trees encircle some gardens, providing fresh fruit to anyone who maintains a plot.

The goal of our post-acute care strategy is to provide patients with optimal care and for them to remain healthy upon returning to the community. We have learned that patient-centered care must be personalized, intensive, and involve one-on-one creative engagement. Nothing is "off the table," whether it be arranging for a follow-up appointment with a primary care physician, obtaining medications, providing healthy meals, arranging for transportation for one of our many patients in rural locations, or setting up remote monitoring in the home.

Partnerships Key to Post-Acute Strategy

Partnerships with key providers continue to be the most essential component of our post-acute care strategy. Our results reflect improved patient care and success: We have reduced admissions by 27 percent since 2011, readmissions by 26 percent, and ED visits by 15 percent. Each improvement is directly tied to our comprehensive post-acute care strategy.

The Governance Institute thanks Barry P. Ronan, FACHE, President and CEO of Western Maryland Health System, in Cumberland, MD, for contributing this article. He can be reached at bronan@wmhs.com.