

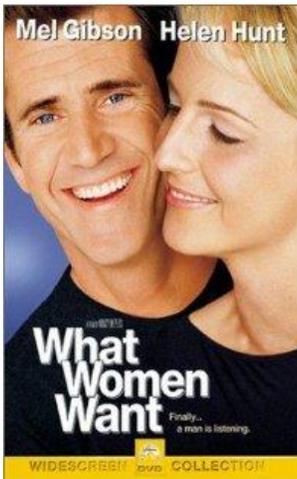


# How Are Hospitals Measuring SNF Performance?

Building an Offensive Strategy in the  
Outcomes-Driven World of Healthcare

Teresa Chase, President & CEO  
American HealthTech





<http://www.imdb.com/title/tt0207201/>

## Executive Summary

In the 2000 movie “What Women Want” Mel Gibson, an advertising executive, experiences a fluke accident and suddenly can hear what women are really thinking. After his initial panic, he learns to use his insights to his advantage.

### What Do Hospitals Want?

What’s unfolding across the country in skilled nursing is not unlike Gibson’s experience. On October 1, hospitals in the bottom quartile will face across-the-board cuts from Medicare. SNFs are in a powerful position to **use data to their competitive advantage**, and become attractive partners to hospitals in trouble...or to hospitals on top who want to stay on top. Data is key to a Gibson-like competitive advantage.

### The Takeaway

In this paper, you will get:

- How skilled nursing readmission rates compare to other sectors in post-acute care
- What hospitals want, as described by 3 major health systems
- What data SNFs will need to be attractively positioned with hospitals at the negotiating table
- Three imperatives for SNFs as they prepare for meetings with hospitals in the outcomes-driven world of healthcare

### The Bottom Line

Facts are friends, and you must line them up to win partnerships in the new era of post-acute care. This paper will give you insights into what hospitals want in order to focus your intelligence gathering, reporting, and marketing to hospital executives.

# How SNFs Stack Up

SNFs have a very attractive opportunity to step up their game. At the February 2012 Health Dimensions Group National Summit, Dr. Kathleen Griffin in her opening keynote shared:

	<b>30-day Readmission Rate</b>	<b>Average Payment</b>
Long-Term Acute Care (LTAC)	10%	\$38.6K
Inpatient Rehab Facility (IRF)	7.2%	\$17K
<b>SNF</b>	<b>21%</b>	<b>\$10.2K</b>
Home Health	29%	\$2.6-3.1K
MedPAC Target	8%	

From a taxpayer’s perspective, LTACs and IRFs, albeit with lower readmissions, are still pricey options. Home health, while attractive from a cost perspective, results in an eye-brow raising bounce back rate of nearly one in three. **The door is wide open for SNFs.** For those willing to attack readmissions and position quality benefits, there are attractive reasons to partner with them from a hospital’s standpoint given the real value: great care at a great price. Prove you can sustain low readmissions, and you’ll be well positioned with the hospitals on which your revenues and reputation depend.

“MedPAC’s target for 30 day readmission rates is 8%.”

*Dr. Kathleen Griffin,  
National Director of Post  
Acute and Senior  
Services, Health  
Dimensions Group*

# Pre-Emptive Opportunity

There is another compelling reason to attack readmissions: not only is it a marketing play, but in the future it may be a preservation play. AHCA as well as the Alliance for Quality Nursing Home Care are both calling on Congress to stem further universal cuts by targeting cost savings in the form of penalties for SNFs with high readmission rates.

## \$3.39 Billion in Savings

From 2000 to 2006, the rate of SNF readmissions grew 29%. MedPAC is particularly interested in avoidable readmissions as a cost-savings opportunity. Today five conditions account for 78% of all avoidable 30-day SNF readmissions:

- Congestive heart failure (CHF)
- Respiratory infection
- Urinary tract infection (UTI)
- Sepsis
- Electrolyte imbalance

In 2006 the cost to Medicare for all SNF-related readmissions was \$4.34 billion, and 78% or \$3.39 is estimated at potentially avoidable.<sup>1</sup> When you take into account that the cost to Medicare for all unplanned readmissions is \$17.4 billion,<sup>2</sup> the SNF contribution of \$3.39B is 20%. At this rate of 1 in 5, it won't be long before budget hawks take notice.

## Position to Win and Avoid Penalties

What is happening with hospitals is an early warning: cuts are likely to come to SNFs with high readmit rates. Embrace the gift of early intelligence: attack readmissions now, market your attractive outcomes, win census from hospitals, and be well positioned when readmissions-related cuts come to your neighbors caught flat-footed.

“Skilled nursing facilities with above-average re-hospitalization rates should be subject to the same penalties hospitals face under the Affordable Care Act.”

*Alan Rosenbloom,  
President,  
Alliance for Quality  
Nursing Home Care*

# Three Health Systems Speak: How SNFs Are Measured

“We’re assessing post-acute care capacity and creating a credentialing system.”

*John DiCola, SVP,  
Strategy & Business  
Development,  
Catholic Health  
Initiatives*

Hospitals around the country are creating credentialing systems to evaluate providers. In this section, we profile the yard stick against which SNF performance is being measured.

## #1: Catholic Health Initiatives

Catholic Health Initiatives (<http://www.catholichealthinit.org/>) operates 73 hospitals and has a large post-acute network across 19 states. Maximizing performance to manage to Medicare rates, capitalizing on payment incentives, and clinical quality are top strategic priorities. The building of infrastructure for accountable care is actively underway.

John DiCola, of Catholic Health Initiatives, shared his company is “assessing post-acute care capacity and creating a credentialing system, including expectations for quality, cost, satisfaction, and of course readmissions.” Here’s how a partner will be sized up:

- Beds, census, discharge status, LOS
- 7- and 30-day readmissions
- Functional Independence Measures (FIM) Scores
- Patient and family satisfaction
- Emergency department visit rates
- Infection rates<sup>3</sup>

Post-acute teams will be responsible for identification, selection, and on-going measurement of partners. Partners will be expected to provide financial, quality, and outcomes data on a regular basis.

Mr. DiCola notes that as the outcomes-driven world of healthcare evolves, “We will be refining the criteria as we go.”

“Clinical outcome metrics are imperative.”

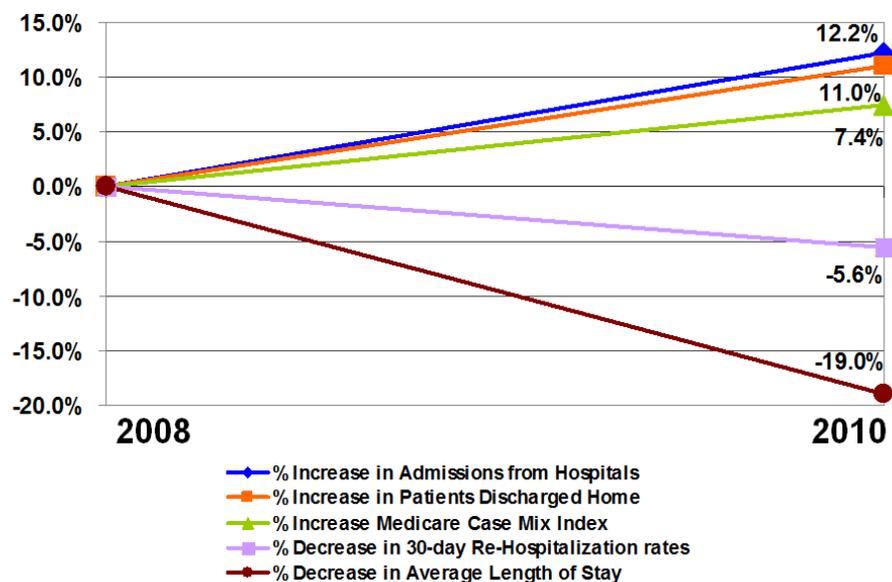
*Dr. Keith Krein, MD, CMD, Senior VP Medical Affairs,*

## #2: Kindred Healthcare

When considering how SNFs will be measured by hospitals it is insightful to see how a post acute care organization providing post acute care services measures performance of its own 225+ SNF network. Kindred Healthcare offers a full range of post-acute care services including LTACH, IRF, SNF, ALF, hospice and home health.

Dr. Keith Krein, MD, CMD, Senior VP Medical Affairs for Kindred Healthcare, offered two years of performance metrics for Kindred’s skilled nursing facilities, which includes:

### Kindred Healthcare Skilled Nursing Key Metric Performance



Importantly, Dr. Krein noted that: “The value proposition must be based on transparent Outcome Metrics that can be shared with patients and families, physicians, hospitals, Managed Care Organizations, our own SNFs and the community at large. Clinical outcome metrics are imperative.”

Kindred Healthcare is tracking hospitalization rates in short-stay and long-stay populations:

- Within 30 days of admission and total
- Weekday vs. weekend
- Relationship to case mix index and nurse staffing<sup>4</sup>

“The medication process is critical: it’s a big determiner of readmissions. We put a lot of attention on the right order, the right pill, and the right frequency.”

*Mark Enger, VP & COO,  
Care Delivery, Kaiser  
Permanente Northwest*

### #3: Kaiser Permanente Northwest

The Kaiser Permanente (<https://healthy.kaiserpermanente.org>) network in the Northwest serves Northwestern Oregon and Southwestern Washington, and covers nearly 500,000 members. Corporate focus is on prevention and evidence-based medicine across the entire network. Mark Enger, Vice President and Chief Operating Officer, Care Delivery, offered insight for the Northwest region.

#### SNF Metrics<sup>5</sup>

##### ***Improve patient satisfaction***

- Press Ganey SNF satisfaction at 50<sup>th</sup> percentile for American Hospital Association
- Patient satisfaction with Kaiser Permanente Contact = 78%

##### ***Administer benefits in a compliant manner***

- Lower member appeals and overturns
- Ensure 85% of Kaiser Permanente members have access to a Kaiser-contracted SNF

##### ***SNF quality***

- 100% of SNF facilities are at CMS 3 stars or above
- Favorable functional Independence Measure (FIM) and therapy hours per day variance

##### ***Avoid readmissions***

- Increase Emergency Department transfers to SNF
- Achieve 15% or lower readmissions during SNF stay
- Address hospital readmissions within 30 days of SNF discharge

##### ***Eliminating barriers to hospital discharge***

- Lower avoidable hospital days

##### ***Achieve low ALOS***

- Favorable Senior Metrics ALOS variance

# Prepare For Hospital Meetings

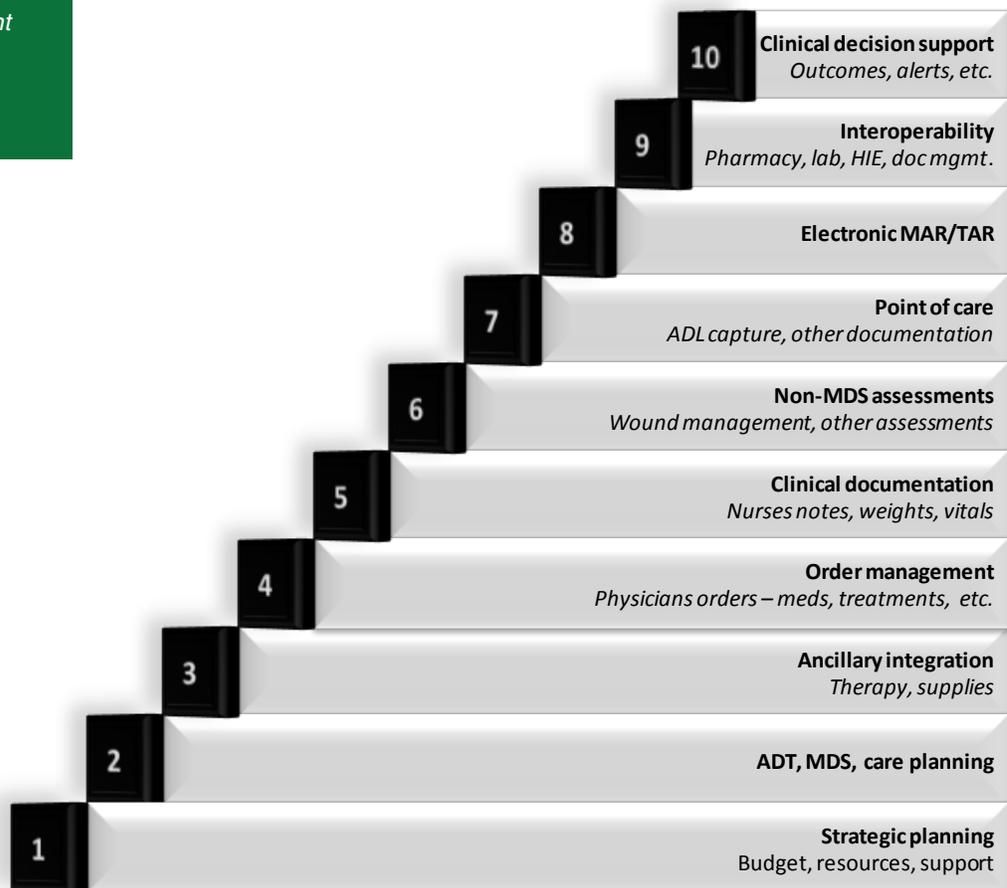
“Cash is still king,  
but there’s a new  
queen in  
town...and her  
name is data.”

*Teresa Chase, President  
& CEO, American  
HealthTech*

## 1. Get your EMR house in order

- Drive paperless in every corner – you’ll need analytics. Link to a white paper to get started “EHR: from 0 to 60 mph in 5 Steps - How to Justify, Architect, Execute, and Sustain a Successful EHR Program.”

<http://www.healthtech.net/white-paper-ehr-from-0-to-60-in-5-steps/>



“Knowledge is power, and we’re well positioned to compete with Outcomes Reporting in the regions we serve.”

*Dearl Layton, Director of IT, Presbyterian Homes & Services of Kentucky*

## 2. Get your sales pitch ready

- Which hospitals area struggling in your backyard? Rank them:

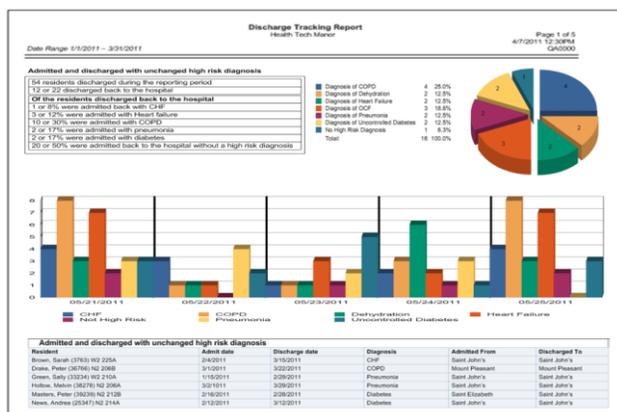
<http://yourlife.usatoday.com/health/story/2011/07/Compare-hospitals-on-heart-attack-heart-failure-and-pneumonia/49683752/1>

- Here’s sample of *USA Today’s* data. The national readmission rate for heart failure is 24.7%, and here’s how hospitals in Nebraska compare:

Hospital	Readmission
ALEGENT HEALTH-MIDLANDS	30.3%
SAINT ELIZABETH REGIONAL	27.4%
BRODSTONE MEMORIAL HOSP	26.8%
ST FRANCIS MEDICAL CENTER	26.6%
OMAHA VA MEDICAL CENTER (VA	26.5%
ALEGENT HEALTH IMMANUEL	26.2%
VALLEY COUNTY HEALTH SYSTEM	26%
PENDER COMMUNITY HOSPITAL	25.8%
PHELPS MEMORIAL HEALTH	25.7%
GREAT PLAINS REGIONAL MEDICAL	25.5%
MEMORIAL HEALTH CARE	25.4%

- Where can you help?
  - You’ll need to create outcomes reports with your costs, quality, and readmissions – to 1) attack areas of concern before you pitch to a hospital; and 2) prepare your pitch.
  - Link to white paper: “**Marketing Your Outcomes: How to Make Your Most Strategic Information Assets Work to Your Competitive Advantage to Win Medicare Census.**”

<http://www.healthtech.net/outcomesmarketing/>



“The Federal Government wants horizontal systems, not vertical. It’s time to create partnerships and rid the industry of silos.”

*Clint Maun, President & Senior Partner, Maun-Lemke*

- SNF readmissions state wide: How do you compare with others?

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2826971/table/T1/>

State	Number of SNF Episodes	% Rehospitalized	Total Rehospitalization Payments (in millions)	% of SNF Episodes with Prior NH Stay Rehospitalized	Rehospitalization Payments with Prior NH Stay (in millions)
Alabama	30,143	22.2	\$56.67	25.6	\$26.81
Arkansas	19,584	24.1	\$42.78	25.6	\$21.63
Arizona	16,862	20.3	\$36.99	25.1	\$14.45
California	122,477	23.8	\$425.11	29.1	\$227.05
Colorado	17,032	17.6	\$30.63	21.4	\$13.20
Connecticut	38,061	23.4	\$93.20	28.6	\$50.01
District of Columbia	2,651	24.1	\$9.69	29.3	\$4.95
Delaware	5,743	22.3	\$13.00	25.7	\$5.68

- What ACOs are forming in your backyard? Link to Premier’s readiness and implementation collaboratives:

<http://www.premierinc.com/about/news/10-may/aco052010.jsp>



### 3. Coordinate Care Transitions

Today’s silos of care will be increasingly replaced by strong, interconnected alliances responsible for outcome-driven care instead of volume-driven care.

- You’ll need a business case for interoperability and critical steps for getting started.
- Link to a paper: “Connecting Our World: How Interoperability is Redefining the New Era of Healthcare and Producing Better Outcomes” <http://www.healthtech.net/interoperability/>

## About the Author

**Teresa Chase** is President of American HealthTech. With over 30 years of leadership roles in healthcare, Teresa is passionate about helping providers form the alliances, access, and answers on which quality outcomes depend in the new era of post-acute care. Teresa empathizes with the demands of a people-intensive business in hiring, motivating, and devoting one's life to helping others. Prior to American HealthTech Teresa served 21 years at Blue Cross & Blue Shield, including VP of Customer Relations and HR.

## About American HealthTech

American HealthTech is **Your Ultimate Connectivity Partner**, connecting caregivers, partners, and healthcare networks to drive higher outcomes in the new era of post-acute care. Coast to coast, a fifth of the nation's providers depend on AHT daily for innovations that free hands to care for others. For more information, visit [www.healthtech.net](http://www.healthtech.net).

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1 The Revolving Door of Rehospitalization From Skilled Nursing Facilities, Vincent Mor, PhD, Orna Intrator, PhD, Zhanlian Feng, PhD, and David C. Grabowski, PhD. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2826971/>

2 N Engl J Med. 2011 Apr 21;364(16):1582.  
<http://www.ncbi.nlm.nih.gov/pubmed/19339721>

3 "Accountable Care Organizations: It's More Than Acute Care, Catholic Health Initiatives A National System's Approach to Building Accountable Care Capability", Presented by: John DiCola, Senior Vice President, Strategy & Business Development, February 2012.

4 Dr. Keith Krein, MD, CMD, Senior VP Medical Affairs for Kindred Healthcare, "Transforming your Business for the Outcomes World of Healthcare," August 2011.

5 Mark Enger, Vice President and Chief Operating Officer, Care Delivery, "The Post Acute Continuum , Kaiser Permanente Northwest," February 2012.