Postacute Care Partnerships and Patient Progression

PENNY GILBERT, MSN, MBA, RN, NE-BC, CPHQ; NANCY J. MAGGARD, MSN, RN, NE-BC; CHERYL TALBERT, MSW, LCSW; AND DONNA VELA, MSN, RN, NE-BC, CPM

ABSTRACT

Postacute care preferred partnerships create transparency between various care delivery arenas. This transparency offers an opportunity to improve patient outcomes and safety. Program development should be data driven, with implementation of best practices, costs analysis, and sustainment of partnerships throughout the patients' care continuum. Program effectiveness requires data (outcomes and financial) collection with the opportunity to discuss improvement areas. Various postacute care entities are available for partnership. It is important to choose those that most benefit the patient populations served.

The American Journal of Accountable Care. 2017;5(3):34-37

According to Gray,[1] as healthcare increases in complexity, acute and postacute care organizations may struggle with accountability. Healthcare organizations must successfully navigate through internal and external forces and encourage collaboration among multidisciplinary teams and community resources for successful discharge planning and partnership alignment. The University of Kentucky HealthCare (UKHC) Preferred Partnership Program works to develop and drive postacute care alliances. According to Evans, 1 in 5 patients with public payer coverage (Medicare) leaves the hospital and goes to a skilled nursing facility (SNF).[2] UKHC partnerships labor to create transparency among various care settings while driving quality outcomes with low utilization of services. Collaboration among multidisciplinary teams and community resources is critical for successful discharge planning and partnership alignment. "Effective health management is not a collection of assets—but a scalable, coordinated, and flexible effort across healthcare organizations."[3] During the first year, postacute care partners must meet specific data-sharing and quality outcomes.

UKHC also tracks referrals made and accepted or declined through the case management electronic health record (EHR) module. The above specific data points are used to determine partnership continuation or termination. Currently, partnerships include inpatient physical rehabilitation hospitals, SNFs, long-term acute care organizations, and community partnerships, such as the one previously mentioned. As UKHC moves into the next phase of postacute care partnerships, a high-level dashboard will extend into quality measures that must be reported by partners (**eAppendix** [eAppendices available at **ajmc.com**]) and home care partnerships will enter the mix of postacute care providers.

Program Implementation

The first step in program development is to identify the type of program need. UKHC leadership recognized the need to develop a preferred postacute care partnership program through data analysis of length of stay (LOS) and opportunity days. The greatest numbers of both appeared with SNF services.

Inpatient Physical Rehabilitation Unit

Initially, the chief nurse executive worked to identify patient flow through alignment of partnerships. Creation of a new position, "postacute care/transitions director," was completed. UKHC began building a partnership with a local 232-licensed bed physical rehabilitation hospital. This partnership acted as a stepping stone for future alliances, creating a greater flow of processes, practices, and transparency.

Data indicated bottlenecks in processes, but there was no way to identify the cause of delays without partnership development and practice transparency. UKHC physical medicine and rehabilitation physicians assisted with streamlining patient transitions, yet delays still existed. Patients were being evaluated prior to transition to the inpatient physical rehabilitation unit (IRU), creating care continuity, but this was not enough. Once the partnership was implemented, alignment of activities occurred. Five on-site IRU liaisons were placed strategically across the Enterprise to conduct preadmission screening and determine patient acceptance prior to discharge orders. The IRU liaisons communicated via the EHR with detailed assessment screens, allowing caregivers to quickly view the liaisons' findings and recommendations. Opportunity days decreased by more than 50% and have remained steady over 6 months; for IRUs they initially ran more than 1000 days per month, indicating that patient transition delays accounted for 1000 days' variance between a risk-adjusted expected hospital stay and observed stay. These opportunity days identified a loss of revenue due to lack of hospital bed back-fill capabilities and an inability to fulfill the Enterprise mission.

Concerns and issues still arise within the partnership, but now official forums exist to facilitate resolutions. Monthly multidisciplinary team meetings occur in addition to executive support from both teams. It is important to note, the UKHC Finance Business Partners division is of exceptional value to all partnership agreements through data collection, dashboard development, and key reporting, including financial impacts.

Skilled Nursing Facilities

UKHC patients experience high utilization needs (high Case Mix Index [CMI]), creating situations where patients fall between long-term acute care services and skilled nursing services. Families are often unable or unwilling to care for patients at home, even when home care services may be available. SNFs encounter their own hurdles with patient transitions due to lack of training and resources. Some SNFs do not accept patients with tracheostomies and others have no way to provide intense wound care services; further, many are unable to take patients with tracheostomies while requiring hemodialysis. State Medicaid reimbursement for services is often low compared with providing the skilled nursing service needed; thus, patients are not accepted.

The UKHC postacute care provider program allows preferred partner employees to attend Enterprise training courses, which expands preferred partners' services. Quarterly SNF expos are held in an effort to provide participants' access to dynamic speakers, with up-to-date topics related to care in the postacute arena. This forum promotes networking among partners and helps facilities drive higher quality. As various partnerships have developed, the SNF Expo name is being changed to Post-Acute Care Expo, ensuring inclusion of all postacute care providers.

Kentucky Appalachian Transition Services

According to CMS, care transitions occur when a patient moves from one healthcare provider or setting to another. Readmission risk increases with each transition. Nearly 1 in 5 Medicare patients discharged from the hospital—approximately 2.6 million seniors—is readmitted within 30 days, at a cost of over $26 billion every year.[9]

Kentucky Appalachian Transitions Services (KATS) supports the 3-part aim of making healthcare safer, more reliable, and less costly for those served by UKHC. The program emerged as part of the Partnership for Patients, a public–private partnership charged with reducing hospital-acquired conditions by 40% and hospital readmissions by 20%, by 2013. Patients are screened and identified for transitional services using the Care Transitions Intervention or the Transitional Care Model.[10,11] The program has expanded to the homeless population with high emergency department (ED) utilization. To date, 39 patients have been contacted, resulting in 3 patients receiving visits from a KATS coach. Thus far, the program has not resulted in reduction of ED utilization, but the trial is ongoing.

KATS executives and frontline staff attend various internal collaborative forums, such as with the readmission team(s), in addition to scheduled monthly partnership meetings. UKHC Finance Business Partners monitor and report financial outcomes related to return-on-investment, including back-fill of acute care beds and services provided. Analyses of control groups versus inclusion groups are reviewed quarterly, to date revealing a lower utilization and readmit rate for the cardiac population.

After 22 months of the KATS program, 484 patients participated compared with 204 who were eligible but did not participate. The initial cost per encounter was $2472 more for the KATS group versus the control group, but $3459 less for readmission encounters. The readmission rate for the KATS group overall was 16.1% compared with 18.1% for the control group. The impact was particularly significant in the cardiovascular population, in which the CMI for KATS was 2.91 and was 2.29 for the control group. The readmission rate in the 211 cardiovascular KATS patients was 6.2% compared with 17% in 53 patients in the control group. The infectious and immunological diagnosis group had a dramatic response to KATS, with a 6.1% reduction in readmissions compared with the control group. The population for this KATS group had readmission costs of $26,991 less than that group's control participants. Not all subsets within KATS have had results this dramatic, but the Enterprise and the KATS teams continue to refine the work that is being done.

Discharge Hurdles

The second step in program development is the recognition of discharge hurdles, such as physical and mental illness and homelessness.

Patients With Opioid Addiction/Substance Use Disorder

Overcoming sources of physical and mental illness is often an underlying challenge, especially when a substance use disorder (SUD) is present. According to the Kentucky Drug Control Update,[4] Kentucky was one of the top 10 states for use in several drug categories among individuals 12 years or older. In the absence of appropriate resources and skill sets, this population may go without proper SUD treatment. Lack of recovery creates vicious patterns of abuse and multiple acute care requirements.[5] Review and evaluation is currently being conducted at UKHC, with goals to identify feasibility and implementation of an internal consultative medical division for this population. Many of these patients suffer from behavioral outbursts and need substance withdrawal management, which requires skills not often acquired by healthcare providers and staff.[5] Nonetheless, these individuals will continue to require physical care, thereby necessitating that acute care organizations construct standard practices for optimal outcomes.

U.S. News & World Report referred to heroin and methamphetamine addiction as the "quiet epidemic,"[7] as heroin abuse has more than doubled in the past decade.[13] In 2008, *The Journal of Addiction Medicine* published a study exploring the prediction of abstinence in patients who are opioid-dependent.[8] Low predictive value for abstinence was identified in that study for all variables; based on Cook's findings, addiction abstinence predictors appear to remain elusive.

The Alcohol and Drug Addiction Rehab Admission Statistics for Kentucky identify several Kentucky counties as national leaders for the quantity of narcotic pain medication distributed per person. Likewise, cocaine, heroin, methamphetamines, and marijuana are immensely available and abused within Kentucky state borders.[3] On any given day, 6% of UKHC's average daily census is related to substance abuse (percentage excludes neonatal abstinence syndrome babies). This group of patients is frequently treated for endocarditis, osteomyelitis, overdose, and other harms related to addiction.

Once the patient is physically ready for discharge, the history of intravenous (IV) substance abuse frequently generates reluctance to discharge as IV antibiotic therapy often extends or is needed well beyond acute care stay. In 2015, UKHC formed a partnership with a residential substance abuse rehabilitation facility, with the partnership goal being to provide substance abuse therapy while allowing the completion of IV antibiotics. An on-site addiction program liaison visits with patients several times during their hospitalization in an effort to obtain agreement to transition once physically stable. Many patients refuse, but others typically agree although they may leave the program prior to completion (~50%).

Due to substance abuse population volume, extended LOS, and the loss of transferred patients from across the state, an Opioid Use Disorder Taskforce was formed. The Taskforce proposed development of an addiction medicine consultative service within the Enterprise. The service, on track for approval, will assess and treat substance abuse during the inpatient stay and provide transitional management. A business plan for the service has been submitted and is currently under review for approval by senior leadership.

Homelessness

Thinking of poverty in third-world countries is often easier than thinking in the context of developed countries.[12] "Most Americans would probably acknowledge there is poverty here, but it has not been seen as a serious problem since the 1970s."[13] Homelessness is another challenge being addressed through community partnerships. In Kentucky, the homeless population creates challenges for healthcare providers. UKHC has partnered internally and externally in an effort to guarantee care for the homeless population.

Internally, the team is working with ED physicians to identify and create standard plans of care for high ED utilizers. This often includes incorporating KATS services to follow patients once they have been discharged. Financial services become involved if there is

no payer source, and social services work to reconnect patients with estranged family or friends and needed resources. Social workers are positioned to provide a voice for homeless populations, thus ensuring better response to patients who are low income and/or experience SUD.[6] A UKHC social work manager attends quarterly community health and homelessness coalition meetings within the community. One main goal for Lexington and UKHC, currently, is to create a medical program respite for homeless individuals who do not require skilled services, but are also not well enough to go back to the street.

Externally, the team is working with the city liaison in addition to other acute care providers in the region to assist with identifying the unique number of healthcare challenges experienced by the homeless, and potential locations for respite when facility care is no longer needed. The team further partners with the Area Agency on Aging, city health coalition, and the state quality improvement organization. The partnership allows for a diverse group of individuals/teams to problem-solve for homeless situations.

Conclusions

It has been said, "In healthcare, the days of business as usual are over."[14] Preferred partnerships are a necessity rather than a luxury. Program implementation requires data analysis to identify focus areas, return on investment, and ultimate patient outcomes. It is important to set expectations of data sharing and transparency and to use the data to drive enhancement for all parties. Although partnerships may be similar, each will bring unique challenges and rewards.

Author Affiliations: University of Kentucky HealthCare (PG, NJM, CT, DV), Lexington, KY.

Source of Funding: None.

***Author Disclosures*:** The authors report no relationship or financial interest with any entity that would pose a conflict of interest with the subject matter of this article.

Authorship Information: Concept and design (PG, NJM, CT); acquisition of data (PG); analysis and interpretation of data (PG, DV); drafting of the manuscript (PG, NJM, CT); critical revision of the manuscript for important intellectual content (PG, NJM, CT); statistical analysis (DV); provision of study materials or patients (PG); administrative, technical, or logistic support (PG); and supervision (PG).

Send Correspondence to: Penny Gilbert, MSN, MBA, RN, NE-BC, CPHQ, University of Kentucky HealthCare, 800 Rose St, Office H-149, Lexington, KY 40536. E-mail: penny.gilbert@uky.edu.

REFERENCES

1. Gray CS, Berta W, Deber R, Lum J. Organizational responses to accountability requirements: do we get what we expect? *Health Care Manage Rev*. 2017;42(1):65-75.

2. Evans M. Hospitals select preferred SNFs to improve post-acute outcomes. Modern Healthcare website. http://www.modernhealthcare.com/article/20150509/MAGAZINE/305099987. Published May 9, 2015. Accessed August 2017.

3. Weaver D. Power your population health strategy. Advisory Board website. https://www.advisory.com/consulting/infographics/2015/power-your-population-health-strategy. Published June 29, 2015. Accessed November 27, 2016.

4. Overdose fatality report. Kentucky Office of Drug Control Policy website. http://odcp.ky.gov/Pages/Overdose-Fatality-Report.aspx. Published 2015. Accessed November 27, 2016.

5. Kermack A, Flannery M, Tofighi B, McNeely J, Lee JD. Buprenorphine prescribing practice trends and attitudes among New York providers. *J Subst Abuse Treat*. 2017;74:1-6. doi: 10.1016/j.jsat.2016.10.005.

6. McCabe HA, Wahler EA. The Affordable Care Act, substance use disorder, and low-income clients: implications for social work. *Soc Work*. 2016;61(3):227-233.

7. Cook L. The heroin epidemic, in 9 graphs. *U.S. News & World Report* website. http://www.usnews.com/news/blogs/data-mine/2015/08/19/the-heroin-epidemic-in-9-graphs. Published August 19, 2015. Retrieved December 12, 2016.

8. Dijkstra BA, De Jong CA, Krabbe PF, van der Staak CP. Prediction of abstinence in opioid-dependent patients. *J Addict Med*. 2008;2(4):194-201. doi: 10.1097/ADM.0b013e31818a6596.

9. Community-based care transitions program fact sheet. CMS website. https://innovation.cms.gov/files/fact-sheet/cctp-fact-sheet.pdf. Published April 2011. Accessed December 11, 2016.

10. Coleman EA. Falling through the cracks: challenges and opportunities for improving transitional care for persons with continuous complex care needs. *J Am Geriatr Soc*. 2003;51(4):549-555.

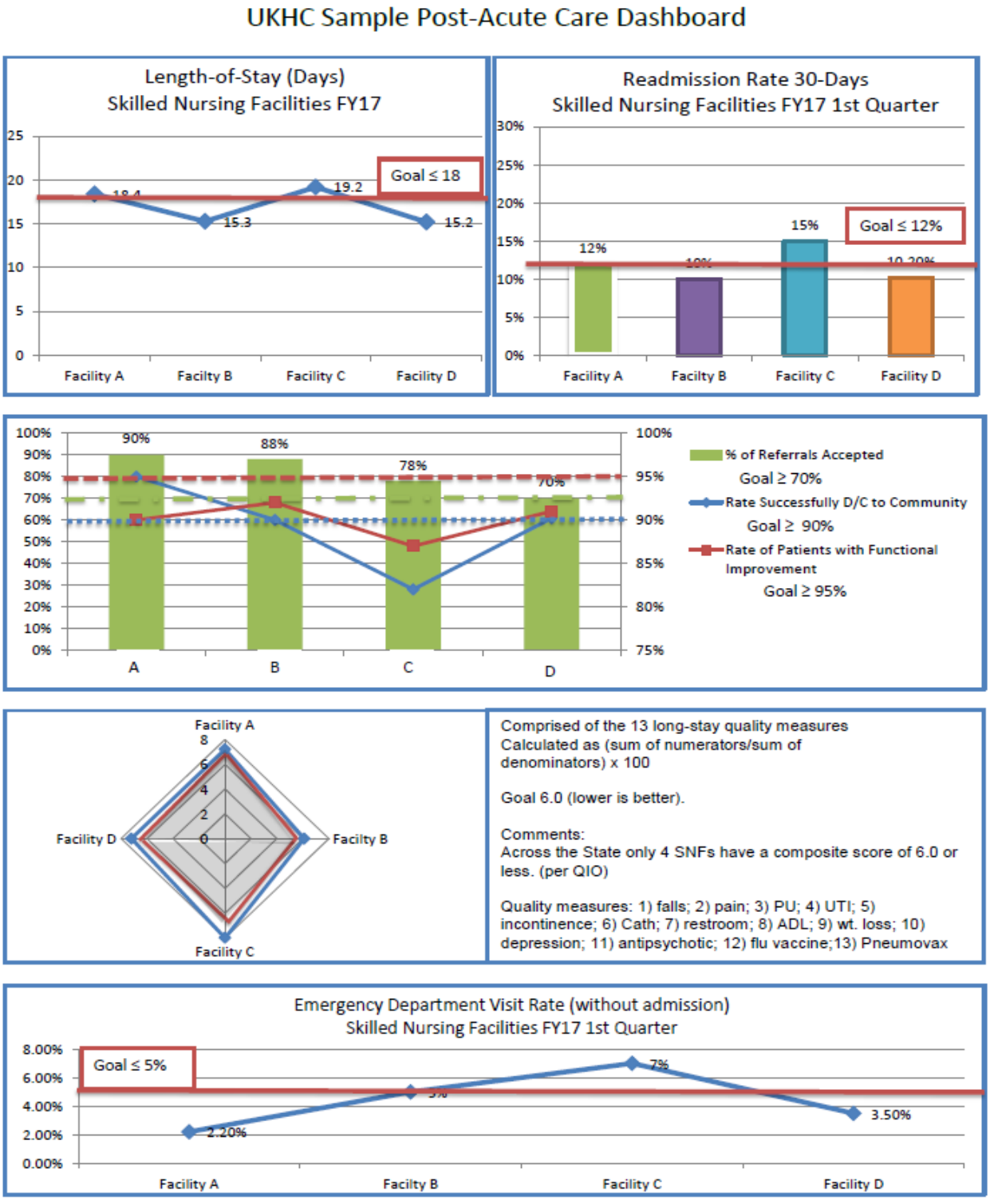
11. Naylor MD. Advancing high value transitional care: the central role of nursing and its leadership. *Nurs Adm Q*. 2012;36(2):115-126. doi: 10.1097/NAQ.0b013e31824a040b

12. Kilty KM. Hiding from poverty. *J Poverty*. 2008;11(3):85-88. doi: 10.1300/J134v11n03_08.

13. Kentucky health care for the homeless planning report. National Health Care for the Homeless Council. 2015.

14. Porter ME, Lee TH. The strategy that will fix health care. *Harvard Business Review*. 2013;91(10):50-70.

eAppendix


UKHC Sample Post-Acute Care Dashboard
Length-of-Stay (Days)
Skilled Nursing Facilities FY17
Goal ≤ 18
19.2
15.3
15.2
Facility A
Facilty B
Facility C
Facility D
Readmission Rate 30-Days
Skilled Nursing Facilities FY17 1st Quarter
Goal ≤ 12%
12%
15%
90%
88%
78%
70%
% of Referrals Accepted
Goal ≥ 70%
Rate Successfully D/C to Community
Goal ≥ 90%
Rate of Patients with Functional Improvement
Goal ≥ 95%
A
B
C
D
Comprised of the 13 long-stay quality measures
Calculated as (sum of numerators/sum of denominators) x 100
Goal 6.0 (lower is better).
Comments:
Across the State only 4 SNFs have a composite score of 6.0 or less. (per QIO)
Quality measures: 1) falls; 2) pain; 3) PU; 4) UTI; 5) incontinence; 6) Cath; 7) restroom; 8) ADL; 9) wt. loss; 10) depression; 11) antipsychotic; 12) flu vaccine;13) Pneumovax
Emergency Department Visit Rate (without admission)
Skilled Nursing Facilities FY17 1st Quarter
Goal ≤ 5%
2.20%
7%
3.50%