



Relationship-Based SNF Collaboration

Henry Ford Health System's Approach

Domain: Quality
Category: Integration Strategies and Partnerships
Competency: Q.2.1 Develop a process to leverage resources across the health care and social service spectrum based on the needs of your patient population

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BACKGROUND

When CMS issued the first Hospital Readmission Reduction Program penalties in 2012, Henry Ford Health System's (HFHS) downtown Detroit hospital was one of the eight worst hospitals in the country for readmissions. Since that time, HFHS has focused many efforts on readmission prevention, seeing one of the greatest opportunities in hospital readmissions from skilled nursing facilities (SNFs). With the goal to build closer relationships and facilitate shared learning, HFHS created a SNF Collaborative to better understand the challenges of local SNFs and to collaboratively identify areas for improvement. Since its inception in 2012, HFHS' SNF Collaborative has evolved into a large, tri-county effort with 2 other health systems and more than 130 SNFs. This case study details the strategy and process behind the program's evolution.

About Henry Ford Health System

Founded in 1915, HFHS is a not-for-profit health system comprised of hospitals, medical centers, and a large group practice of more than 1,200 physicians in over 40 specialties.

Location: Southeast, MI
Website: www.henryford.com

VBP Activity:

- Employer-sponsored shared savings with Health Alliance Plan of Michigan (~93k lives)
- Next Generation ACO participant (~22k lives)

APPROACH

To lead this work, HFHS created the System Oversight Committee with representation from case management, physician leadership, and home care from all of its hospitals as well as its medical group. Charged with developing a strategy for SNF engagement, this steering committee began by performing chart reviews to identify common causes for post-SNF readmissions. Then, case management leaders from each HFHS hospital led the development of a hospital-specific SNF Collaborative by identifying the hospitals' high-volume SNFs and also by inviting the Director of Nursing and/or the SNF Administrators from these facilities to attend a monthly meeting to share ideas for improving care transitions and reducing readmissions.

During the early stages, hospital and SNF representatives spent most of their meetings trying to understand each other's challenges, regulatory requirements, and discussing ways they could better support one another. As the level of trust increased, the Collaborative moved to quarterly meetings.

After challenges and areas for improvement had been identified, HFHS launched the second phase of the work, moving beyond relationship building and focusing on performance improvement. With the help of SNF leaders, the newly-created HFHS Post-Acute Care Value Council began to set specific, reasonable targets for SNFs to mitigate readmissions and improve care quality. By meeting these targets, SNFs would demonstrate their commitment to collaborate with the health system and would be rewarded as high-value referral partners. In the beginning, these requirements included attendance by the proper SNF employees at 80% of Collaborative meetings, a 2-hour response time after a referral had been made, and access to Epic with a direct inbox to receive transition of care documents. Over time, the Council added more performance requirements, including a referral acceptance rate of at least 60% to prevent cherry-picking patients. About two years after these metrics were introduced, HFHS highlighted designated SNFs as active partners with HFHS in improving the quality of care. Currently, HFHS includes 44 SNFs on this high-value list.

As a result of Collaborative meeting discussions and learnings from site visits, HFHS has developed several system-wide initiatives to support the SNFs, such as providing direct access to interventional radiology with transportation to and from appointments, furnishing a three-day supply of medications to patients discharged to a SNF, and enabling closer collaboration between SNFs and infusion centers.

It was in listening to a SNF member that Henry Ford learned that two other nearby health systems were engaging in similar collaborative efforts. To share learnings, streamline improvements, and ease the administrative burden on the SNFs, in 2014, HFHS joined with the Detroit Medical Center and St. John Providence to create the Tri-County SNF Collaborative. The collaborative engaged MPRO, the state's quality improvement organization, as an objective convener. MPRO created a portal for the 130 participating SNFs to report quarterly data (detailed below) that allows the participating hospitals and SNFs to review transparent comparison reports.

RESULTS TO DATE

After the first two years HFHS' SNF readmissions decreased by 18.9%. From January 2015 to the second quarter of 2016, after implementation of the Tri-County SNF Collaborative, HFHS' SNF readmissions decreased by another 15.6%. Detroit Medical Center and St. John Providence have also seen similar results. The Collaborative has also resulted in several process improvements. For example, the average percentage of patients with a follow-up appointment with their PCP within seven days of discharge from the SNF increased from about 20% to approximately 70%.

Qualitatively, HFHS has noticed a large cultural shift. In the beginning, SNFs were protective of their facilities' ideas, but because of the Collaborative, SNFs are now open—even eager—to share their best practices. The health system promotes this shared learning by identifying successful facilities and inviting them to present to their peers.

TOOLS & VENDOR PARTNERS

HFHS uses Allscripts for its referral management, as it is the platform used by all the area SNFs. The health system has found this solution to be helpful and beloved by HFHS case managers. HFHS also works with EHR vendor Epic and requires members of the SNF Collaborative gain access to EpicCare Link. HFHS' internal analytics team takes data reported through Allscripts and Epic to create actionable reports. After the creation of the Tri-County SNF Collaborative, the SNFs began reporting their data using the MPRO portal. Data reported include the 30-day discharges, ED visits following a hospitalization, discharge summaries sent by the SNF to the PCP, follow-up PCP visit within seven days of discharge, infection rates (i.e., nosocomial pneumonia and UTI), worsening or new pressure ulcers, and falls with injuries. Each quarter, MPRO creates a report for hospitals and SNFs to compare facility performance.

CHALLENGES WITH IMPLEMENTATION

Although HFHS benefited from its highly competitive and progressive market, it still found some difficulty in engaging the SNFs. Because the Collaborative is solely relationship-based, it took significant time and effort to convince the SNFs of its value. Asking facilities to dedicate time and resources to transformation without direct compensation can be difficult, which is why HFHS focused first on developing trusting relationships. Still, about 10-20% of SNFs dropped out of the Collaborative when it introduced performance targets.

HFHS' greatest challenge with the SNF Collaborative was obtaining accurate, actionable data. First, their hospital readmission rates were inherently inaccurate without knowing if a patient had been readmitted to a different hospital. Additionally, HFHS could only track where patients were referred, not the facilities from which they were being readmitted. Second, in relying on self-reported SNF data, there were concerns about data accuracy. To validate, HFHS compares external MPRO claims data with SNF-reported data.

KEY LEARNINGS

- **Seek to understand** – Health systems must be willing to understand the challenges facing SNFs and make changes to support them.
- **Involve SNFs early on** – SNF representatives should be included in strategy and planning. Work with SNFs to develop and refine performance metrics.
- **Find additional sources** – Use external sources to supplement and verify SNF-reported data.

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