Building Post-acute Relationships in ACOs Is a Complicated Journey

Goal is improved efficiency and quality

Hospitals, post-acute care organizations, and payers need to develop solid relationships and work well together in order to make an accountable care organization (ACO) arrangement successful.

While post-acute networks, historically, were referral centers to get patients out of the hospital, these have changed dramatically, notes **Karen R. Vanaskie**, DNP, MSN, RN, senior network director of the care management program at Innovation Care Partners in Scottsdale, AZ.

"It's a complicated journey to building strong post-acute relationships," Vanaskie says. "We have to have collaboration and not just be a referral center. It's a partnership."

This means organizations must be transparent with their data and outcomes. They must be innovative, constantly learning new ways to do things. The legacy healthcare system is broken and inefficient, in need of repair and replacement, she says.

"We're really a clinically integrated network with 1,600 physicians — 400 in primary care," Vanaskie says.

Innovation Care Partners works with health systems and payers in shared savings contracts.

"We work with many payers — not just Medicare," she says. "Our goal is efficiency and management of patients with the highest quality. Collaboration with post-acute care is critical."

The following are some of the organization's strategies to build strong post-acute relationships:

• **Survey physicians and other referral sources.** "We surveyed physicians, asking who they refer patients to and who patients talk about," Vanaskie says.

The survey focused on four acute care areas: nursing homes, acute rehabilitation, home health, and hospice care. Thirty percent of physicians responded to the survey.

"We also surveyed case managers who referred patients to facilities," she says.

Those surveys looked at the availability of beds and case managers' insights, Vanaskie says.

• **Learn which physicians have relationships with post-acute facilities.** Some doctors provide coverage at post-acute facilities as medical directors or other roles. Since those facilities often were rated positively with case managers and payers had contracts with them, the organization decided to narrow its network to those facilities, Vanaskie says.

"We had a preferred provider list," she says. "We took everything into consideration and then narrowed our network."

• **Focus on quality, data, and solutions.** "We reviewed data on length of stay [LOS] and took a deep dive into readmissions," Vanaskie says. "What caused them and what could we do differently?"

One possible solution is to provide educational activities to post-acute care staff, including those in skilled nursing facilities (SNFs). Wound care training is one example.

"We can offer educational services to post-acute [facilities] as needed, Vanaskie says. "The more quality care we give in the post-acute setting, the fewer readmissions to the hospital."

• **Collaborate closely with SNFs.** "A close collaborative working relationship with SNFs allows us to be more innovative," she says. "We can try different pilot programs."

They launched one pilot program in November 2016, where the hospital provided congestive heart failure education to post-acute providers and SNFs, she says.

"They continue teaching when the patient gets to the SNF, and our preferred home health provider goes into the skilled facility and understands where they are with their therapy," Vanaskie adds. "Then they continue the teaching and reinforcement as the patient goes home from the nursing home with congestive heart failure monitoring."

Within a preferred provider

EXECUTIVE SUMMARY

For accountable care organization (ACO) arrangements to succeed, healthcare organizations need good working relationships and continual communication.

• Organizations should be transparent with data and outcomes.

• They need to embrace innovation, learning new ways to do things.

• In building relationships, it's wise to survey stakeholders to learn what they think and need.

network, it's possible to ensure a good handoff and transition of care throughout the care continuum, she says.

"In the nursing home, we have weekly meetings to review cases, including the home health agency and Innovation Care partners," Vanaskie says. "They make sure everybody is talking and there's good collaboration."

Handoffs focus on providing patient education, pre-visits to the patient's home, and therapy. The goal is to reduce the patient's stay in the nursing home.

• **Transitional care managers are communication conduits.** Independent case managers develop care plans, while the transitional care manager shares information about the plan, ensuring safety in care transition.

The transitional care manager's role is to communicate with community providers, keeping them updated on what is happening in the hospital with their patients, Vanaskie explains.

"So, the transitional care manager has a lot of information to give the inpatient case manager that she might never have known without our ability to communicate with the primary care provider," she says. "The transitional care manager is the communication conduit between the hospital and outpatient care."

Transitional care managers also visit with patients, meet their families, and stay in contact after patients are transferred to post-acute care. They also contact the primary care provider office and conduct home visits. They'll stay closely in touch with patients for 30 days, but are available for patients to contact after that, as well, she says. ■