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Scholarly Report Title: Creating a Network of High-Quality Skilled Nursing Facilities: Preliminary Data on the Postacute Care Quality Improvement Experiences of an Accountable Care Organization

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Creating a Network of High-Quality Skilled Nursing Facilities: Preliminary Data on the Postacute Care Quality Improvement Experiences of an Accountable Care Organization

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Postacute care (PAC) is an important source of cost growth and variation in the Medicare program and is critical to accountable care organization (ACO) and bundled payment efforts to improve quality and value in the Medicare pro- gram, but ACOs must often look outside their walls to identify high-value external PAC partners, including skilled nursing facilities (SNFs). As a solution to this problem, the integrated health system, Partners HealthCare System (PHS) and its Pioneer ACO launched the PHS SNF Collaborative Network in October 2013 to identify and partner with high- quality SNFs. This study details the method by which PHS selected SNFs using minimum criteria based on public scores and secondary criteria based on self-reported measures, describes the characteristics of selected and nonselected SNFs, and reports SNF satisfaction with the collaborative. The selected SNFs (n = 47) had significantly higher CMS Five-Star scores than the nonselected SNFs (n = 93) (4.6 vs 3.2, P < .001) and were more likely than nonselected SNFs that met the minimum criteria (n = 35) to have more than 5 days of clinical coverage (17.0% vs 2.9%, P = .02) and to have a physi- cian see admitted individuals within 24 (38.3% vs 17.1%, P = .02) and 48 hours (93.6% vs 80.0%, P = .03). A survey sent to collaborative SNFs found high satisfaction with the pro- cess (average satisfaction, 4.6/5, with 1 = very dissatisfied and 5 = very satisfied, n = 19). Although the challenges of improving care in SNFs remain daunting, this approach can serve as a first step toward greater clinical collaboration between acute and postacute settings that will lead to better outcomes for frail older adults.

Description of Student Role in the Work:

I spent the summer of 2014 working with Dr. Clay Ackerly (formerly of HMS/MGH) and Prof. David Grabowski (current mentor) on this project, studying Partners Healthcare's attempts to create a high-quality network of skilled nursing facilities (SNF). The Partners SNF Collaborative Network already existed when I came to the project, but this innovative quality improvement model had not been systematically described or evaluated. My role was to be the primary leader of the efforts to describe and evaluate the SNF collaborative network. I first completed a literature review on the use of skilled nursing facilities (SNFs). I also attended multiple staff meetings at MGH and Partners HealthCare where issues of SNF use were discussed in order to learn about the relevant issues. I consulted both with staff at Partners HealthCare and with Prof. David Grabowski about the methodology and design of the study.

The bulk of my work consisted of analyzing data on the SNFs that applied to be a part of the Partners SNF network, in order to see the differences between those selected and not selected. This data included publicly reported information, private information submitted by the SNFs, as well as information within the Partners database. I then conducted all statistical analyses independently, and drafted the initial manuscript. I received detailed feedback from all of the co-authors, and then completed the final draft. We prepared the manuscript for the *Journal of the American Geriatrics Society* under their "Innovative Care Delivery Models: Preliminary Data" section, and the manuscript was accepted and published in 2015.

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Postacute care (PAC) is an important source of cost growth and variation in the Medicare program and is critical to accountable care organization (ACO) and bundled payment efforts to improve quality and value in the Medicare program, but ACOs must often look outside their walls to identify high-value external PAC partners, including skilled nursing facilities (SNFs). As a solution to this problem, the integrated health system, Partners HealthCare System (PHS) and its Pioneer ACO launched the PHS SNF Collaborative Network in October 2013 to identify and partner with high-quality SNFs. This study details the method by which PHS selected SNFs using minimum criteria based on public scores and secondary criteria based on self-reported measures, describes the characteristics of selected and nonselected SNFs, and reports SNF satisfaction with the collaborative. The selected SNFs (n = 47) had significantly higher CMS Five-Star scores than the nonselected SNFs (n = 93) (4.6 vs 3.2, $P < .001$) and were more likely than nonselected SNFs that met the minimum criteria (n = 35) to have more than 5 days of clinical coverage (17.0% vs 2.9%, $P = .02$) and to have a physician see admitted individuals within 24 (38.3% vs 17.1%, $P = .02$) and 48 hours (93.6% vs 80.0%, $P = .03$). A survey sent to collaborative SNFs found high satisfaction with the process (average satisfaction, 4.6/5, with 1 = very dissatisfied and 5 = very satisfied, n = 19). Although the challenges of improving care in SNFs remain daunting, this approach can serve as a first step toward greater clinical collaboration between acute and postacute settings that will lead to better outcomes for frail older adults. **J Am Geriatr Soc 63:804–808, 2015.**

Key words: postacute care; skilled nursing facilities; accountable care organizations

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Postacute care (PAC) cost variation explains a large part of the variation in Medicare spending,[1] is a major driver of cost growth,[2] and is an increasing focus of Medicare reform programs such as accountable care organizations (ACOs) and bundled payments.[3]

ACOs, for example, must often look outside themselves to create an integrated care continuum that encompasses PAC providers, such as skilled nursing facilities (SNFs). SNFs are high-cost, high-volume PAC providers; 20% of all Medicare fee-for-service (FFS) hospital admissions in 2012 required a SNF stay, with 1.7 million Medicare FFS beneficiaries receiving $28.7 billion of SNF care from 15,000 SNFs.[4] There has also been much recent concern at a national level about high readmission rates from SNFs.[5,6] Readmission rates have increased significantly over time,[7] and stronger linkages between hospitals and SNFs have been associated with lower readmissions, pointing to the benefits of acute and postacute collaboration.[8]

Nevertheless, from the perspective of an ACO looking at the PAC market, the challenge of identifying high-value partners is daunting. Publicly reported measures, such as the Centers for Medicare and Medicaid Services (CMS) Five Star score for SNFs, provide objective and comparable quality measures, but these measures do not necessarily encompass SNF characteristics relevant to ACOs, such as ability to coordinate care, reduce readmissions, and provide quality medical coverage within facilities. Medicare Advantage (MA) plans have experience creating SNF networks, but most ACOs are just beginning to explore partnerships with SNFs.

This study documents how one ACO has developed a network of SNFs, reporting characteristics of the selected facilities and providing early data on SNF satisfaction with the network.

METHOD OF CREATING A COLLABORATIVE NETWORK

To identify high-value PAC providers, Partners HealthCare (PHS) led an effort in 2013 to identify high-quality SNFs

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in the Massachusetts market. PHS owns several PAC providers, including long-term acute care hospitals (LTACs), inpatient rehabilitation facilities (IRFs), SNFs, and home health, but discharges to PHS-owned SNFs represent less than 10% of total discharges to SNFs, requiring additional SNF partners to meet patient needs. Simply put, the goal of the network is to meet the needs of complex patients with complex medical needs in a scalable and sustainable way to improve patient satisfaction, reduce SNF readmissions, reduce unnecessary SNF stays, and reduce excess SNF length of stay (LOS).

Defining the Criteria

In spring 2013, PHS used a multistakeholder process (including case managers, physicians, and experts) to identify and weight criteria for the inaugural SNF Collaborative Network using publicly reported quality metrics and self-reported information from SNFs (Appendix 1). Because the collaborative was anchored on quality, participating facilities were required to meet minimum criteria of at least three stars on their most recent CMS Five Star score and to have a Massachusetts Department of Public Health (MA DPH) Survey Performance score of greater than 125 (50th percentile) before they were scored on secondary criteria.

Selection Process

PHS advertised the new SNF Collaborative Network to all SNFs in eastern Massachusetts, and interested SNFs submitted applications in July 2013. The collaborative was launched in October 2013. To achieve its goals, the collaborative is engaging in bidirectional data sharing with SNFs. For example, SNFs are reporting individual-level data on each PHS referral and admission regarding the care transition (e.g., completeness of discharge information, frequency of warm (face-to-face) handoffs between discharging acute providers and admitting postacute providers) and care in the SNF. Conversely, PHS reports to SNFs their readmission rates and average lengths of stay based on claims data. At PHS acute facilities, case managers highlight collaborative SNFs to patients, and the PHS website lists collaborative SNFs. SNFs join biannual quality improvement meetings with PHS to learn about matters such as polypharmacy in older adults, share their concerns through open discussion, and engage in small-group sessions on quality improvement topics. All of this supplements the relationships between specific PHS acute care hospitals and their SNF partners.

Method of Analysis

Self-reported and publicly available data describe the characteristics of the SNFs applying for membership in the collaborative. Publicly reported scores were used to set the minimum criteria, and a set of self-reported characteristics were used to score SNFs in a secondary selection process (Appendix 1). These measures included number of days of clinical coverage on site by a doctor or nurse practitioner (NP); whether a doctor or NP sees residents within 24, 48, or 72 hours of admission; the tenure of the SNF medical, nursing, and executive directors; and other characteristics that public measures do not capture. A total of 25 points was awarded for these secondary criteria, and a score of 14 (the average score of all facilities meeting the minimum scoring criteria) was set as the threshold for selection.

SNFs were divided into three groups based on the results of the selection process. Facilities with CMS ratings of less than three stars or MA DPH survey scores of less than 125 (50th percentile) were categorized as "did not meet minimum criteria; not selected"; those that met the minimum criteria of a three-star CMS rating and a MA DPH score of 125 or greater but did not meet the scoring threshold of 14 of 25 points on the secondary criteria were categorized as "met minimum criteria; not selected"; and those that met the minimum criteria and scored 14 or higher on the secondary selection criteria were categorized as "selected." For the purposes of analysis, selected SNFs were compared with those in the other two categories using *t*-tests. Stata MP 13.1 was used to conduct statistical tests (Stata Corp., College Station, TX).

ACO claims data that CMS provides have been found to be insufficient in risk-adjusting SNF performance and understanding case-mix in a particular facility. As a proxy, in this analysis, the OnPoint-30 Readmission Measure from the third quarter of 2013 was included as a measure of case-mix within SNFs.[9] OnPoint-30 calculates an expected readmission rate for each SNF using variables from the Minimum Data Set (MDS) to adjust for illness severity. This measure is made available through the American HealthCare Association and has been submitted to the National Quality Forum for approval as a validated quality measure.[10]

In April 2014, PHS sent out a satisfaction survey to collaborative SNFs. Average scores on 5-point Likert scales are reported herein. The collaborative Year 2 application process closed July 2014, and the number of Year 1 selected SNFs that reapplied to continue participating in the collaborative in Year 2 are reported.

This project was undertaken as a quality improvement at PHS, and as such, the institutional review board did not formally supervise it, according to their policies. The Harvard Medical School institutional review board also determined that this study was not human subjects research.

RESULTS

As shown in Figure 1, of the 140 SNFs that applied to the collaborative in Year 1, 82 (59% of applicants) met the initial criteria, and 47 (34% of applicants) met the secondary criteria. These 47 SNFs represented 34% of PHS discharges to SNFs in the second quarter of fiscal year 2013.

Characteristics of the SNF Applicant Pool

The characteristics of the three groups of SNFs are summarized in Table 1. Selected SNFs were more likely to have more than 5 days of clinical coverage (17.0% vs 8.6% overall). They were also more likely to have a doctor or NP see resident within 24 hours (38.3% vs 27.9% overall) and within 48 hours (93.6% vs 87.9% overall). Selected SNFs were also more likely to have at least two

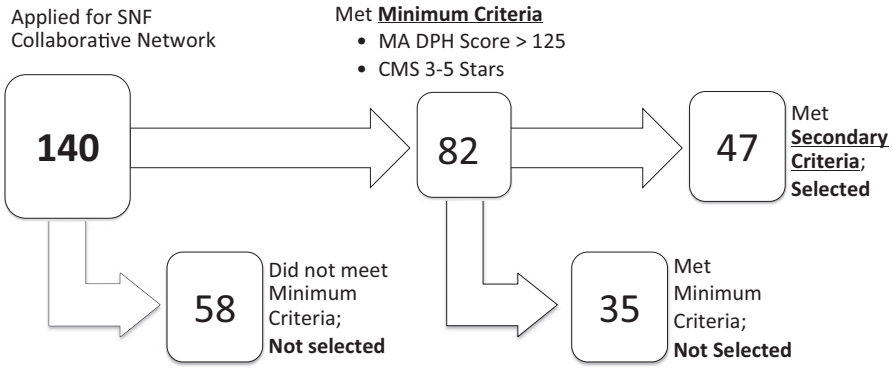

Figure 1. Selection process for Partners HealthCare Skilled Nursing Facility (SNF) Collaborative Network. Source: Partners HealthCare SNF Collaborative Network Working Group. MA DPH Score = Massachusetts Department of Public Health Score (out of 132); CMS = Centers for Medicare and Medicaid Services.

Table 1. Characteristics of Skilled Nursing Facilities (SNFs) According to Selection Status

Characteristic	Did Not Meet Minimum Criteria; Not Selected, n = 58	Met Minimum Criteria; Not Selected, n = 35	Selected, n = 47	Total, N = 140
Organizational structure				
Number of Medicare-certified beds, average	127.4[a]	120.4[a]	109.5	119.7
Average occupancy, %	90.1[a]	89.7[a]	90.8	90.2
Medicare average length of stay, days (2012)	25.3	28.8[a]	25.4	26.2
≥2 of 3 directors had tenure of ≥1 year, %	5.2[b]	34.3	42.6	25.0
Clinical capabilities, %				
Doctor or NP on site ≥3 d/wk	74.1	71.4	72.3	72.9
Doctor or NP on site >5 d/wk	5.2[a]	2.9[a]	17.0	8.6
Dedicated postacute care unit	86.2[a]	68.6	70.2	76.4
Medical coverage, %				
Doctor or NP sees patients in <24 hours	25.9	17.1[a]	38.3	27.9
Doctor or NP sees patients in <48 hours	87.9	80.0[a]	93.6	87.9
Doctor in Partners quality infrastructure	19.0[b]	11.4[b]	72.3	35.0
EMR integrated with acute care hospital	19.0	5.7[b]	34.0	20.7
Quality				
Complaints per year, n	1.8[b]	1.5	0.9	1.4
Joint Commission accredited, %	82.8	77.1	74.5	78.6
Massachusetts Department of Public Health Survey score (out of 132)	118.8[b]	127.5[b]	129.3	124.5
Centers for Medicare and Medicaid Services Five Star rating (out of 5)	2.7[b]	4.1[b]	4.6	3.7
American Medical Directors Association certification, %	39.7	28.6[a]	53.2	41.4
Infrastructure, %				
Using EMR	70.7	45.7[b]	76.6	66.4
Using Interventions to Reduce Acute Care Transfers	91.4	88.6	95.7	92.1
OnPoint-30 Average Expected Readmissions in Quarter 3, 2013, %[c]	19.8	20.4	18.4	19.4

EMR = electronic medical record.

Source: Partners HealthCare SNF Collaborative Network Application Data.

$P <$ [a].05, [b].01 using *t*-tests between "did not meet minimum criteria; not selected" and "selected" and between "met minimum criteria; not selected" and "selected."

[c] OnPoint-30 data were missing from six or fewer SNFs in each category.

of three directors (nursing, medical, executive) with more than 1 year of tenure (42.6% vs 25% overall). No statistically significant differences were found in complaints, Joint Commission accreditation,[11] or Interventions to Reduce Acute Care Transfers use,[12] even though points were awarded for these categories.

In the subset of SNFs that had available OnPoint-30 Readmissions data (n = 128), the average expected readmissions rate was 19.4%. For selected SNFs, this rate was slightly lower (18.4%), and for the "met minimum criteria; not selected" SNFs, the rate was 20.4%.

SNF Satisfaction with the Network

In April 2014, the 47 network SNFs were surveyed regarding their satisfaction. The 19 respondents (of 47, 40% of

network SNFs represented) expressed an overall satisfaction level of 4.6 on a 5-point Likert scale (1 = very dissatisfied, 5 = very satisfied). Regarding the functioning of the network, SNFs were satisfied with the application process, the partnership with PHS, and the alignment between PHS and the SNFs goals (all ≥4.5 on a 5-point Likert scale). They found that "a lot of improvements" were needed regarding warm hand-offs (4.3) and felt that participating in the collaborative would improve the care they provide (4.6). Forty-six of the 47 selected Year 1 SNFs reapplied for inclusion in the network for Year 2, and the only one that dropped out would not have met the minimum criteria in Year 2.

Discussion: Building for the Future

Several important lessons have emerged.

Clinical Care Capabilities

The clinical capabilities of SNFs vary dramatically. Because higher levels of clinical staffing—whether onsite or through telemedicine—can reduce readmissions,[13,14] ACOs and their physicians will need to work with SNFs to invest in clinical infrastructure. Of all SNFs that applied to the collaborative, the availability of onsite medical teams was low, as evidenced by particularly low weekend coverage (8.6% overall) and infrequent ability to see residents newly admitted to postacute care within 24 hours (27.9% overall). SNFs selected to participate in the collaborative performed better than the overall group on these measures, but the low level of clinical capability signals the need for deeper clinical collaboration, through initiatives such as ensuring complete transfer documentation and warm handoffs between discharging and receiving clinicians. Future efforts in the collaborative will focus on these areas for quality improvement.

Risk Adjustment

A critical concern for PHS in creating the collaborative was to meet the needs of the ACOs highest-risk patients, but SNFs may look worse if they take sicker individuals, even if they perform well in preventing readmissions and discharging them back home. In the absence of solid risk-adjusted data, ACOs should be cautious about using ACO claims data or other unadjusted measures to judge SNFs, because unadjusted metrics may provide incentives to their partners to "cherry-pick" (select) healthier patients rather than improve quality. This study found that selected SNFs had lower expected readmissions based on OnPoint-30 Readmissions data and, thus, healthier patients. Furthermore, the SNFs that did not meet the minimum criteria were more likely to have a dedicated postacute unit (86.2% vs 76.2% overall). Because PAC-focused SNFs have a higher average acuity and throughput of patients, they are at greater risk of inspection deficiencies and lower CMS ratings.[15] This finding points to the need for validated, risk-adjusted quality measures that patients, clinicians, case managers, and ACO management can use when choosing SNFs.

Limitations

This study explores just one ACO's approach to selecting high-quality SNFs in the Massachusetts market, and other ACOs may find other approaches more fitting. Although the collaborative selection process used publicly reported measures as minimum criteria, the secondary criteria were based on expert opinions and have not yet been validated—because criterion standard outcomes metrics are lacking. Furthermore, SNF self-reported data for several categories were used to score facilities, and the survey of SNFs had a response rate of 40%. PHS also hopes to add patient satisfaction measures into the selection process, but a valid and reliable PAC patient satisfaction measure is not available. Because ACOs are not allowed to restrict patient choice of SNFs in any way, the long-term success of the collaborative depends on partnering with patients to choose high-quality facilities that meet their preferences as well as objective quality measures.

CONCLUSION

Overall, this analysis of the PHS SNF Collaborative Network describes one ACO's early attempts to define SNF quality beyond publicly reported metrics. Criteria other than publicly reported measures could be useful in further differentiating among SNFs with good publicly reported scores. Because measures potentially associated with better care coordination were low across the board, these networks could serve as the basis for greater cross-continuum collaboration between clinicians, with the potential to improve patient care between acute and postacute episodes of care. This approach is an important first step in improving PAC quality and may serve as the foundation for future efforts.

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Conflict of Interest: Donna Rusinak, Darcy Carr, and D. Clay Ackerly are employees of PHS, an integrated delivery system devoted to improving the health of patients across the continuum of care. PHS is also part of the CMS Pioneer ACO program. D. Clay Ackerly reports other support from CarePort Health outside the submitted work. David C. Grabowski reports personal fees from naviHealth, Inc. outside the submitted work.

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Author Contributions: Lage, Rusinak, Carr, Ackerly: study concept and design, acquisition of data, analysis of data. All authors participated in the interpretation of data and preparation of the manuscript.

Sponsor's Role: The sponsor had no role in the study.

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APPENDIX 1: SECONDARY SELECTION CRITERIA FOR SKILLED NURSING FACILITY (SNF) COLLABORATIVE NETWORK

Criteria
Organizational structure (maximum points = 1)
Number of Medicare-certified beds, average occupancy, tenure of directors
Clinical capabilities, including but not limited to: (maximum points = 2)
Specialized clinical programs and services, such as wound care, hospice, and tracheostomy
Medical coverage (including but not limited to): (maximum points = 7)
Clinical staffing model: See patients within 24, 48, or 72 hours
Doctor or nurse practitioner on site 3–5 days per week or >5 days per week
Doctor is member of a team that is part of PHS quality management infrastructure
Quality (maximum points = 9)
Massachusetts DPH score 125–127, 128–130, or 131–132
≤1 DPH Complaint Surveys received in the past 12 months
Centers for Medicare and Medicaid Services Five Star rating 3, 4, or 5
Joint Commission accredited
Medical Director American Medical Directors Association certified
Infrastructure (maximum points = 2)
Currently use electronic medical record
Currently use Interventions to Reduce Acute Care Transfers
Reimbursement (maximum points = 2)
Take 2 of 4 major payers
Take Medicaid
Geography (maximum points = 2)
In strategically important areas for PHS acute hospital and patients

DPH = Department of Public Health.

SOURCE: Partners HealthCare (PHS) SNF Collaborative Network Working Group.

To capture quality beyond publicly reported metrics, SNFs were scored out of 25 points on the secondary criteria listed in the table. The criteria are reflective of the areas assessed, although the weightings for each item varied.