Post Acute Networks Becoming the Norm to Reduce Readmissions as CMS Looks to Provider Community to Lead the Way

by Dr. Josh Luke

While progressive hospitals and health systems began forming “Post Acute Networks” to improve the care continuum several years ago, 2015 marks the year that this became the norm. Post Acute Network (PAN) is the most common term used to describe a hospital’s coordinated effort to reduce the number of skilled nursing facilities (SNF’s) it partners with, and then gather and educate select local post acute providers.

Each month when I present at readmission and bundled payment conferences nationwide, I ask representatives from the Centers for Medicare and Medicaid Services about how hospitals are narrowing SNF networks and how they intend to regulate or adjust the condition of participation in the Medicare program that prevents “steering” to select post acute providers. The common answer I get is that each patient deserves the right to make an informed decision about where they will receive post acute care. One representative from CMS said to me, “I do not know how you could be successful in an ACO or bundle if you do not narrow your network.” Confusing times indeed.

In the book, Readmission Prevention: Solutions Across the Provider Continuum, a detailed description of the goals of a post acute network are discussed. Also, on the case studies page of the National Readmission Prevention website (www.NationalReadmissionPrevention.com), there are several examples of post acute networks proving to be effective tools in reducing unnecessary hospitalization.

With that said, consultants across the country are being pegged by hospitals in a weekly basis to assist them in creating a post acute network for their hospital. You might be surprised to hear how the process has evolved in recent months. To create a post acute network for your hospital, there are three key steps that require strategy and coordination: 1) Legal/compliance support; 2) Establish criteria to determine which post acute providers will be included; 3) Implementation and support from hospital discharge planners and physicians.

Want to guess which of the three steps has become the most difficult to implement? It is no doubt number three. Getting case managers to change their practices and approach is a nearly impossible task. More on that in a minute.

First, gaining support from the hospital legal and compliance team has actually become almost a formality in recent months. While hospital attorneys for years ran scared from any form of patient steering to specific post acute providers, the financial penalties for hospitals who work with sub-par post acute providers have started to take a toll. In 2008, Northshore LIJ Health System in New Jersey became one of the first to create a post acute network. In 2014, Banner Health in Arizona did an exhaustive review of more than 100 SNF’s in the Arizona market before ruffling a few feathers of those left out by creating a post acute network of just 34 SNF’s. In 2014, post acute networks began popping up at hospitals all over the country, and in 2015 the momentum has continued to increase.

“Post Acute Networks Becoming the Norm to Reduce Readmissions as CMS Looks to Provider Community to Lead the Way” by Dr. Josh Luke

To create a post acute network for your hospital, there are three key steps that require strategy and coordination: 1) Legal/compliance support; 2) Establish criteria to determine which post acute providers will be included; 3) Implementation and support from hospital discharge planners and physicians.”

“In 2008, Northshore LIJ Health System in New Jersey became one of the first to create a post acute network.”

(continued on page 2)
Post Acute Networks Becoming the Norm to Reduce Readmissions ...continued from page 1

Most hospital attorneys and compliance teams have grown comfortable with soft steering now that it has become more common and the concern over being "first to market" no longer exists. Narrow post acute networks are rapidly becoming the norm. While as recent as 2013 the conversation was often a non-starter for many health systems, between articles in Modern Healthcare, CMS discussions and recommendations from the Medicare Payment Advisory Commission, the legal hurdle has become merely a formality in the process of forming a post acute network.

Second, selecting criteria for your post acute network should be a quick, clean and fluent process. Three years ago, I myself let the criteria bog me down and delay the process of implementation and this should be avoided. Here is the good news: the criteria selected for post acute providers to qualify to be part of your post acute network is completely up to you. And even better, no one can tell you that you are wrong! That's right, regulators understand that healthcare is local and do not want to involve themselves in the process. In fact, once you select criteria, you don't even need to share the criteria with potential members unless you choose to do so!

So what are the most common criteria? Again, hospitals are free to include what they want, but here are six common criteria most hospitals consider when forming a post acute network.

1. CMS Star rating: While very few people sing the praises of the 5 star system, it is the chosen system of the regulatory body so it is essential it be included in your list of criteria.
2. Long-term community presence: Hospitals are not as concerned about the newest, biggest or best provider, but more so that provider that has successfully served its community for many years.
3. Joint Commission Accreditation for skilled nursing providers: While TJC accreditation is not required in SNF’s, TJC is the Gold Standard for accreditation industry-wide and those SNF’s who have chosen to seek TJC accreditation have shown a willingness to go above and beyond to exceed all quality and customer service initiatives.
4. Survey history. This one is a no brainer.
5. Physician alignment: By aligning with SNF’s that active hospital doctors already frequent, the likelihood of disruption and resistance when the narrow network of SNF’s is implemented is drastically reduced.
6. Case manager/discharge planner preference: Hospital discharge planners should know which SNF’s are providing the highest quality care and communicating best with the hospital to ensure timely, safe and fluent discharge. Case managers will be a lot more willing to support this drastic change in their daily routine if one or two of the SNF’s they prefer are included in the narrow network of SNF’s.

Finally, the most difficult step in implementing a post acute network at your hospital is getting your own employees, the case managers to change their processes! For years hospital case managers and discharge planners have served as the symbolic “self-proclaimed defenders of patient choice.” The days of the case manager carrying more clout than the c-suite when it comes to patient discharge disposition are rapidly coming to an end.

It takes a well-thought out strategy and inclusion of case managers, discharge planners and social workers in the planning process when the hospital implements the narrow network and a new protocol for discharging patients by soft-steering them to preferred providers within the narrow network. The truth of the matter is that many case managers will not be able to handle this drastic change in protocol and will likely need a change in position or hospital to make the adjustment.

The reality is that these changes are in the best interest of the patient and the organization so there should be no resistance to these changes if the organization clearly communicates its interpretation of patient choice and soft-steering. A narrow post acute network is essential if an organization is to be successful in the post ACA model. Personally, it is my belief that CMS is looking to us as a provider community to blaze the trail by developing narrow networks that ensure a patient is given the opportunity to make an informed decision, and any steering that takes place be for reasons relating to improved quality, communication and patient satisfaction, and not rooted in simply inappropriately driving increased patient volume to one doctor, hospital or post acute provider. So let’s blaze this trail together in the best interest of the patient, organization and community.

Dr. Josh Luke serves as adjunct faculty for the University of Southern California, Sol Price School of Public Policy, Founder of the National Readmission Prevention Collaborative and author of ACHE’s Best Selling book of the year, Readmission Prevention: Solutions Across the Provider Continuum.