HOME IS THE HUB
An Initiative to Accelerate Progress to Reduce Readmissions in Virginia
Deep Dive: Post-Acute Care Strategies
May 17, 2017
HOUSEKEEPING

- Slides were sent this morning
- Webinar is being recorded
- Please use the “telephone” option
  - Audio pin prompt
- All participants are muted
- Raise your hand
- Ask a question
- Warm up
WELCOME AND OVERVIEW

Abraham Segres

VHHA

Vice President, Quality & Patient Safety
asegres@vhha.com
(804) 965-1214
VIRGINIA HOSPITAL & HEALTHCARE ASSOCIATION

An association of 30 member health systems representing 107 community, psychiatric, rehabilitation and specialty hospitals throughout Virginia.

Vision

Through the power of collaboration, the association will be the recognized driving force behind making Virginia the healthiest state in the nation by 2020.

Mission

Working with our members and other stakeholders, the association will transform Virginia’s health care system to achieve top-tier performance in safety, quality, value, service and population health. The association’s leadership is focused on: principled, innovative and effective advocacy; promoting initiatives that improve health care safety, quality, value and service; and aligning forces among health care and business entities to advance health and economic opportunity for all Virginians.
VHHA 2015-2020 IMPROVEMENT PRIORITIES

1. Hospital readmissions
   1a. Hospital-wide
   1b. Post-acute transfers
   1c. Total hip/Total knee Replacement 30-day readmissions

2. Clostridium difficile – Healthcare-acquired Infections
3. Patient Experience – HCAHPS
4. Serious Safety Events
HOME IS THE HUB: 2016

Activities

• Identify “High-Leverage Strategies”
• Presentation to VHHA Board
• Partnership with Virginia’s QIO (HQI)
• Webinar Series: “High Leverage Strategies”
• In-Person Learning Event
• Meeting with SNF Association leadership

Events

• May       VHHA Board Presentation
• June      “High Leverage Strategies”
• August    Data / Measurement
• September Post-Acute Care
• October   Multi-Visit Patients (high utilizers)
• November  In-person Learning Event
• December  Articulate your Strategy
**HOME IS THE HUB: 2017**

<table>
<thead>
<tr>
<th>Activities</th>
<th>Planned Events</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Building Collaborations</td>
<td>• January 25 Deep Dive: ED-based Strategies</td>
</tr>
<tr>
<td>• Deep Dive webinars</td>
<td>• February 22 Special Topic: Payer-Based Efforts</td>
</tr>
<tr>
<td>• Special Topic webinars</td>
<td>• April 19 Special Topic: CHWs</td>
</tr>
<tr>
<td>• Office Hours for individual coaching</td>
<td>• May 17 Deep Dive: Post-Acute Care</td>
</tr>
<tr>
<td>• Home is the Hub “Playbook”</td>
<td>• June 14 Office Hours with Dr. Boutwell</td>
</tr>
<tr>
<td>• In-Person Meeting</td>
<td>• July 12 Home is the Hub Playbook</td>
</tr>
<tr>
<td></td>
<td>• August 16 Office Hours with Dr. Boutwell</td>
</tr>
<tr>
<td></td>
<td>• October 18 In-Person Meeting</td>
</tr>
</tbody>
</table>

*All webinars will be offered at 10am*
PARTNERING WITH VIRGINIA’S SKILLED NURSING FACILITIES

April R. Payne, LNHA

Vice President of Quality Improvement
Virginia Health Care Association
Virginia Center for Assisted Living
(VHCA-VCAL)
VIRGINIA HEALTH CARE ASSOCIATION
VIRGINIA CENTER FOR ASSISTED LIVING (VHCA-VCAL)

Who We Are

The Virginia Health Care Association – Virginia Center for Assisted Living (VHCA-VCAL) is a member-driven organization dedicated to advocating for and representing the interests of over 290 Virginia nursing centers and assisted living communities, the 29,000 residents they serve through the selfless efforts of nearly 30,000 dedicated care-giving staff.

VHCA-VCAL members are dedicated to providing the highest standard of care and enhancing the quality of life for individuals needing traditional long term residential nursing home, sub-acute or short-term care, rehabilitative and assisted living services.
# VHCA-VCAL Quality Initiatives

## AHCA/NCAL Quality Initiatives - Short Stay/Post-Acute Care

<table>
<thead>
<tr>
<th>Initiative</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hospital Readmissions</strong></td>
<td>Safely reduce the number of hospital readmissions within 30 days during a skilled nursing center stay by an additional 15% or achieve and maintain a low rate of 10% by March 2018.</td>
</tr>
<tr>
<td><strong>Discharge Back to the Community</strong></td>
<td>Improve discharge back to the community by 10% or achieve and maintain a high rate of at least 70% by March 2018.</td>
</tr>
<tr>
<td><strong>Functional Outcomes</strong></td>
<td>Improve functional outcomes by 10% or maintain an average rate of improvement of 75% by April 2018.</td>
</tr>
</tbody>
</table>
DEEP DIVE: POST ACUTE CARE STRATEGIES

Amy Boutwell, MD, MPP

Collaborative Healthcare Strategies
President
amy@collaborativehealthcarestrategies.com
(617) 710-5785
• Setting the stage: Available Data and Best Practice Concepts

• How one Virginia system built strong working relationships with SNFs

• Discussion

• Recommendations
OBJECTIVES

1. Understand, in detail, the steps one system has taken to build effective collaborations between hospitals and SNFs to reduce readmissions

2. Identify 3 practical steps to take at your organization to develop or advance your hospital-SNF collaborations to reduce readmissions
KNOW YOUR DATA

Data from the CMS Quality Improvement Organization in Virginia to Inform Work
OVERALL & SNF READMISSION RATES

Red = High Readmission Rates

Dark Blue = High SNF Readmission Rates

Medicare FFS data, courtesy HQI
Contact: Carla Thomas cthomas@hqisolutions
DAY TO READMISSION: OVERALL AND SNF

Histogram of Days Until Readmission by Day and Readmit Location
- Readmitted to Same Hospital
- Readmitted to Other Hospital

Histogram of Days Until Readmission for Patients Discharged to Facility #ABC NURSING & REHAB CENTER and Readmitted Back to Any Hospital Within 30 Days (Q1 2016 to Q4 2016)

Medicare FFS data, courtesy HQI
Contact: Carla Thomas cthomas@hqi.solutions
## Table 3b. Hospital-Specific 30-Day Readmission Rates for All Medicare Patients Discharged from Hospitals by Primary Discharge Destination

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Discharged to SNF on primary hospitalization</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td># of Live Discharges</td>
<td>471</td>
<td>511</td>
<td>433</td>
<td>415</td>
<td>431</td>
<td>417</td>
<td>446</td>
<td>408</td>
</tr>
<tr>
<td>30 day Readmissions</td>
<td>106</td>
<td>113</td>
<td>89</td>
<td>92</td>
<td>98</td>
<td>85</td>
<td>112</td>
<td>103</td>
</tr>
<tr>
<td>Total readmission rate</td>
<td>22.5%</td>
<td>22.1%</td>
<td>20.6%</td>
<td>22.2%</td>
<td>22.7%</td>
<td>20.4%</td>
<td>25.1%</td>
<td>25.2%</td>
</tr>
<tr>
<td>Virginia Pooled Rate</td>
<td>20.6%</td>
<td>20.1%</td>
<td>20.0%</td>
<td>20.9%</td>
<td>21.3%</td>
<td>19.4%</td>
<td>19.9%</td>
<td>20.3%</td>
</tr>
</tbody>
</table>

## Table. Hospital-Specific Rates of Hospital Utilization Coming From SNFs

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>All-Cause Re-Hospitalization</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td># Obs Stays</td>
<td>129</td>
<td>116</td>
<td>109</td>
<td>122</td>
<td>116</td>
<td>160</td>
<td>131</td>
<td>148</td>
</tr>
<tr>
<td># Obs Stays from SNFs</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>% Obs Stays from SNFs</td>
<td>1.6%</td>
<td>1.7%</td>
<td>3.7%</td>
<td>1.6%</td>
<td>0.0%</td>
<td>1.3%</td>
<td>0.8%</td>
<td>1.4%</td>
</tr>
<tr>
<td># ED Visits</td>
<td>2,397</td>
<td>2,383</td>
<td>2,608</td>
<td>2,459</td>
<td>2,172</td>
<td>2,160</td>
<td>2,353</td>
<td>2,342</td>
</tr>
<tr>
<td># ED Visits from SNFs</td>
<td>11</td>
<td>25</td>
<td>18</td>
<td>12</td>
<td>15</td>
<td>16</td>
<td>9</td>
<td>16</td>
</tr>
<tr>
<td>% ED Visits from SNFs</td>
<td>0.5%</td>
<td>1.0%</td>
<td>0.7%</td>
<td>0.5%</td>
<td>0.7%</td>
<td>0.7%</td>
<td>0.6%</td>
<td>0.4%</td>
</tr>
<tr>
<td># Admissions</td>
<td>1,319</td>
<td>1,389</td>
<td>1,366</td>
<td>1,283</td>
<td>1,282</td>
<td>1,458</td>
<td>1,348</td>
<td>1,287</td>
</tr>
<tr>
<td># Admissions from SNFs</td>
<td>74</td>
<td>81</td>
<td>70</td>
<td>47</td>
<td>82</td>
<td>84</td>
<td>74</td>
<td>73</td>
</tr>
<tr>
<td>% Admissions from SNFs</td>
<td>5.6%</td>
<td>5.8%</td>
<td>5.1%</td>
<td>3.7%</td>
<td>6.4%</td>
<td>5.8%</td>
<td>5.5%</td>
<td>5.7%</td>
</tr>
</tbody>
</table>
# 30-Day Medicare Re-hospitalization Measure Report

**ABC NURSING & REHAB CENTER (49XXXX)**

## Table 1. SNF-Specific 30-Day Readmission Rates for All Medicare Patients Discharged from Hospitals

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>All-Cause Re-hospitalization</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Denominator: # of residents admitted to your facility from acute care within 30 days after hospital discharge whether readmitted or not (excludes readmissions prior to being admitted to your facility)</td>
<td>62</td>
<td>58</td>
<td>63</td>
<td>66</td>
<td>84</td>
<td>78</td>
<td>59</td>
<td>66</td>
<td>63</td>
<td>73</td>
<td>67</td>
<td>70</td>
</tr>
<tr>
<td>Numerator: # of residents with a readmission that occurred within 30 days after the initial hospital discharge</td>
<td>9</td>
<td>10</td>
<td>10</td>
<td>13</td>
<td>16</td>
<td>23</td>
<td>5</td>
<td>15</td>
<td>10</td>
<td>9</td>
<td>9</td>
<td>7</td>
</tr>
<tr>
<td>Readmission rate to acute care (%)</td>
<td>14.5</td>
<td>17.2</td>
<td>15.9</td>
<td>19.7</td>
<td>19.1</td>
<td>29.5</td>
<td>8.5</td>
<td>22.7</td>
<td>15.9</td>
<td>12.3</td>
<td>13.4</td>
<td>10.0</td>
</tr>
<tr>
<td>Rank of your facility readmission rate among VA SNFs (lower is better, excludes facilities with &lt;10 cases)</td>
<td>60 of 267</td>
<td>96 of 267</td>
<td>83 of 266</td>
<td>124 of 266</td>
<td>105 of 267</td>
<td>242 of 265</td>
<td>15 of 264</td>
<td>167 of 264</td>
<td>77 of 266</td>
<td>46 of 265</td>
<td>48 of 267</td>
<td>27 of 262</td>
</tr>
<tr>
<td>VA SNF average readmission rate (calculated based on all eligible discharges, not averages across facilities)</td>
<td>20.36</td>
<td>20.15</td>
<td>19.79</td>
<td>20.73</td>
<td>21.00</td>
<td>18.96</td>
<td>19.56</td>
<td>20.05</td>
<td>19.93</td>
<td>19.13</td>
<td>20.05</td>
<td>19.39</td>
</tr>
</tbody>
</table>

Last Updated: 5/5/2017

Contact: Carla Thomas cthomas@hqisolutions
MANAGE CARE ACROSS SETTINGS

Reducing readmissions involves active management across settings & over time
WARM HANDOFFS WITH “CIRCLE BACK” CALL

SNF Circle Back Questions (Hospital calls back SNF 3-24h after d/c):
✓ Did the patient arrive safely?
✓ Did you find admission packet in order?
✓ Were the medication orders correct?
✓ Does the patient’s presentation reflect the information you received?
✓ Is patient and/or family satisfied with the transition?
✓ Have we provided you everything you need to provide excellent care to the patient?

Key Lessons:
• Transitions are a process (forms are useful, but need intent)
• Best done iteratively with communication

Source: Emily Skinner, Carolinas Healthcare System
“WARM FOLLOW UP” AFTER DISCHARGE TO SNF

PIONEER ACO EXPERIENCE

“Warm follow-up” after transfer to SNF

Process with SNFs:

Support staff were available to facilitate logistics (patient lists, meeting time, etc)
Telephonic “card flipping” between ACO team & SNF

Key lessons:

Took a while to develop collaborative rapport v. “in-charge”
No substitute for verbal communication and problem solving
CO-MANAGE ACROSS SETTINGS, OVER TIME
AS SEEN IN BUNDLES, ACOS

• **Dedicated Team**: A Point Person
  - ACO or Bundle clinical *coordinator*

• **Co-Management**: Physical or Virtual Rounds in SNF
  - RN / NP to see patient, discuss plan with SNF staff
  - Respond to changes in clinical status to *manage in setting*
  - Weekly telephonic rounds ACO/bundle coordinator and SNF
  - LOS, progress toward discharge goals, transitional care planning
  - Tele-medicine consults in SNF to manage on-site

• **Direct admit back** to SNF from home
ED TREAT-AND-RETURN TO SNF

2 hospital system, 20 ED docs, 17 PAs
- “Why are almost all SNF patients admitted?”
- “Patients only seen once a month”; “can’t do IVs”, etc
- “If they send them here they can’t take care of them”

• Actions:
  - Asked ED providers to consider returning patient to SNF
  - Education: posted INTERACT SNF capacity sheets in ED
  - Simplicity: establish contacts, standard transfer information
  - Reinforce: Thanked providers when ED-SNF return occurred

• Results: increase in number of patients transferred from ED to SNF

Source: Dr Steven Sbardella, CMO and Chief of ED
Hallmark Health System Melrose, MA
BEST PRACTICES OF CROSS SETTING COLLABORATION

• Shared understanding of (best-available) data
• Shared understanding of patients and caregivers’ perspective
• Shared understanding of “receivers” perspective
• Clearly identified specific, feasible improvement ideas
• Improvements are “hardwired” into new standard processes
• Regular meetings, joint problem-solving
A Journey: Building the SNF Network

Mary Catharine Ginn Kolbert
Post-Acute Care Coordinator, Senior Services
Bon Secours Virginia
Bon Secours Health System

- Presence in 6 states and 3 countries

- Bon Secours Virginia
  - 8 hospitals in Richmond and Hampton Roads
  - 750 providers

- Senior Services
  - Post-Acute Care Coordinator
BSHSI good CARE Model

DEFINE POPULATION

MEASURE OUTCOMES

IDENTIFY CARE GAPS

MANAGE CARE

AUTOMATED & ONGOING

› DATA INTEGRATION
› ANALYSIS
› REPORTING
› COMMUNICATIONS

ENGAGE PATIENTS

STRATIFY RISKS
Why a Post-Acute Strategy?
CLOSE THE GAP

Health System

Patient

CONNECT

Partners

CLOSE THE GAP

CLOSE THE GAP

CLOSE THE GAP
Why a Post-Acute Strategy?

Payment Improvement Models

- ACO - Medicare Shared Saving Program (MSSP) patients
- Bundled Payment Arrangements with CMS
- Value-Based Purchasing and Readmission Reduction Programs
Building the SNF Network
## Focus Areas

<table>
<thead>
<tr>
<th>Area</th>
<th>metrics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stratify Facilities by Quality &amp;</td>
<td>- CMS Star rating &gt; 3</td>
</tr>
<tr>
<td>Performance Metrics</td>
<td>- Number of beds and average daily availability</td>
</tr>
<tr>
<td></td>
<td>- Acceptance rate and turnaround time</td>
</tr>
<tr>
<td>Ensure Adequate Scope &amp; Availability of</td>
<td>- Define minimum service level required to participate in network</td>
</tr>
<tr>
<td>Services</td>
<td>(Wound Care, Rehabilitation Services or other Advanced Care Certifications)</td>
</tr>
<tr>
<td></td>
<td>- Availability of rehab therapies and services on weekends</td>
</tr>
<tr>
<td>Ensure Adequate Geographic Coverage</td>
<td>- Define geographic distance to membership, primary care, and BSH hospitals</td>
</tr>
<tr>
<td>Willingness to Collaborate on</td>
<td>- Establish standard clinical pathways</td>
</tr>
<tr>
<td>Improvements</td>
<td>- Develop primary care access procedures for urgent patient care needs</td>
</tr>
<tr>
<td></td>
<td>- Engage family and community support resources</td>
</tr>
</tbody>
</table>
Bon Secours Evaluation of SNFs

- Mission and Vision alignment
- Data Collection
  - Public & Payor Data Collection
    - CMS (www.medicare.gov); Google searches
    - Evaluation tool for the SNF to complete
    - Cost per case; LOS; readmissions
- Internal resources
  - Case management
    - Referral patterns; response times; acceptance rates
  - Own medical group involvement
Individual SNF Analysis

- SNF Evaluation Tool
- Site Visits
  - 90 minutes
  - From the SNF: Administrator, DON, admissions, therapy, social work
  - From BSV, senior health, care management, BSMG, population health, nurse navigators, home health, therapy
  - Conversation plus a tour
SNF Selection for the network

- Side by side analysis
- Site visit team input
- Focus area criteria

- Once selected, each SNF signs a Clinical Service Agreement (CSA)
Bon Secours Virginia Engagement with SNFs

- Quarterly meetings
  - all SNFs we refer to, both partner and non-partner
  - One in Richmond, 2 in Hampton Roads
- Transitions of Care Quarterly meetings
  - Acute Care facility based
  - Just the partner SNFs that work closely with that hospital
- One on One Monthly meetings
  - Partner SNFs
  - Patient specific
## Metrics

<table>
<thead>
<tr>
<th>Self Reported Monthly</th>
<th>MSSP and Bundle Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Short Stay residents:</td>
<td>• LOS</td>
</tr>
<tr>
<td>• Pressure Ulcers</td>
<td>• Hospital readmission rate</td>
</tr>
<tr>
<td>• Antipsychotics</td>
<td>• Cost per case</td>
</tr>
<tr>
<td>• ED visits</td>
<td>• Cost per admission</td>
</tr>
<tr>
<td>• Hospital Readmits</td>
<td>• Network utilization</td>
</tr>
<tr>
<td>• All Residents:</td>
<td></td>
</tr>
<tr>
<td>• UTIs</td>
<td></td>
</tr>
<tr>
<td>• Falls with Fractures</td>
<td></td>
</tr>
<tr>
<td>• Pneumonia</td>
<td></td>
</tr>
<tr>
<td>• MSSP and Bundle Patients</td>
<td></td>
</tr>
<tr>
<td>• LOS</td>
<td></td>
</tr>
<tr>
<td>• Hospital readmission rate</td>
<td></td>
</tr>
<tr>
<td>• Cost per case</td>
<td></td>
</tr>
<tr>
<td>• Cost per admission</td>
<td></td>
</tr>
<tr>
<td>• Network utilization</td>
<td></td>
</tr>
</tbody>
</table>
“Working” the network

- Messaging to patients
- Scripting for case management
  - For all of Bon Secours Health System
  - Balancing patient choice
- Bundle networks
  - Physician education
Successes

- RELATIONSHIPS!
  - Increased communication with post-acute partners
    - Sharing of best practices
    - Education opportunities
  - Increased opportunity for Bon Secours medical group presence in SNFs
  - Specific examples of success
    - Bundles
    - Care Transition Coalitions across Virginia
    - Community Care Teams
    - A SNF’s perspective
## Bundles

### Hip/Knee/Fracture BPCI Milliman Data

<table>
<thead>
<tr>
<th>Year</th>
<th>SNF Utilization</th>
<th>SNF LOS</th>
<th>Rehab utilization</th>
<th>Readmissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>26.5%</td>
<td>31.8 days</td>
<td>5.1%</td>
<td>7.3%</td>
</tr>
<tr>
<td>2015</td>
<td>20.8%</td>
<td>28.3 days</td>
<td>6.4%</td>
<td>7.3%</td>
</tr>
<tr>
<td>2016</td>
<td>21%</td>
<td>20.9</td>
<td>5.1%</td>
<td>6.2%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>2016 Targets</th>
<th>2017 Targets</th>
</tr>
</thead>
<tbody>
<tr>
<td>Readmissions</td>
<td>10%</td>
<td>5%</td>
</tr>
<tr>
<td>SNF utilization</td>
<td>25%</td>
<td>17%</td>
</tr>
<tr>
<td>SNF Avg LOS</td>
<td>20 days</td>
<td>17 days</td>
</tr>
</tbody>
</table>
**Community Care Teams**

- **Focus**
  - Track patients from acute care to skilled facility and back to community
  - Address health management issues with the team – SNF and PCP

- **Goals**
  - Improve outcomes for patients through weekly virtual rounds with Network SNFs
  - Continue to strengthen network SNF partnerships
  - Readmission reduction and prevention
  - Schedule PCP follow up appointments
  - Impact length of stay through the use of care pathways
  - Facilitate the Continuum of Care through effective handoff
Community Care Team Work Flow

- Identify patient populations (Medicare Shared Savings Program, Heart Failure Bundle, and High Risk patients) discharged to network SNFs
  - Notify SNF within 24-48 hours
- Weekly telephonic review of patients with network SNFs
- Document patient’s status and progression
- Provide weekly updates and/or handoff to BSMG Nurse Navigators (Specialty or PCP)
- Track readmissions from SNF and 30 days post SNF discharge
Community Care Team Telephonic Rounds

- Review discharge summary and discharge instructions including follow up appointments
- Utilize circle back questionnaire
- Manage length of stay
- PT, OT, SLP goals & progress
- Discuss SNF medication changes
- Identify patient barriers
- Emphasize the benefits of the continuity of care
- Collaborate with team regarding LTC, Hospice, or other discharge needs (including advanced care planning)
- Schedule PCP appointments prior to SNF discharge
Community Care Team Success Stories

• Foley use and avoiding a potential readmit

• Patient complained of dizziness

• Successful discharge home
Care Transition Coalitions

- Coordinated by Health Quality Innovators (Virginia QIO)

- Bon Secours participates in three in Virginia
  - Richmond CTC
  - Hampton Roads CTC
  - Eastern Virginia CTC

- Use the SNF network to roll out readmission reduction strategies
  - Circle Back
  - Capabilities Check List
  - Sepsis initiative
SNF’s Perspective

Scott Williamson, Administrator
The Laurels of Willow Creek
What’s next?

- Messaging
- Balancing the demand on the SNFs
- Data collection
- Better coordination of efforts in the hospital
- Development of protocols across the continuum
- Re-evaluation of the network partners
- What to expect when you go to a SNF?
QUESTIONS & DISCUSSION

Building and strengthening effective hospital-SNF working relationships
RECOMMENDATIONS

1. **Use data** to guide outcomes-oriented cross-setting collaborations

2. **Target** improvement efforts based on the root causes of readmissions

3. **Develop** personal working relationships with a key contact at each facility

4. **Manage** patients discharged from hospital to SNF and SNF to home

5. **Create new options** to treat-in-place or treat-and-return to avoid (re)admit
THANK YOU FOR YOUR COMMITMENT TO REDUCING READMISSIONS

Amy E. Boutwell, MD, MPP
Advisor, VHHA Center for Healthcare Excellence
President, Collaborative Healthcare Strategies
amy@collaborativehealthcarestrategies.com