Empowering SNF Administrators and CFOs: Leveraging Social Determinants for Stronger Hospital Partnerships in the Post-Acute Space

“A Pathway to Improved Patient Outcomes”

Advantage

Celebrating 20 years as your trusted post-acute partner

Presented by:
Amy Hancock

Advantage

Strategic Insights for Strengthening Relationships, Enhancing Patient Outcomes, and Gaining a Competitive Edge

- The goal of this session:
  - Dive into various aspects of Social Determinants of Health (SDOH)
  - Examine hospitals increased focus on SDOH
  - Hospitals newly introduced Quality Measures
  - TEAM new mandatory bundled model
  - Provide information on how to create opportunities
  - And explore take away suggestions for your facility
- Healthcare landscapes are rapidly evolving, demanding new approaches to collaboration between providers.
- Leveraging effective strategies to improve patient outcomes, reduce healthcare costs, and enhance your position in the marketplace
  - What are key considerations to your strategy development?
  - How can your facility respond effectively and deliberately?

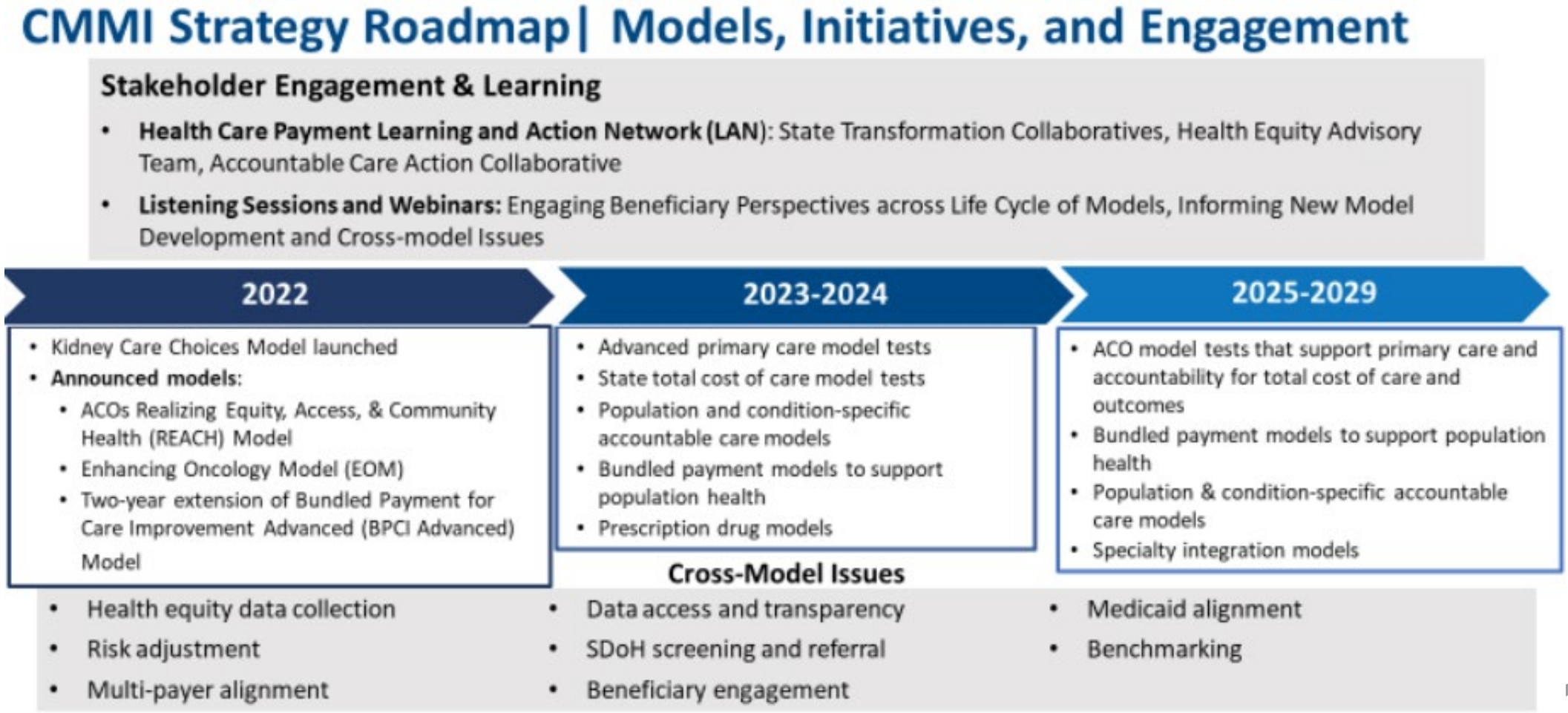
Advantage

Important Strategic Probing Questions

- What is impacting your referrals sources?
  - Social Determinants of Health
  - Bundled Payments
  - Quality Measures
  - Outcome-Based Relationships
- Rethinking your market positioning and market share
- How can you differentiate yourself from your competitors
  - Aligning healthcare and care delivery transformation to your strategic initiatives

Advantage

CMS Innovation Center's Strategic Roadmap



Social Determinants of Health

The Growing Focus of Hospitals on Social Determinants of Health

- CMS' effort to expand collection, reporting, and analysis of standardized data.
- Integrating SDOH into the healthcare continuum promotes more effective, equitable, and sustainable health system.

8 Key Reasons Hospitals are Prioritizing SDOH	
1. Improved Patient Outcomes	5. Regulatory and Accreditation Requirements
2. Cost Reduction	6. Equity and Access to Care
3. Preventive Care and Chronic Disease Mngt	7. Community Health Improvement
4. Enhanced Patient Engagement and Satisfaction	8. Data-Driven Decision Making

Advantage

Social Risk Factor Data Driving Meaningful Provider Relationships

Hospital New SDOH Quality Measures Reporting

- CMS mandated hospitals reporting in the Inpatient Quality Reporting submit two new measures
  - SDOH-1, screening for SDOH, seeks how many patients have been screened
  - SDOH-2, identifies of the screened patients how many were positive for SDOH

SDOH Required Domains of SDOH

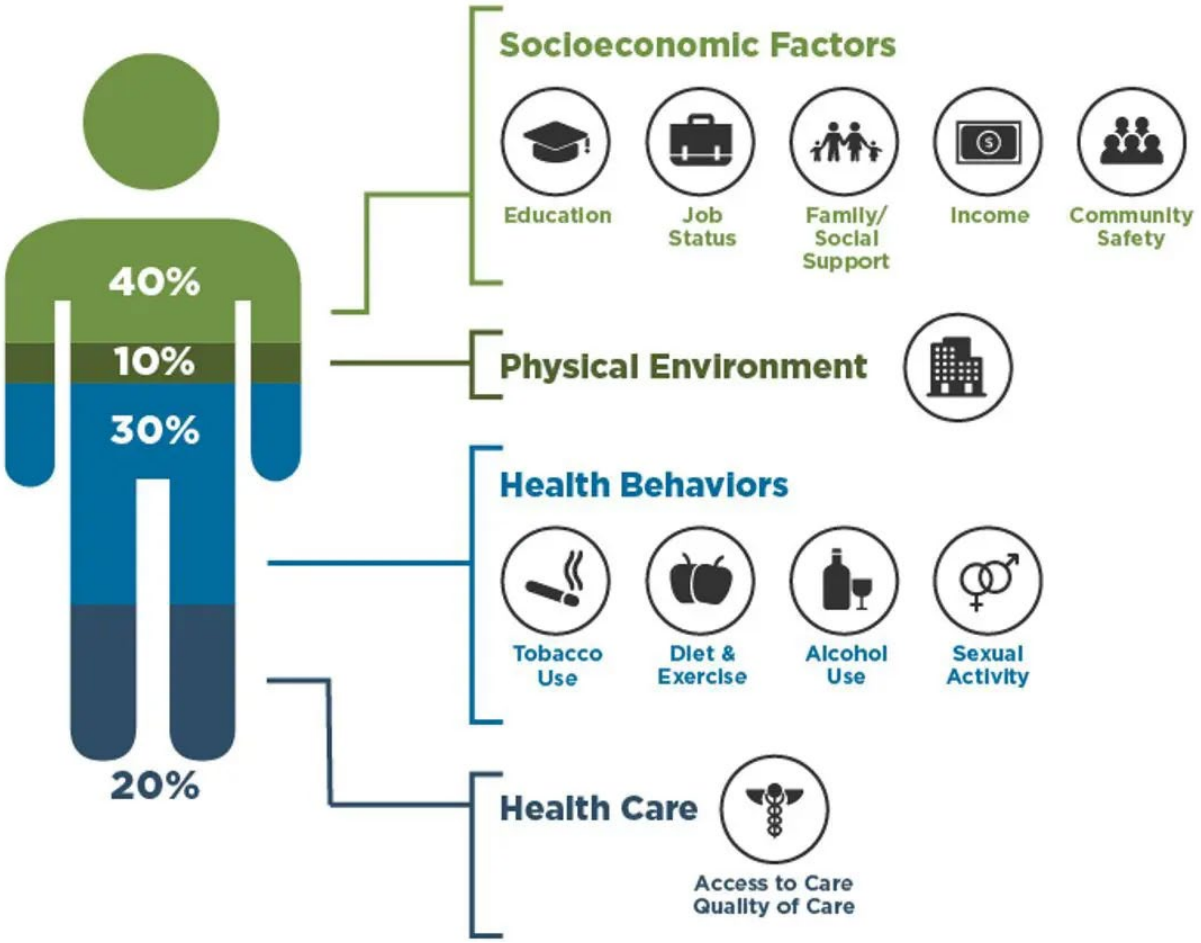
1. Food Insecurity
2. Interpersonal Safety
3. Housing Insecurity
4. Transportation Insecurity
5. Utilities

GOAL:

- Identify and address these nonmedical needs in a clinical setting
- These social risk factors disproportionately impact underserved communities, policies to address them are crucial to advancing health equity

Advantage

Unpacking Social Determinants of Health: A Comprehensive Breakdown

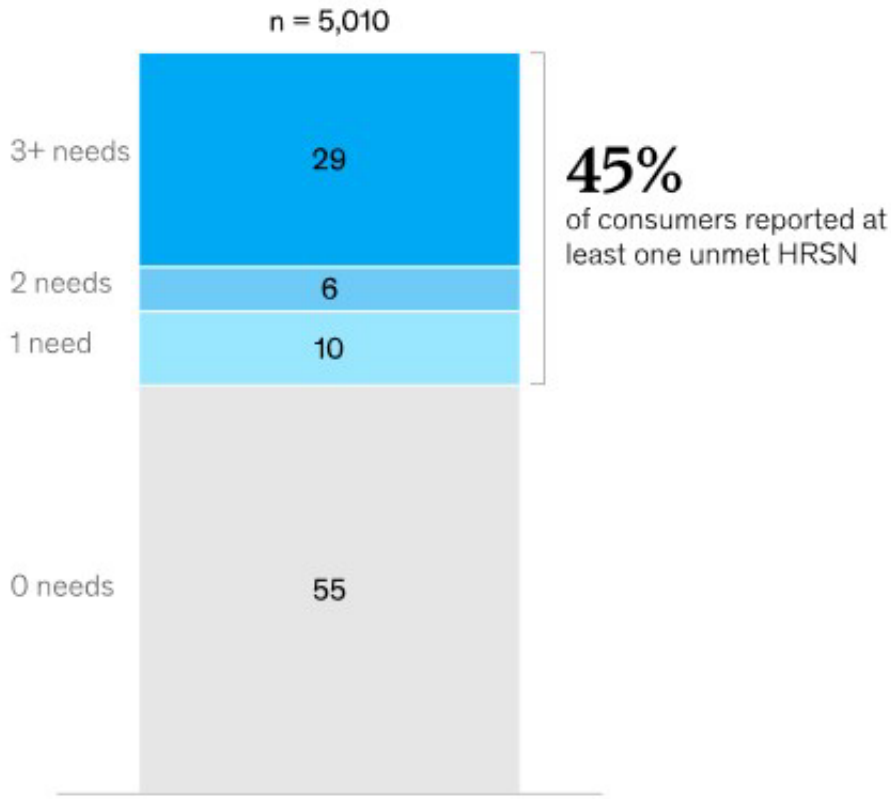


- 80% can be attributed to health-related social needs (HRSNs)
- Of the 80% the largest segment is made up of Socioeconomic Factors
- 50% can be traced back to your zip code
- Clinical factors are responsible for only 20% of health outcomes

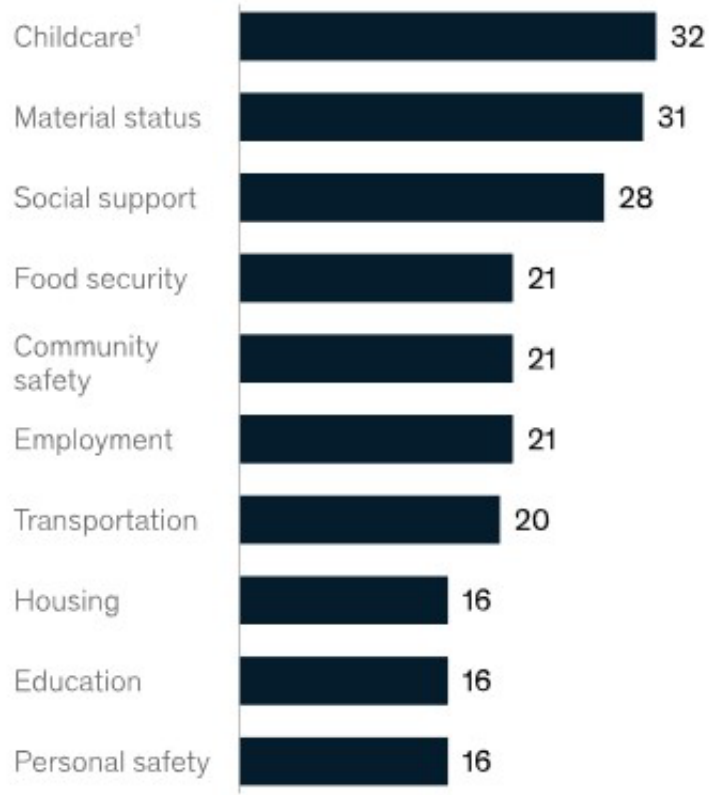
Advantage

Nearly half of US consumers have unmet health-related social needs, and the majority of this segment have more than one.

Number of unmet health-related social needs (HRSNs), % of individuals



Consumers facing unmet HRSNs at least every 1–2 months, by type of need, %



[1]Among individuals who indicated they have children.
Source: McKinsey Health-Related Social Needs Consumer Survey, 2022

McKinsey & Company

Advantage

Bridging Care: SNF and Hospitals Collaborate to Address SDOH

1. **Economic Stability:** Offer financial counseling and supportive services to your residents and families to help manage healthcare costs and access to financial aid programs
2. **Education Access and Quality**: Provide educational programs for your residents and staff on health literacy, disease management, and preventive care. Partner with local schools and universities for intergenerational programs and internships
3. **Health Care Access and Quality**: Ensuring upon discharge resident will have access to high-quality care, including regular check-ups, specialist visits, and telehealth services. Collaborate with hospitals to create a seamless care transition for residents
4. **Neighborhood Environment:** Create a safe and supportive living environment with accessibility, green spaces and transportation options.
5. **Social and Community Context:** Foster a sense of community within your facility through social activities, support groups, and volunteer opportunities.Build partnerships with local organizations to enhance social support and community engagement.

Advantage

Reducing Clinician Burden through Universal Foundation Measures

Advantage

- Released 2023, across all programs, such as Medicare and Medicaid
- CMS goal:
  - Standardization: Aim to create a consistent framework, reducing the burden on providers
  - Improved Health Outcomes: Core quality measures will drive improvements in patient outcomes, reduce disparities in care, and ensure patients receive high-quality care
  - Data-Driven Decisions: Standardization measures enable better benchmarking and comparison across different healthcare providers and settings.

Age-Friendly Quality Measure

Introduction to the 2025 Age-Friendly Hospital Measure

- Overview:
  - Introduced by CMS, effective January 1, 2025
  - Aimed to improve care for older adults in hospitals
  - Part of the Hospital Inpatient Quality Reporting Program (IQR)
- Keys Goals:
  - Ensure high-quality, patient-centered care for seniors
  - Focused-composite metric evaluating the hospital's commitment to providing high-quality care for older adults in various settings, i.e. ED, OR and the hospital
  - Drive improvements in five critical areas for seniors

Advantage

Key Domains of the Age-Friendly Hospital Measure

- Five Domains:
  1. Elicit patient health care goals:
     - Understand and prioritize what matters most to the patient
  2. Manage medications responsibly
     - Ensure safe medication practices to avoid potential harm
  3. Frailty screening and intervention:
     - Access and address frailty, including cognition and mobility
  4. Access social vulnerability:
     - Identify and mitigate risks like social isolation and caregiver stress
  5. Designate age-friendly leadership:
     - Appoint leaders to champion age-friendly practices within the hospital

Advantage

4Ms Framework of an Age-Friendly Health System

What Matters	• Align care with each older adults specific health outcome goals and care accross settings of care.
Medication	• Use medications that are Age-Friendly and that do not interfere with What Matters to the older adult, Mobililty or Mentation accross settings of care
Mentation	• Prevent, treat, identify and manage dementia, depression and delirium accross care settings
Mobility	• Ensure older adults move safely every day to maintain function and do What Matters

Advantage

Aligning Nursing Home Executives with Hospitals Referral Sources: Strategies for Meeting 2025 Age-Friendly Quality Measures

1. **Collaborative Care Planning**
   - **Joint Care Protocols:** Develop and implement joint care protocols with hospitals to ensure seamless transitions and continuity of care for seniors
   - **Shared Electronic Health Records (EHR):** Utilize shared EHR systems to facilitate real-time information exchange and continuity care planning
2. **Focus on the 4Ms Framework:**
   - **What Matters**: Regularly elicit and document patient health care goals and preferences
   - **Medication:** Implement robust medication management practices to ensure safe prescribing and monitoring
   - **Mentation:** Screen for cognitive issues and provide appropriate interventions
   - **Mobility:** Assess and support mobility to prevent falls and enhance physical function

Advantage

Aligning Nursing Home Executives with Hospitals Referral Sources: Strategies for Meeting 2025 Age-Friendly Quality Measures

3. **Frailty and Social Vulnerability Assessments**:
   - **Frailty screening:** Conduct regular frailty assessments and develop personalized care plans to address identified risks
   - **Social Vulnerability:** Identify and mitigate social vulnerabilities such as isolation and caregiver stress through targeted interventions and support services
4. **Age-Friendly Leadership and Training**
   - **Designate Leaders:** Appoint dedicated age-friendly care leaders to champion best practices and drive quality improvements
   - **Staff Training:** Provide ongoing training for staff on age-friendly care principles and the requirements of the new quality measure
5. **Enhanced Communication and Partnerships**
   - **Regular Meetings:** Establish regular meetings with hospital partners to discuss patient outcomes, care coordination and areas for improvement
   - **Feedback Mechanisms:** Implement patient and hospital feedback processes for continuous improvement
6. **Participation in Learning Collaboratives**
   - **Join Initiatives**: Participate in initiatives like the Age-Friendly Health Systems Action Community to stay updated on best practices and collaborate with hospitals

Advantage

Transforming Episode Accountability Model TEAM

TEAM CMS's Mandatory Bundle Model

- Advancing prior work on the episode-based alternative payment models
  - Bundled payments for care improvement advanced
  - Comprehensive care for joint replacement
- Launching Jan. 2026 and running for 5 years (Dec. 31, 2030)
- Participating hospital responsibilities include:
  - All costs of care for the episode
  - Overseeing care from hospital admission/outpt procedure through 30 days after the individual leaves the hospital
  - Improving patient care transitions
  - Decreasing risk of avoidable readmission
  - Coordination and communication across all care settings and providers
  - Follow-up PCP visit

Advantage

TEAM CMS's Mandatory Bundle Model

- 5-year mandatory model
- Hospitals required to participate based on selected CBSA, from across the country
- Included procedures:
  - Lower extremity joint replacement
  - Surgical hip femur fracture treatment
  - Spinal fusion
  - Coronary artery bypass graft
  - Major bowel procedure
- TEAM has three tracks:

TRACK 1	TRACK 2	TRACK 3
No downside risk and lower levels of reward for one year for all TEAM participants and up to three years for safety net hospitals.	**Lower levels of risk and reward** for certain TEAM participants, such as safety net hospitals or rural hospitals, for years two through five.	**Higher levels of risk and reward** for years one through five.
Episodes of focus will be Lower Extremity Joint Replacement, Surgical Hip Femur Fracture Treatment, Spinal Fusion, Coronary Artery Bypass Graft, and Major Bowel Procedure.		

Advantage

Mapping Participation: Identifying Hospitals in Your Region

Penn State Health Holy Spirit Medical	Meadville Medical Center
Geisinger Medical Center	Warren General Hospital
Saint Vincent Hospital	Indiana Regional Medical Center
Lehigh Valley Hospital-Schuylkill	Upmc Horizon
Reading Hospital	St Luke's Miners Memorial Hospital
Geisinger-Lewistown Hospital	Millcreek Community Hospital
Upmc Carlisle	Sharon Regional Health System
Upmc Hamot	Milton S Hershey Medical Center
Upmc Pinnacle Hospitals	Grove City Hospital
Penn Highlands Dubois	Edgewood Surgical Hospital
Upmc Northwest	Surgical Institute Of Reading
Penn State Health St. Joseph	Geisinger St. Luke's Hospital
Upmc Kane	Penn State Health Hampden Medical C

Advantage

TEAM Model: Nursing Homes Viewed as Collaborators in the Latest Bundled Initiative

- Critical to position your facility as a high valued partner
  - Nursing home operators will be looked at as a COLLABORATOR under this new model
- Need to develop value-proposition to demonstrate:
  - Comfort of managing episode of care
  - Showcase your position as a high valued partner
  - Willing to move down the path of value-based care

Advantage

7 Strategies for Competitive Positioning of Skilled Nursing Facilities

1. **Patient Experience:**

   TEAM aims to improve the patient experience from surgery through recovery through coordination and transitions of care between providers.

2. **Quality of Care Indicator: Patient Satisfaction:**

   Patient satisfaction is a direct indicator of the quality of care delivered. Within the TEAM model, patient feedback serves as a crucial performance metric.

3. **Coordination of Care:**

   Effective communication among hospitals, physicians, and other providers is vital. Strong communication and collaboration with all members of the care team is essential.

Advantage

7 Strategies for Competitive Positioning of Skilled Nursing Facilities, (Cont.)

4. **Quality of Care and Outcomes:**
   Under the TEAM bundled model, skilled nursing homes are frequently assessed based on patient outcomes, including readmission rates and patient satisfaction.
5. **Cost Management:**
   Skilled nursing homes must manage costs effectively to remain profitable under the fixed payments associated with the TEAM bundle.
6. **Data Reporting and Analytics:**
   Participation in TEAM bundles requires providers to collect and report data on various performance metrics.
7. **Compliance with Regulations:**
   Providers must stay updated on regulations and guidelines associated with TEAM bundles.

Advantage

Outcome-Based Relationship

Developing Outcome-Based Relationships: A Pathway to Building a Referral Pipeline

- Outcome-Based Relationship: Refers to a partnership or collaboration where success is measured by specific, predefined outcomes or results.
- Focusing on achievement of certain goals or benchmarks, typically related to:
  - Quality
  - Efficiency
  - Patient satisfaction
  - Financial performance
  - Enhancing care
  - Reducing readmissions
  - And, optimizing resource utilization

Advantage

Developing Outcome-Based Relationships: Key Aspects

- Outcoming-Based Relationship can help with:
  - **Improve Patient Outcomes:** Leading to better management of chronic conditions, reduced readmissions, and overall improved health
  - **Enhance Care Coordination:** Seamless communication and shared care plans ensure that patients receive consistent and coordinated care, reducing risk of medical errors and improving patient experience
  - **Cost Management:** Hospitals are held accountable for the total costs of care, including post-acute costs.
  - **Increased Patient Satisfaction:** Patients benefit from a more integrated and responsive care experience, leading to higher levels of satisfaction and trust.

Advantage

Cultivating Outcome-Based Relationships: Strategic Takeaways for Success

- **Shared Patient Care Plans:** Plans should be patient-centered and tailored to address individual needs
- **Ongoing Communication and Collaboration:** Establish regular communication channels between hospital, physicians, and skilled nursing provider
- **Shared Health Records:** Utilize integrated EHR to ensure seamless data sharing
- **Performance Metrics:** Implement metrics that focus on patient outcomes
- **Coordinated Discharge Planning:** Collaborate to ensure smooth transition from hospital to skilled nursing to home.
- **Patient Education and Engagement:** Educate patients and families on importance of care planning and engaging in their own health

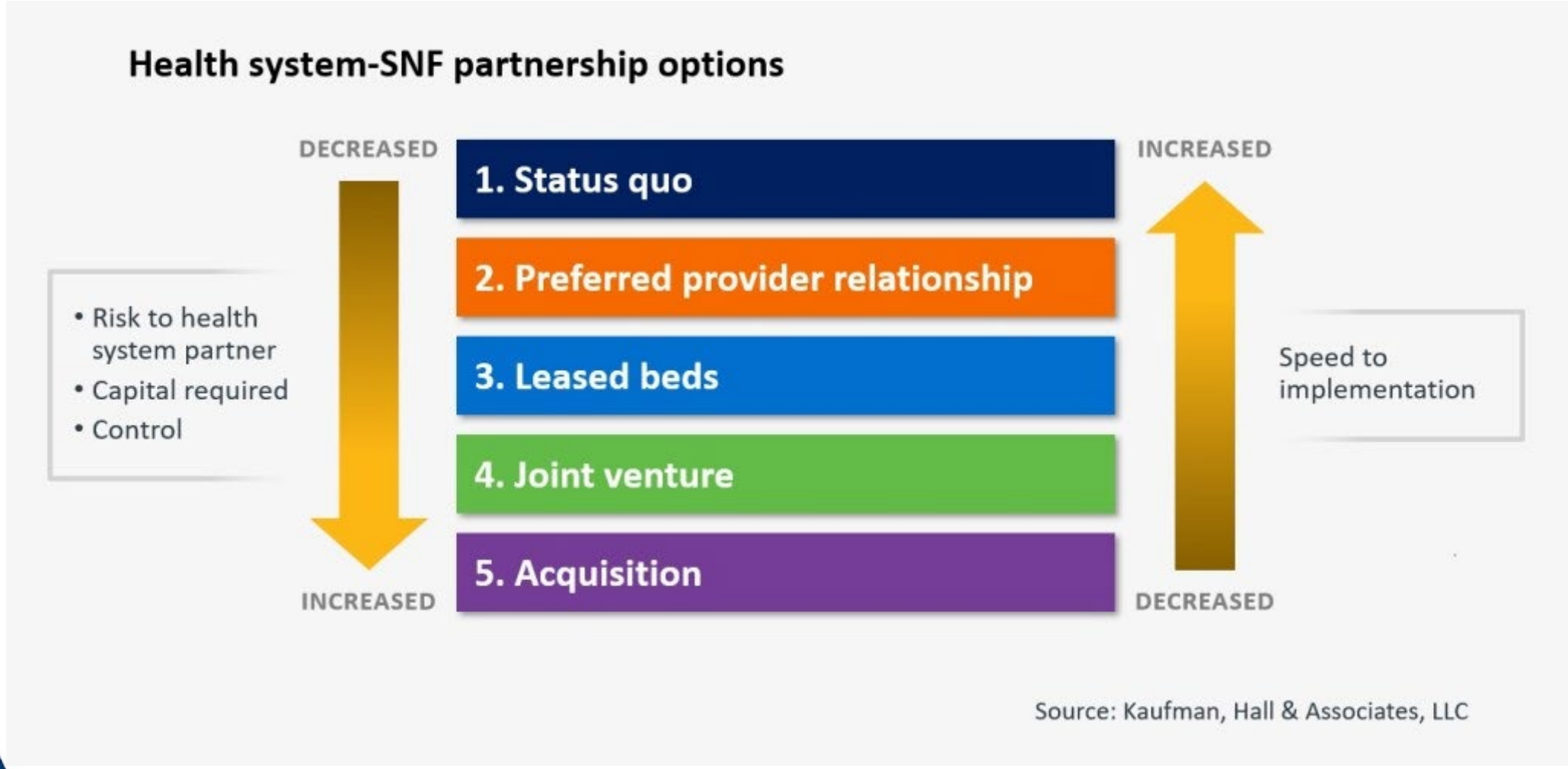
Advantage

Fostering Skilled Nursing Partnerships to Reduce Hospital Length of Stay

- Timely discharge to skilled nursing remains a significant concern for hospitals
- Elevated ALOS keeps labor costs up and constrains hospital bed capacity, potentially impacting revenue
- KaufmanHall's 2023 State of Healthcare Performance Improvement survey indicates hospitals need to establish successful partnerships with SNFs.
- Hospitals Key Interests:
  - Geographically dispersed SNF beds throughout service area
  - Availability of SNF beds for medically complex patients
  - Developing a trusted relationship with the SNF as a reliable discharge source
  - Gaining insight into the patient's full continuum of care

Advantage

Evaluating Hospital-SNF Options



Thank you

Questions, Comments

Presenter: Amy Hancock
ahancock@feeltheadvantage.com