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Priority Health's Post-Acute Strategy Led To Shorter SNF Stays, Fewer Readmits

Recognizing a wide variation in the performance of its skilled nursing facilities (SNFs) — often measured by lengths of stay as well as readmission rates — Michigan-based Priority Health has undertaken a variety of efforts to better manage outcomes and spend in this area. One of those efforts involves a 4-year-old partnership with post-acute care (PAC) benefit manager and technology company naviHealth that relies on a range of data to help Priority Health design targeted — and ultimately less costly — post-discharge regimens for many of its vulnerable elderly as well as other patients.

Priority Health is a not-for-profit health plan serving more than 800,000 members in western Michigan, including 140,000 lives in its fast-growing Medicare Advantage prescription drug product. It is owned by Spectrum, the dominant health system in Michigan. When their partnership began in 2013, Priority Health contracted with more than 200 SNFs in Michigan and had witnessed "a lot of variation from a geographic standpoint to a cultural standpoint to a volume standpoint," remarked the plan's medical director for network innovation and education, Gregory Gadbois, M.D., at a session of the 13th Annual Government Health Care Congress, held July 18 and 19 in Tysons, Va. And with about 70% of its membership admitted to approximately 25 SNFs that are mostly in the western part of Michigan, Priority Health saw an "opportunity to affect a large change in our membership," he recalled.

Meanwhile, the plan's average length of stay for its members in SNFs was 22 days, which is not surprising given that a patient's SNF copay typically kicks in on day 21, pointed out Gadbois. And although it had a modest 930 SNF days/1,000 rate — a key metric for PAC utilization — and a "middle of the pack" 30-day readmission rate of 18.1%, the plan felt SNFs were not incentivized to consider a shorter length of stay even if it made sense for the member. "It was like the wild west out there," he quipped. "There wasn't any objective way to determine how short the plan of care should be for the patient. Could patients really benefit from another two weeks of therapy? [We thought] it would be so much better if they could back that up with objective information as well."

Enter naviHealth, a Cardinal Health company, which in 2013 began a license and consulting deal with Priority Health that uses naviHealth's vast database of clinical, demographic and "patient function" data to inform the plan's strategy for designing a rehab regimen and returning the patient to the community as quickly as possible. The third set of data is not typically found in claims data and is a combination of three factors — lower body ambulation, upper body functionality and applied cognition, explains Carter Paine, chief operating officer for naviHealth, who also spoke at the session. "So we're establishing a patient's functional ability on those three different domains when it's time for post-acute care and we take that level of function, apply it against our database — which now has more than 2 million outcomes — to find, for example, the 128 customers who have the same functional score, the same comorbidities and similar reasons for being in the hospital and say, 'Those types of patients followed this kind of rehab regimen to return to the community as efficiently and as safely as possible,'" Paine tells AIS Health in a follow-up interview.

"All we're doing is running the data to help [the SNF] objectively determine the right course of action," added Gadbois during the session. But it took a fair amount of convincing on the part of Priority Health to get its SNFs on board and to view this as a "tool, not a rule," he remarked. "Getting that buy-in is extremely important, and it takes time and it takes relationships and you have to work at it. But at the end of the day I think they do trust that we have that patient's best interest at heart."

Early Discharge Planning Is Critical

Priority Health used its own care managers to guide transitions of care from the hospital to the SNF and beyond. But naviHealth also offers a delegated arrangement where it sets up and hires clinicians on behalf of the health plan to work in the field. "They essentially serve as the patient advocate as they go from the hospital to the SNF, go home with home health [assistance] and then return to the community fully functioning, because there's no mechanism in the way our current health system works nationally for handoffs because you're dealing with all separate provider entities that are all paid

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differently," remarks Paine. "And what we try to do is start discharge planning on day 1" of the SNF visit with patients and/or caregivers.

"We don't like the word 'discharge,'" added Gadbois. "We transition patients, because discharge really gives them the idea that, 'We're done with you, you're no longer our responsibility,' and that's not the case."

Other tactics to consider when implementing a post-acute strategy are to treat the "most appropriate next setting" as the goal, conduct home evaluations to determine the level and number of hours of home care needed once patients are released from the SNF, and get a "hybrid team" involved, he advised. Priority Health uses a two-person team of a social worker and a care manager who can "act as a bridge" for the member and wrap their services around the patient until they're comfortable at home, he added.

The partnership since its inception has yielded positive results, including:

◆ ***12% reduction in SNF admissions per 1,000,*** although some of that is due to the plan's "Home First" program in which it requests a rationale from surgeons when they indicate a post-operative SNF stay on prior authorization forms. "In cases where intervention could possibly allow the member to go home straight away, having this info further upstream gives us the opportunity to put together a plan to get them home," remarks Gadbois in a follow-up interview. "Most often we weren't hearing about the member going to the SNF until after surgery, at which point the horse is already out of the barn."

◆ ***33% reduction in SNF length of stay,*** which now averages 15 days.

◆ ***3% reduction in readmissions within 30 days.***

◆ ***Fewer 30-day and 90-day readmissions and a lower average length of stay observed internally for its Tier 1 vs. Tier 2 SNFs.*** Gadbois explains that the Tier 1 facilities are its higher volume partners where it has embedded care managers. "For those where the volumes can't justify the cost of embedding [a full-time employee], we communicate with the facility telephonically," he explains. As of March 2016, every facility contracted by Priority Health is either using the tool with its care manager face to face or by phone.

Additionally, Priority Health is taking steps to promote its high-quality providers and is participating in a Clinical Consortium of higher volume partners to share best practices "amongst the facilities that can give us the biggest bang for our buck," adds Gadbois. "As time progresses, the ability to stay in the Consortium will focus more on high performance metrics, many of which are influenced by the data we receive from naviHealth," he tells AIS Health.

For more information, contact Gadbois at gregory.gadbois@priorityhealth.com or Paine via Katie Lamb at klamb@gregoryfca.com. ✧

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