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Reducing Hospital Readmissions Through Preferred Networks Of Skilled Nursing Facilities

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Abstract

Establishing preferred provider networks of skilled nursing facilities (SNFs) is one approach hospital administrators are using to reduce excess thirty-day readmissions and avoid Medicare penalties or to reduce beneficiaries' costs as part of value-based payment models. However, hospitals are also required to provide patients at discharge with a list of Medicare-eligible providers and cannot explicitly restrict patient choice. This requirement complicates the development of a SNF network. Furthermore, there is little evidence about the effectiveness of network development in reducing readmission rates. We used a concurrent mixed-methods approach, combining Medicare claims data for the period 2009–13 with qualitative data gathered from interviews during site visits to hospitals in eight US markets in March–October 2015, to

examine changes in rehospitalization rates and differences in practices between hospitals that did and did not develop formal SNF networks. Four hospitals had developed formal SNF networks as part of their care management efforts. These hospitals saw a relative reduction from 2009 to 2013 in readmission rates for patients discharged to SNFs that was 4.5 percentage points greater than the reduction for hospitals without formal networks. Interviews revealed that those with networks expanded existing relationships with SNFs, effectively managed patient data, and exercised a looser interpretation of patient choice.

In 2009 the Centers for Medicare and Medicaid Services (CMS) focused attention on reducing unplanned hospital readmissions by initiating public reporting of selected risk-adjusted readmission rates. The Affordable Care Act (ACA) further stimulated efforts to reduce excess thirty-day readmissions by establishing a rehospitalization penalty, which started as a 1 percent reduction in Medicare payments on October 1, 2012, and has since increased to 3 percent. While there has been a steady decline in national rehospitalization rates,¹ the mechanisms underpinning these reductions are unclear.²

Additionally, hospitals—faced with the increasing use of value-based reimbursement, such as accountable care organizations (ACOs) and bundled payment—are seeking more effective ways to manage the total cost of care. Post-acute care management is often a primary focus of such efforts.^{3–6}

While several care models exist for managing patients discharged to home (with or without home health care),^{7–9} 20 percent of Medicare-financed hospitalizations conclude with a discharge to a skilled nursing facility (SNF),¹⁰ where patients are at high risk of rehospitalization.¹¹ Many care management models seek to ensure that patients follow up with primary care and specialty physicians, manage prescriptions, and adhere to discharge instructions. But these initiatives are often inappropriate for managing patients discharged to an institutional setting. Because of the complexity of coordinating care in a SNF, it is unclear how hospitals influence postdischarge care for such patients and whether any such strategies reduce readmissions.

Some evidence suggests that rehospitalization rates can be reduced by concentrating patient referrals to a limited number of SNFs (that is, to a preferred network).¹² Accordingly, a hospital could develop a preferred network of SNFs and target its care coordination and management efforts toward these facilities.¹³

We used a concurrent mixed-methods approach, combining Medicare claims data with qualitative information about preferred network development, to examine changes in rehospitalization rates and differences in practices between hospitals that developed formal SNF networks and those that did not.

Study Data And Methods

We used Medicare fee-for-service claims-based rehospitalization rates for the period 2009–13 adjusted for age, principal diagnosis, and co-morbidities, combined with qualitative findings from fifty-five semistructured field and telephone interviews with staff members at

sixteen hospitals in eight US markets. The interviews were conducted in the period March–October 2015. (For a detailed description of the quantitative methods, see the Quantitative Analysis section of the online Appendix.)¹⁴

SITES, RESPONDENTS, AND QUALITATIVE DATA

Site selection occurred in August and September 2014 in anticipation of visits in 2015. We selected eight geographically diverse US counties, each of which had at least 40,000 Medicare beneficiaries and which collectively covered all four census regions and six of the nine census divisions. (For a map of the census regions and divisions and a table showing the geographical location of each market, see online Appendix Exhibit 1.)¹⁴ Using Medicare Advantage county penetration data from CMS, we purposefully chose four counties that had Medicare Advantage penetration rates above the national average of 30 percent and four that had rates lower than 30 percent. Our hypothesis was that hospitals in a high managed care environment might approach organizational partnerships differently than those in a low managed care environment—although this turned out to not be the case in our comparison of hospitals with and without SNF networks.

Using data from the American Hospital Association Annual Survey, we selected community hospitals of equivalent size in each county, based on numbers of staffed beds. From these, we chose one hospital with a low readmission rate and one with a higher rate, surmising that hospitals might employ different approaches to postacute care management depending on their relative “rank” within a site. We derived hospital readmission rates from publicly available data, which we accessed from the Commonwealth Fund’s whynotthebest.org website.¹⁵ (For an illustration of the selection process, see Appendix Exhibit 2.)¹⁴

We recruited discharge planners, strategic planning executives, chief medical officers, and hospitalists from each hospital, yielding a total of fifty-five interviews. The qualitative analysis team made revisions to the interview protocols based on pilot testing and internal consistency reviews. Interviews lasted about forty-five minutes and were conducted in person when possible and by telephone when not. Interviews were audiorecorded and transcribed.

Brown University’s Institutional Review Board approved the study.

QUALITATIVE DATA ANALYSIS

We analyzed the data using deductive and inductive approaches.¹⁶ We devised an initial coding structure based on our interview guide¹⁷ and made modifications to it throughout the analysis to reflect new and emerging codes. To achieve rigor in transcript analysis, interviews were initially coded by each member of the five-person qualitative analysis team. Then each member of rotating two-person teams analyzed all interviews by reading, coding, and then reconciling coding decisions. We organized and managed the reconciled transcripts using the NVivo qualitative software program. After the coding and reconciliation process was completed for each site, the qualitative analysis team discussed emerging themes from the interviews to clarify patterns across interviews and sites.

HOSPITAL CLASSIFICATION

Based on the interview analysis, we identified four hospitals (representing two sites) that had developed a formal network of preferred SNFs. We considered these to be formal networks because the senior leaders of the hospital or health system had focused organizational efforts on developing preferred SNF networks. For example, these hospitals had committees to request, manage, and process data from targeted SNFs and had formal processes (such as the use of printed brochures) in place during the discharge process to inform patients about the preferred SNFs.

All of these hospitals had contractual relationships with their preferred SNFs, and the contracts included performance standards and expectations of lengths-of-stay, rehospitalization rates, and so on. None of the hospitals had any direct financial relationship with the SNFs. If a hospital had owned a SNF but had no specific processes and protocols in place to manage patients in the facility, we would not have categorized the relationship as formal. While the precise dates at which preferred networks were developed were unobtainable, all four hospitals reported that the ACA was a catalyst for them to begin network development.

The remaining twelve hospitals in the other six sites had not adopted postdischarge care management approaches that included formal development of a SNF network, although several of the hospitals had developed processes to manage patients discharged to home. Several hospitals had recognized the advantages of developing formal networks, and some had begun the process of developing networks, only to abandon it. A small group of geriatricians at one hospital did direct patients to specific SNFs, but we did not classify this hospital as having a formal network because the decision to engage with SNF partners did not originate with senior hospital leaders and the effort was not directed to all fee-for-service Medicare patients. (For a table comparing hospital characteristics, see Appendix Exhibit 3.)¹⁴

QUANTITATIVE DATA ANALYSIS

To illustrate differences in rehospitalization rate reductions, we obtained individual-level claims data for inpatient hospital stays from the Medicare Standard Analytic Files for enrollees in fee-for-service Medicare in the period 2009–13. To compare changes over time in rehospitalization rates, we used 2009 as the pre-ACA baseline period, and we used the Yale all-cause readmission measure¹⁸ to compare the risk-adjusted changes in rehospitalization rates between hospitals with and those without formal SNF networks. We ran separate models for overall changes in rehospitalization rates for patients discharged to a SNF and for patients discharged to home or home health care. (A detailed description of the quantitative methodology is in the Appendix.)¹⁴

LIMITATIONS

This study had several limitations. First, while we were able to examine the association between having a formal SNF network and hospital-level readmission rates, we could not infer any causal relationships.

Second, we focused on sixteen hospitals in eight markets, so our results might not be generalizable to other settings. There may also be additional market-level changes independent of developing a SNF network that contributed to the reductions in rehospitalization rates.

Third, we developed a specific definition of a formal network, which is unique to our data set and is not identifiable through traditional data sources. Therefore, it would be difficult to replicate our study on a larger scale.

Fourth, hospitals that developed SNF networks were found in only two of our eight markets, so we were unable to include any within-market comparisons. Nonetheless, while there are other market-level factors that drive network development, that development and its benefits for patient outcomes may prove successful in other facilities.

Study Results

DISCHARGES TO A SKILLED NURSING FACILITY, AND HOSPITAL READMISSIONS

In 2009 nearly 27,000 Medicare patients were discharged from the four hospitals with formal SNF networks (case hospitals) in our study, and more than 54,000 Medicare patients were discharged from the twelve hospitals without such networks (comparison hospitals) (Exhibit 1). In the same year, one-third of Medicare patients discharged from the case hospitals were discharged to a SNF, and nearly two-thirds were discharged to home or home health care. In contrast, fewer than one-quarter of Medicare patients discharged from the comparison hospitals were discharged to a SNF, and more than two-thirds were discharged to home or home health care.

The overall adjusted rehospitalization rate in hospitals with networks declined by 3.7 percentage points, from 17.0 percent in 2009 to 13.3 percent in 2013—compared with a 2.1-percentage-point decline in comparison hospitals (data not shown). The 1.6-percentage-point relative difference was not significant ($p < .005$; 95% confidence interval: $-4.1, 0.9$). For patients discharged to a SNF, the rehospitalization rate in case hospitals declined by 6.1 percentage points (from 23.8 percent in 2009 to 17.7 percent in 2013)—compared with a 1.6-percentage-point decline (from 21.5 percent to 19.9 percent) in comparison hospitals (Exhibit 2). This relative change of 4.5 percentage points (95% CI: $-8.1, -1.0$) was significant. Among patients discharged home, the difference in the change in rehospitalization rates between hospitals with and those without networks was not significant.

OVERARCHING QUALITATIVE THEMES

From the qualitative interview data, five overarching themes emerged in our comparisons between hospitals with and those without an SNF network.

HOSPITALS WITH NETWORKS MADE USE OF EXISTING RELATIONSHIPS—

Hospitals with SNF networks leveraged their existing referral relationships to develop their lists of preferred SNFs. In other words, instead of choosing the highest-quality facilities (as measured by CMS star ratings, for instance) and having to steer patients to those facilities,

hospitals built their preferred networks using facilities to which they had historically discharged a high percentage of patients. In this way, hospitals avoided having to retrain their discharge planners, recognizing patients' historical choices and their desire to be close to home. Hospitals with formal SNF networks were not necessarily seeking to restrict patient choice; they simply began to develop networks with those facilities where the majority of their patients were already being referred.

One care manager at a hospital with a formal SNF network commented: "We took our top providers that we have historically referred to in our primary service area, so therefore the providers that we've chosen seem to have brand equity with our patients or our physicians or both."

A vice president for strategy at a hospital with such a network reported that health system leaders "said, 'let's form this network,' and we said, 'We already have a network of twenty-five long-term care facilities that have been in this [managed care] program for many years, and we have physicians following [patients in] them. Why don't you approach these twenty-five facilities to see if they want to be in [the network]?' And these facilities came forward and wanted to be in it."

Hospital respondents also spoke of the power of the network to change behavior and improve performance, instead of starting with facilities with the highest quality ratings. For example, a care manager at a hospital with a formal network said, "Now, we don't know for certain that particular SNF is knocking it out of the ballpark.... But there's value to being on our preferred partner list, and they're going to push colleagues from other facilities to perform."

One hospital that did not develop a formal SNF network chose local SNFs by building on prior referral relationships with a three-person employed geriatric group aligned with the hospital. Its chief medical officer said: "We have chosen the facilities [SNFs] that we are medical director in according to discharge numbers from each of the hospitals and saying we would love to have a medical director in your SNF. We toyed around with the idea of going to postacute rehab facilities and seeing [health system] medical group patients, but we found that you can make a higher impact on readmission rate[s] by actually being a presence in the facilities and being a part of staff education and being a connection for after-hours phone calls, and really being more than just that face that comes in a couple times a week."

UNDERSTANDING COST DRIVERS CAN STIMULATE NETWORK

DEVELOPMENT—A hospital's decision to include SNFs in the care management process is aided by an external motivator, such as inclusion in an ACO or participation in a bundled payment model. (For information about hospitals' ACO and bundled payment participation, see Appendix Exhibit 3.)¹⁴ The additional population health metrics that ACOs employ can align organizations around the goal of reducing readmissions. For example, a better understanding of population-level spending could lead hospitals to address SNF spending and utilization if they are higher than national averages.

A vice president for strategy at a hospital with a formal SNF network said: “One of the things we looked at was cost per spend[ing on a patient]. And our nursing home spend[ing] was higher than the national norm, so we knew we had opportunities in relation to dollars spent. We also knew at that time [that] we only had one [skilled nursing] facility. We knew that was not our core competency, and that was not a business that we wanted to get into. So we needed to develop a network in order to address those issues.”

Lacking such motivation, a hospital might take a more hands-off approach to SNFs or wait to participate in a CMS value-based payment model before developing a SNF network. For example, a senior vice president for operations at a hospital without a formal network said, “With the implementation of the Bundled Payments for Care Improvement Initiative, ... we will have preferred providers based on quality.”

EFFECTIVE DATA MANAGEMENT IS CRITICAL—Hospitals with a SNF network often used formal and structured processes to choose the facilities in the network. The process of data collection included setting measures and evaluation criteria, often with input from one or more SNFs. Hospitals frequently developed interdisciplinary teams to evaluate SNFs. SNFs were often asked for data on, for example, readmission rates, staffing ratios, patient satisfaction results, and lengths-of-stay. Several of the hospitals in our study visited SNFs to conduct on-site qualitative evaluations. In one case, the SNFs were even asked to comment on the data request and suggest additional data to include or data to be removed from the original request for information.

A vice president for strategy at a hospital with a formal SNF network said, “We asked the SNF providers to provide us with a report card, and we set the measurement of these quality indicators: patient experience, quality, the connection of our EMR [electronic medical record] to referrals on their side, meaningful use, financials, length-of-stay—a lot of public reporting data we have access to, but we also came up with our own.”

Some hospitals without SNF networks gathered data, but those that did not use specific criteria for evaluating SNFs were overwhelmed by the information they received. A vice president for strategy at a hospital without a formal network said: “We went through the process of trying to determine that [preferred SNF network] for our clinically integrated network, and we just never settled on final [criteria].... We identified all the SNFs in the region and submitted a request for information to all. And [we] had a certain [set] of criteria we wanted to receive from them about quality and availability of providers and hours and that kind of thing. I think the reason it fizzled out was, beforehand, we hadn’t thought about how we would stratify those criteria. When it came down to picking who stood out, how do we assign points or value to each of those different criteria?”

Setting specific guidelines and thresholds for evaluating the data gathered from SNFs can be the difference between success and failure.

‘PATIENT CHOICE’ IS OPEN TO INTERPRETATION—Nearly all hospital respondents referred to CMS’s requirement regarding patient choice in the discharge planning process.¹⁹

However, respondents' interpretations of how choices are presented varied, especially between those at hospitals that had a formal SNF network and those that did not.

Hospitals with such networks recognized that providing information to patients still left final decision-making authority with the patient and his or her family. A vice president for strategy at a hospital with a formal SNF network said, "We have about twenty-six long-term care facilities that make up our long-term care network, but then we have a subset...that we've contracted with as our postacute network and [to provide] short-term [skilled nursing] care, and we've tiered them, and this is how we try to direct our referrals."

Comparison hospitals tended to use much stricter definitions of *choice*, and their risk management offices consequently dictated that patients be given facility lists without offering publicly available quality data, to avoid the impression of influencing patients' choices. The senior vice president for operations at a hospital without a formal network said: "At this time, we're very much into patient choice—you can look it up online and find that type of information. If the patient's not able to go out [to visit a facility], the rep can come in and talk to the patient about the facility. We don't at this time give them, 'This is the five stars, and this is the ratings.' ...We just tell them that they can research it."

A vice president for strategy at a hospital without a formal network commented, "We have tried to develop, using payer language, a narrow network with postacute facilities, and our legal experts have said that we're not able to do that outside of any sort of Medicare innovation programs, because they are very concerned about the requirement for the patient to feel that they have a choice in where they go."

Hospital respondents uniformly described providing choice to patients during the discharge planning process, though the interpretation and the manner in which they provided that choice varied across hospitals.

HOSPITALS WERE ABLE TO LEVERAGE HIGHER VOLUMES AT NETWORK FACILITIES—All hospitals with SNF networks were able to mobilize teams of their providers to make visits to network SNFs to provide continuity of care and treat in place, instead of having patients sent back to the hospital. The teams typically consisted of a physician and one or two nurse practitioners. Patients admitted from the hospital would often be seen every day by the nurse practitioner and generally once per week by the physician.

A vice president for strategy at a hospital with a formal SNF network said: "At the postacute care network level, patients are seen by the physician and the nurse practitioner on a weekly basis, and they're certainly always contacted by the nursing staff at the skilled nursing facility. And they try to make sure that they can do anything possible without readmitting [patients to the hospital]."

Hospitals without SNF networks apparently did not yet fully appreciate the benefits of managing patients in the SNF setting, or perhaps they did not achieve the scale necessary to financially justify a dedicated team.

For example, a care manager in a hospital without a formal network said, “If you’re in the SNF, I don’t know where you would go, other than the ER, because...there isn’t another level of care to send them to.”

A vice president for strategy at a hospital without a formal network said: “We did have employees—geriatrician physicians in our primary care group—that would go into the facilities; we call them SNFists. We would round on [health system] patients. And that program was discontinued about six months ago, more so from physician participation, rather than [lack of patient] satisfaction with the program.”

Discussion

The four hospitals that we identified as having developed preferred skilled nursing facility networks reduced their rehospitalization rates for patients discharged to a SNF faster, compared to the twelve hospitals that did not develop such networks. The hospitals with SNF networks recognized the positive effects of active care management in a number of selected facilities, building upon existing relationships. Furthermore, these hospitals recognized that care management among patients transitioning to a SNF is just as important as managing patients discharged to home, particularly because the former are often sicker and have more complex health care needs.

Our findings, though limited in scope, are consistent with previous research that showed a positive effect of concentrating patient referrals in a narrow network of SNFs,¹² though the hospitals with SNF networks in our study did not appear to actively steer patients to the network facilities. It is possible to create a preferred network either by enhancing existing SNF relationships or by liberally interpreting and implementing the requirement for patient choice. The hospitals that developed SNF networks provided patients with additional information to assist them in making their decision, such as informing patients that a provider team would help manage their care in the network SNFs. Then patients were left to decide if such enhanced continuity of care was important to them.

We uncovered several novel strategies through which hospitals engaged a SNF network. First, a hospital must be motivated to include SNFs in its care management approach. The four hospitals in our study that we identified as having a SNF network had, on average, a greater proportion of patients discharged to a SNF, and one hospital in particular recognized it had higher SNF spending than average.

Second, hospitals that developed SNF networks employed formal processes for data collection and evaluation, including submitting formal data requests to SNFs; making site visits to SNFs; and hosting meetings of regional SNFs for the purposes of education, quality improvement, and discussing best practices. The hospitals started these processes with SNFs to which they had historically referred patients.

Finally, while most of the SNFs in our study had implemented previously studied approaches to reduce rehospitalizations, such as using the INTERACT tool,²⁰ hospitals with formal networks also had teams of physicians and nurse practitioners visit the SNFs to manage patients and provide continuity of care. The volume of patients in the preferred

SNFs allowed the hospital to justify the expense of having a dedicated team visit SNFs to treat its patients. As a result, hospital respondents often spoke of being able to treat in place instead of subjecting patients to unnecessary transfers back to the hospital that could adversely affect patient outcomes.¹¹

Conclusion

Studying the impact of strategies to develop and maintain a SNF network is complex, because of the multitude of factors that can lead to improved outcomes—which likely explains why so little research has been done in this area. Unfortunately, there is also little quantitative or qualitative research on the effect of provider networks, particularly among postacute care providers. By combining qualitative and quantitative data, our study provides insights into the potential effect of restricted SNF networks on rehospitalization rates. Future research might confirm these findings in a national sample and explore additional details of SNF networks.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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NOTES

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EXHIBIT 2. Percent of rehospitalized patients discharged home or to a skilled nursing facility (SNF) from hospitals with and without a formal SNF network, 2009–13

SOURCE Authors' analysis of data for 2009–13 from the Medicare Provider Analysis and Review files and the American Hospital Association Annual Survey. **NOTES** Hospitals with formal SNF networks are defined in the Notes to Exhibit 1. Only one difference in the trends shown was significant ($p < 0.05$): the difference between hospitals with and without a SNF network in SNF discharges.

Characteristics of hospitals with and without formal skilled nursing facility (SNF) networks and of patients discharged from the hospitals, 2009 and 2013

EXHIBIT 1

	With a SNF network		Without a SNF network					
	2009	2013	2009	2013				
HOSPITAL CHARACTERISTICS								
Number	4	4	12	12				
Mean annual Medicare discharges	6,736	6,145	4,540	4,115				
Total Medicare discharges	26,942	24,581	54,475	49,376				
DISCHARGE DESTINATION								
Home or home health care	61.7%	58.6%	71.9%	71.0%				
SNF	33.1	35.4	23.9	24.0				
Other	5.3	6.0	4.2	5.0				
Discharges by cohort	No.	%	No.	%				
Cardiorespiratory	3,774	14.0	3,595	14.6	7,507	13.8	6,535	13.2
Cardiovascular	2,773	10.3	2,198	8.9	7,973	14.6	5,885	11.9
Medicine	11,627	43.2	10,322	42.0	20,652	37.9	19,186	38.9
Neurology	1,429	5.3	1,417	5.8	3,379	6.2	3,484	7.1
Surgery or gynecology	7,339	27.2	7,049	28.7	14,964	27.5	14,286	28.9
Patient characteristics	No.	SD	No.	SD	No.	SD	No.	SD
Average age (years)	79.5	8.1	79.7	8.6	77.9	8.2	77.9	8.5

SOURCE Authors' analysis of data for 2009 and 2013 from the Medicare Provider Analysis and Review files and the Medicare Master Beneficiary Summary File. **NOTES** We defined hospitals with SNF networks as those whose hospital or health system leadership employed a specific process to identify a preferred network of SNFs to which the hospital would attempt to discharge a majority of its patients requiring skilled nursing care. SD is standard deviation.