SNF Collaborative Overview

What is a SNF Collaborative?

- A Skilled Nursing Facility (SNF) Collaborative builds a formal platform that allows hospital and SNF leadership to improve the continuity of care.

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Continuity of Care

Hospital

PCP

Home Health

SNF

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Selecting SNF Partners

There are several quality and clinical outcome criteria for picking SNF partners. The best SNF partners for hospitals are high-quality facilities where data supports their performance on:

- CMS quality star ratings
- Long-Term Care Minimum Data Set measures
- 30-day readmission rate
- Acute LOS
- Referral response time – as reported by care management teams
- Overall referral acceptance
- Complex case acceptance
- SNF impact on total cost of care
- Case Mix Index (CMI) or severity of illness average score
- Satisfaction scores from patients and family members
- **Current working relationship and support of hospital teams**

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Collaborative in Action

The collaborative will meet monthly for a steering committee meeting and quarterly for a joint operating committee to provide a platform to work on a variety of different initiatives like:

- Readmission prevention
- Decreasing hospital length of stay
- Streamlining Hospital Care Management communication and referral review
- Supporting System led programs like Value Based Purchasing (VBP), Medicare Shared Savings Program (MSSP), Comprehensive Joint Replacement Program (CJR), Bundle Payment for Care Improvement Advanced (BPCI-A) and others
- Acute diversion through direct Home Health and Emergency Department admission to SNF
- Focusing on smooth transition of care from hospital to SNF
- Partnering with ACO's working at the hospital
- Providing in-services and education to SNF's
- Sharing best practices SNF to SNF
- Reviewing data and implementing improvement plans
- Building a Providence network continuum of care through utilization of Providence lines of business (Home Health, Hospice, Home Care, etc.)

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Collaborative Goals

- **Improve the continuity of care**

  - *Patient education at acute*
    - Patient choice list and transitions of care brochure educate patients on collaborative program
    - Care Managers and Program managers educate patients on expectations at SNF
  - *Smooth transitions for patients*
    - Escalation mechanism/decision tree/communication ladder between SNF and Acute
    - Clear communication from Acute on discharge plan for patient coming to SNF
    - Care Management gives timely, thorough report
    - Care Management knows SNF bed availability
    - Timely referral response time by SNF, documentation includes information SNF's need to make quick decision
    - Discharge checklist accounts for timely medication at SNF, (triplicates, hard scripts, antibiotic stop dates, etc.)
  - *Decrease Acute LOS for patients going to SNF*
    - Track variances to LOS goals and denials. Implement plans with specific SNF's on how to overcome reasons for denial, delays in admission, etc.
    - Partner SNF's commit to participate in the complex case program
    - Work with ED teams to place patients at SNF instead of admit to Acute when safe
  - *Reduce Readmissions*
    - Create work groups and pathways to address primary causes of readmission
    - Home to SNF direct admission pathway
    - ED to SNF direct admission pathway
  - *Program Management*
    - All partner SNF's have Providence Health Network, Hospice, and other applicable contracts
    - Program Managers (MSSP, CJR. BPCI-A, Sepsis, Ortho, etc.) utilize SNF collaborative
  - *Data Collection*
    - Track Data to address trends and make data driven decisions
    - Total Admissions, Complex Case Admissions, Readmissions, Severity of Illness, Acute LOS, SNF LOS

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Thank you!

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