OhioHealth

Skilled Nursing Facility (SNF) Utilization

A multifaceted initiative including provider education and dedicated teams to reduce unnecessary SNF utilization

Background

- SNF utilization is a large cost driver, contributing to >7% of the total Medicare spending
- OhioHealth's Clinically Integrated Network (CIN) SNF utilization was 20% higher than the National Average in 2019
- Medical Loss Ratio (MLR) performance and medical expense performance at OhioHealth CIN was higher than other high performing networks

Objective

Ensure that the right patient population is going to a SNF and staying an appropriate amount of time

Interventions

2019-2021: Why Not Home Program Launch and Revamp

- Launched the Why Not Home program to ensure the first conversation is focused on getting patients home
- Installed the CarePort Provider Guide, a CMS compliant resource for post-acute choice (SNF, HH, IPR, LTAC)
- Deployed CarePort Connect and Insight, a Data analytics platform that helps to ensure patients are not getting overlooked
- Partnered with MedOne for length of stay reduction

2022: Careful Conversations and DART Review Launched

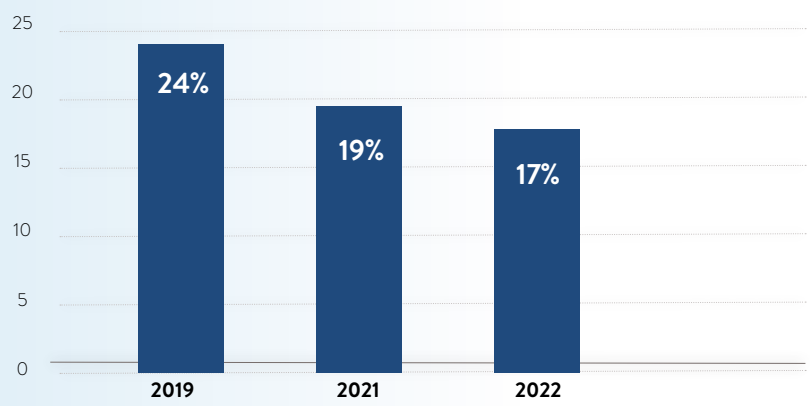
- Implemented Careful Conversations training to guide care teams' discussions with patients about home focused flexible discharge plans to avoid anchoring bias
- Developed Disposition Appropriateness Review Team (DART) review team , a multi-disciplinary team that reviews patients that are on the "cusp" of home vs SNF, to provide recommendations for discharge locations

2023: PCP and Pre-Surgical Education

- Raised awareness with PCPs and surgical specialties about alternatives to SNF stays (eg. missing community resources) to prevent anchoring to SNF discussion
- Developed a SNF liaison role designed to remove barriers that may increase SNF length of stay and advocate for the patient's needs and desires by making sure all stakeholders involved in the patients healthcare are communicating with one another
- Initiated quarterly meetings with SNF partners

Results

SNF Discharge Rate of Attributed Patients



Next Steps

- Continue to keep these initiatives relevant and top of mind for everyone involved.
- Create new interventions to ensure patients are getting the right form of after care.
- Continue to scale to additional therapeutic areas of interest

KEY LEARNINGS

- Reduce anchoring bias to SNF as early in patient stay/ contact as possible
- Encourage patients to have a plan A/plan B and be flexible
- Improve "Careful Conversation" skills
- Ensure open dialogue with post-acute partners on program

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