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Executive Summary:

- The goal of McLaren Physician Partners' (MPP) post-acute care strategy was to develop an aligned network of skilled nursing facilities (SNF) across the State of Michigan which enhanced Care Coordination between hospitals, SNF, and the Patient Centered Medical Home.
- At this time there are 65 SNF facilities (See Appendix A) in our network committed to improving cost and quality.
- The established workflow is designed to support current value-based care and future down-side risk programs.
- We are collaborating with other regional POs and PHOs to share our best practices. We hope to create regional aligned networks, leveraging our ability to influence SNF performance.
- Performance after the first year demonstrated an average decreased length of stay (LOS) of 2 days in the SNF and a 7% decrease in the cost per patient. Our percentage of patients discharged to an aligned SNF is at target of 80% overall.

Category of submission: Care Management Workflow

Title of Submission: Improving Care Across the State of Michigan through the development of an aligned Skilled Nursing Facility Network

When did interventions start and end? In mid-2017, a Steering Committee convened to discuss an aligned skilled nursing facility strategy for McLaren, focused on our largest region, Lansing. In November of 2017, the facilities had been selected and the interventions were launched. Following Lansing, each region's selected facilities joined the aligned network with the last region to go live in the Fall of 2018. On an annual basis performance of each facility is reviewed for continued participation in the network.

Goal of the program/Interventions: The goals of the program are to (1) reduce overutilization of skilled nursing facility resources (appropriateness of admissions and length of stay), (2) improve transitions of care (hospital to SNF and SNF to community), and (3) to improve the quality and experience of care to patients (through an aligned network of quality SNFs and enhanced communication strategies, it increases collaboration amongst all members of the care team across the continuum of care to include PCP.). Each intervention is selected to impact one of these stated goals.

Who developed the program/interventions, and how? The program was developed and overseen by MPP's leadership and a physician-led Utilization Management Committee in collaboration with our regional hospital mini-Board structure (Regional Steering Committee). Others responsible to participate include MPP Care Coordination department and Medical Leadership, McLaren Home Management Group, and McLaren Hospital Care Management and Medical Leadership. Using analytics, each region's SNFs were reviewed for quality and utilization metrics. Each regional hospital provided input into which SNFs to include in the network. SNFs were invited to participate in the network and were required to report quarterly quality data, attend individual and regional meetings to share data reports and best practices, and collaborate with the Centralized MPP Care Coordination team.

Description of the program/interventions. Two key elements were included in our program: (1) Engaging key stakeholders and (2) Centralized Care Management for patients admitted to and discharged from a SNF.

The first key intervention involved the engagement of the key stakeholders (SNF and Hospital Care Management teams). MPP engaged the SNFs through the application of consistent performance standards and transparent reporting. Quarterly on-site meetings are held with each preferred facility where MPP reviews unblinded, regional performance reports including the measures of length of stay, 30/90-day readmission rates, average cost of care and 7-day follow-up appointment post discharge. Each SNF is required to report quality data through the Michigan Peer Review Organization (MPRO) SNF Collaborative database. This quality metric data is also shared with each facility measuring their performance against the State of Michigan Benchmarks. The regional hospital Care Management teams were engaged by including their feedback into the network selection process. Regional performance is reported to the Regional Steering Committee and includes network utilization, average cost of case, year over year cost and year over year length of stay.

The second intervention was to develop a Centralized Care Management workflow for patients admitted to and discharged from the SNF. The adoption of information technology was critical to the effective operation of these services. The expansion and growth of the Michigan Health Information Network allowed us the ability to use ADT connectivity to receive real-time notifications of clinical quality metrics and admission/discharge notifications. The connectivity triggers our Care Management to engage SNFs in care coordination and communicate throughout the length of stay within the SNF. Our team assesses patients through weekly updates applying our diagnostic standardized care pathways to identify target length of stay. A social determinants of health screening tool is used to develop appropriate interventions post-discharge from the SNF that will ensure that our patients remain in the most appropriate setting. Collaborating and communicating weekly ensures that the patient receives the best outcome. Upon discharge from the SNF to the community, MPP's interdisciplinary team (patient navigators, registered nurses and social workers) communicates utilizing our electronic medical record and ADT connectivity with the PCP in the patient-centered medical homes and the specialists in the patient-centered medical home neighborhoods to ensure a safe transition of care. Upon discharge from the SNF, the patient is placed into the Transitional Care Management program. Patients are contacted telephonically for a period of 30 days addressing identified educational and psycho-social needs. If the patient requires additional coordination of care, our team will engage them into our longitudinal chronic care management programs. This program has increased our ability to maintain cost effective care, increase gap closures all while offering high quality pro-active care.

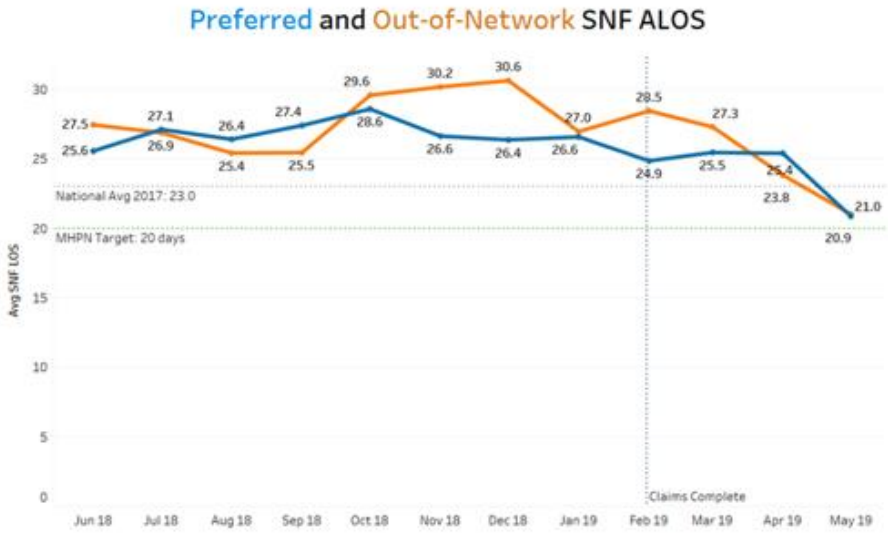
How were patients identified for the program/interventions? Analysis of our data demonstrated utilization and expenditures related to SNFs was above the national benchmark and was highly influencing our overall cost of care. It was determined that we needed to ensure appropriate utilization and reduce avoidable cost for those patients requiring skilled care. The initial targeted patients were identified as those in value-based, at-risk contracts. All patients in these contracts are included in the program. The Lansing region was selected based on volume of patients in the region's population with the rollout sequence continuing based on population size. All regions have been implemented and in place for a period of one year.

How was success measured? Please delineate whether metrics process- based or outcomes based? Success is measured using both process-based and outcomes-based metrics. All data is measured monthly and reported to the individual SNF, Utilization Management Committee, Regional Steering Committees and the MPP Board. The metrics included are as follows:

- Regional LOS Comparison (Outcome measure)
- Region Specific SNF 30-day readmission rate comparison (Outcome measure)
- Region Specific SNF 90-day readmission rate comparison (Outcome measure)
- Region Specific SNF Preferred Provider Average Cost Comparison
- % 7 Day Follow Up with Physician after discharge (Process measure)
- % Discharged to Preferred SNF Network by region (Process measure)
- Year over Year Average SNF Cost Comparison 2018/2019 (Process measure)
- Year over Year Average SNF LOS Comparison 2018/2019 (Outcome measure)

Success is also measured by determining the engagement of the SNF within the network. This is measured through timeliness of reporting, meeting attendance, administrator presence in meetings, feedback from hospital and home care.

What were the program results? The program results for the first year demonstrated an average decreased LOS of 2 days in the SNF in 8/9 regions. There was a 7% decrease in the cost per patient. Our percentage of patients discharged to an aligned SNF is at target of 80% overall. Here is a graph of our LOS data:



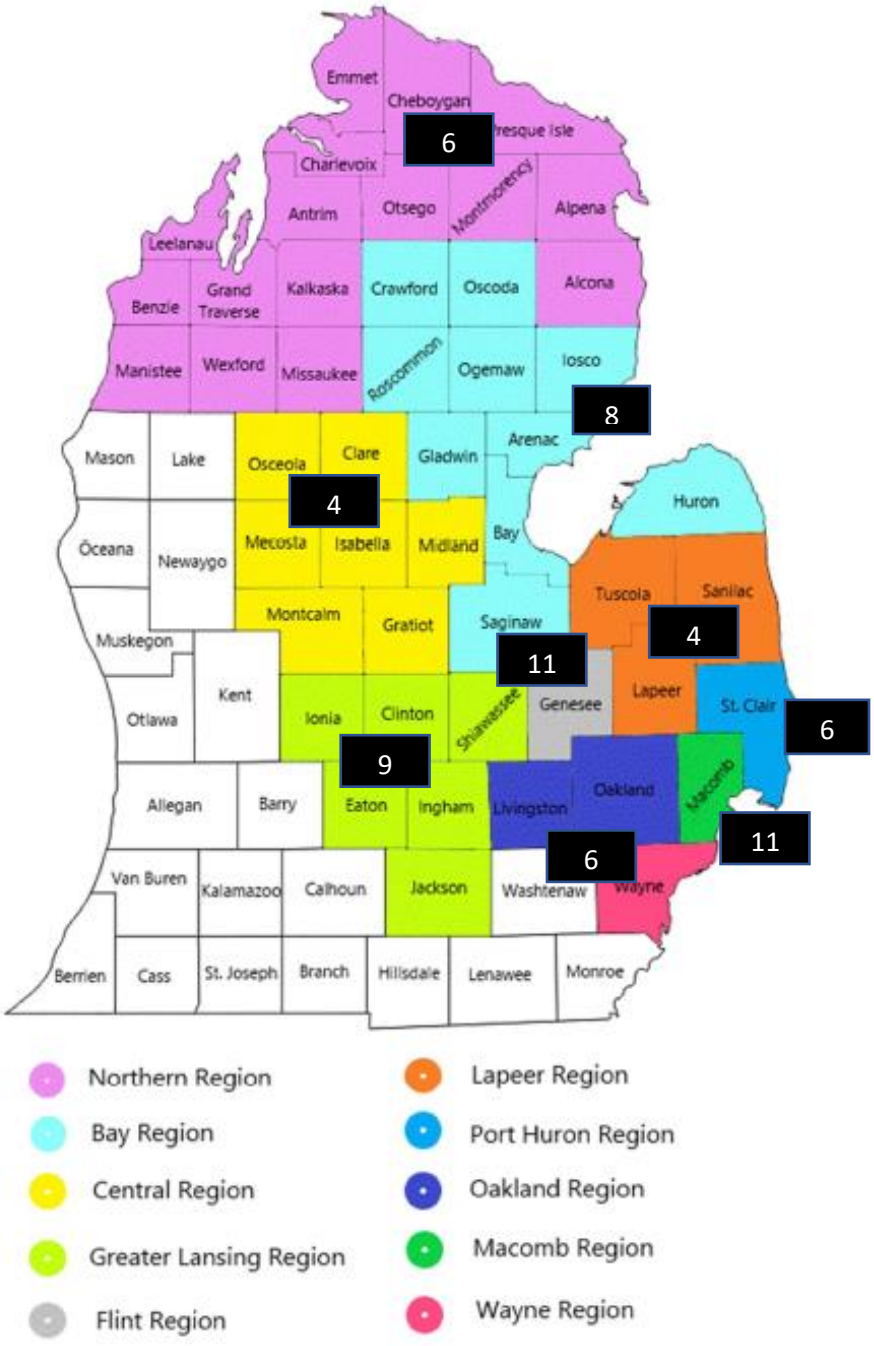
Were any *new tools, processes or resources* developed to aid in the implementation of the program/ intervention? This *SNF workflow* was designed from the ground up. McLaren optimized the use of information technology advances through the continued adoption of a case management platform that incorporates clinical quality metrics and admission/discharge notifications that can identify patients as they receive care across the continuum. During implementation and adoption, *standardized care pathways by diagnosis* and *documentation tools* were developed to capture standardized patient care data to assist with the evaluation of length of stay, clinical quality core measures and social determinates of health. Our *Social Determinants of Health (SDoH) screening assessment* was created through a combination of efforts across McLaren's internal teams, collaborating with partnering PO's/ACOs and evidence-based resources. Over the course of this program, care coordination consisted of telephonic and faxed communication. As this program has evolved care coordination has integrated into utilizing electronic communication with the use of secured portals and health information networks. In doing so, our team has been able to increase the overall volume of patients receiving care management and communicate summaries of care to the patient-centered medical homes and medical home neighborhoods.

What are you proudest of regarding this submission? Why does this work matter? This program is enhancing the standard of care through the development of an aligned SNF network across the State of Michigan. It provides layers of accountability; as an organization we are stewards of the healthcare dollar and are committed to providing the best experience with the best outcome at the lowest cost. This program has reduced the burden from the patient by partnering with the care team allowing the ability to decrease gaps in care and improve communication across the continuum. Partnering with the surrounding health systems has allowed the ability to address barriers and improve healthcare for our patients and the communities we serve.

How will your organization use the funds if your submission wins? If awarded this best practice recognition it would be used to help support the development of post-acute network demonstration pilots (see Appendix B). The focus of these pilots is to use standardized tools to identify next site of care. The outcome of the pilots is to measure, evaluate, and recommend the future next best practices.

APPENDIX A

McLaren Aligned Skilled Nursing Facility Network



APPENDIX B

Post-Acute Demonstration Pilots