

# THE ROLE OF SKILLED NURSING FACILITIES IN ACOs

Governor Mark Parkinson  
President & CEO



American Health Care Association



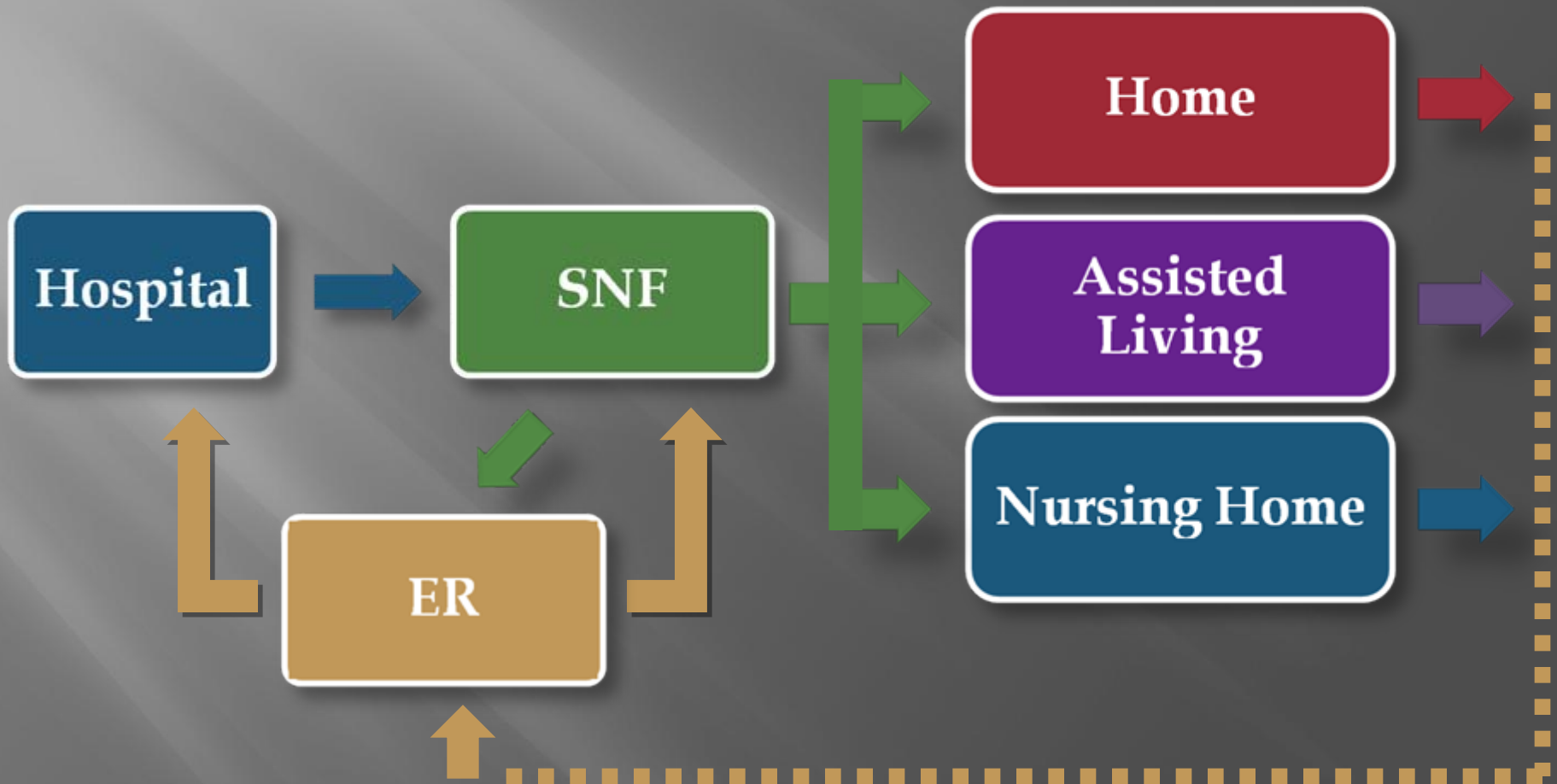
National Center for Assisted Living

# Overview

*The evolution of skilled nursing facilities*

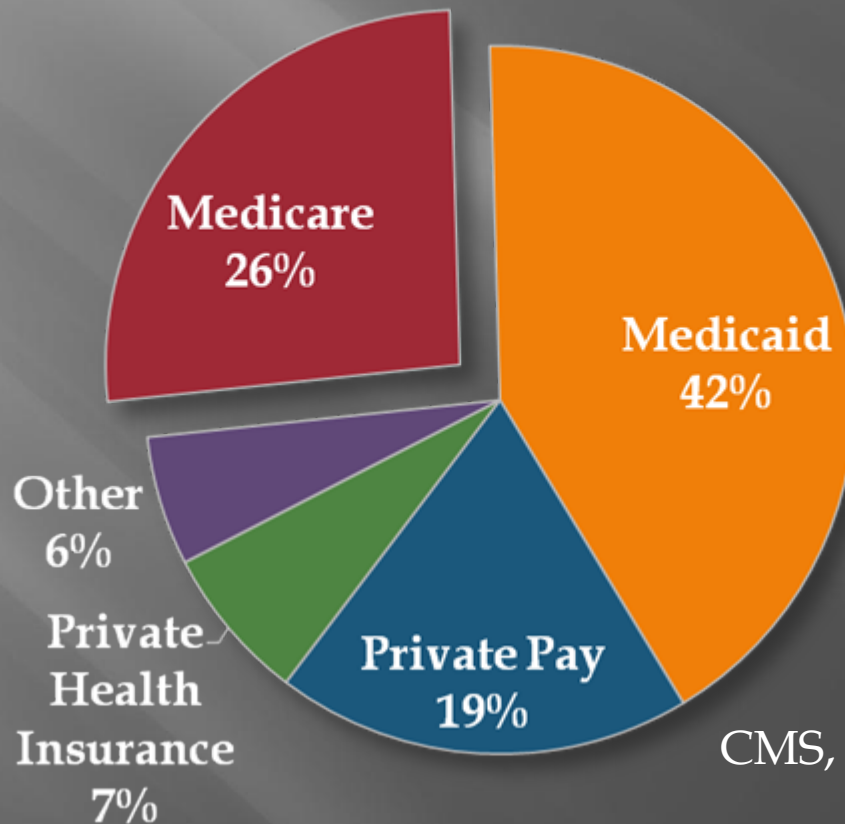


# How SNFs Fit Into the Continuum of Care



# Long Term Care Funding

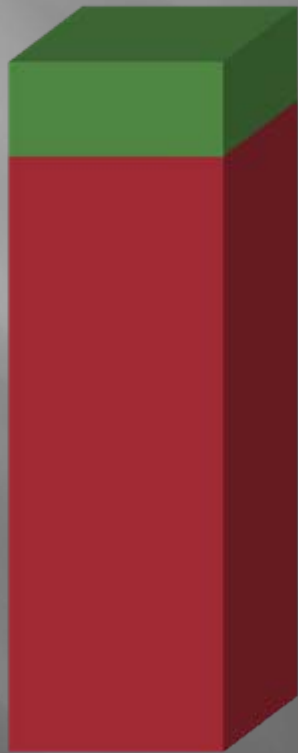
National Spending on Long Term Care  
*Projected for 2011*



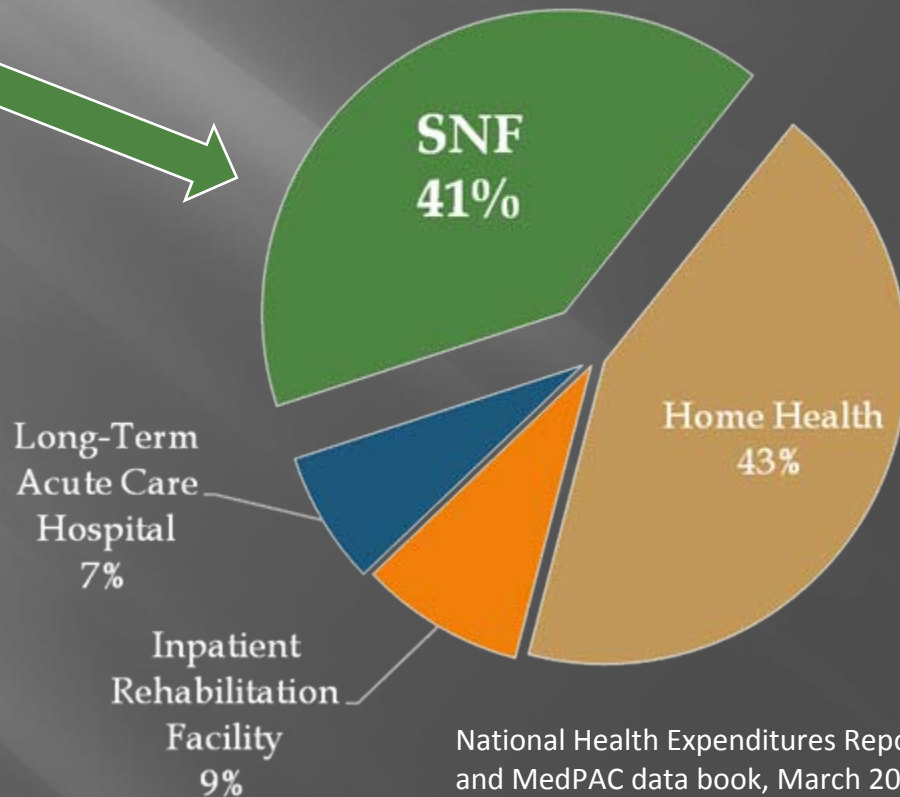
CMS, Office of the Actuary

# SNFs- An Important Component

Long Term Care Funding  
from Medicare =  
\$68 billion or 13.7%



A Breakdown of Long Term Care Funding  
from Medicare



National Health Expenditures Report through 2009  
and MedPAC data book, March 2011

# SNFs – An Important Component

1.7 million Americans received services from the 15,000 nursing facilities across the country under Medicare.

2009, Patients under Medicare Part A,  
CMS' 2010 Health Care Financing Review



# Who are we talking about?

## The 5 Most Common Conditions of SNF Medicare Beneficiaries

1. Pneumonia
2. Heart failure
3. General symptoms
4. UTI's
5. Hip fracture

*But most patients have multiple chronic conditions.*

# How SNFs Can Help ACOs Succeed

- ✓ Provide lower cost settings with high quality care
- ✓ Prevent rehospitalizations
- ✓ Safe and effective care transitions across the continuum of care

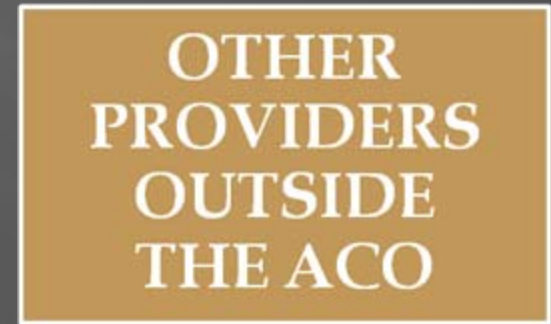
# The Role of SNFs in ACOs

## Illustrative ACO

## Value-Based Opportunities



e.g. SNF Post-Acute Facilities



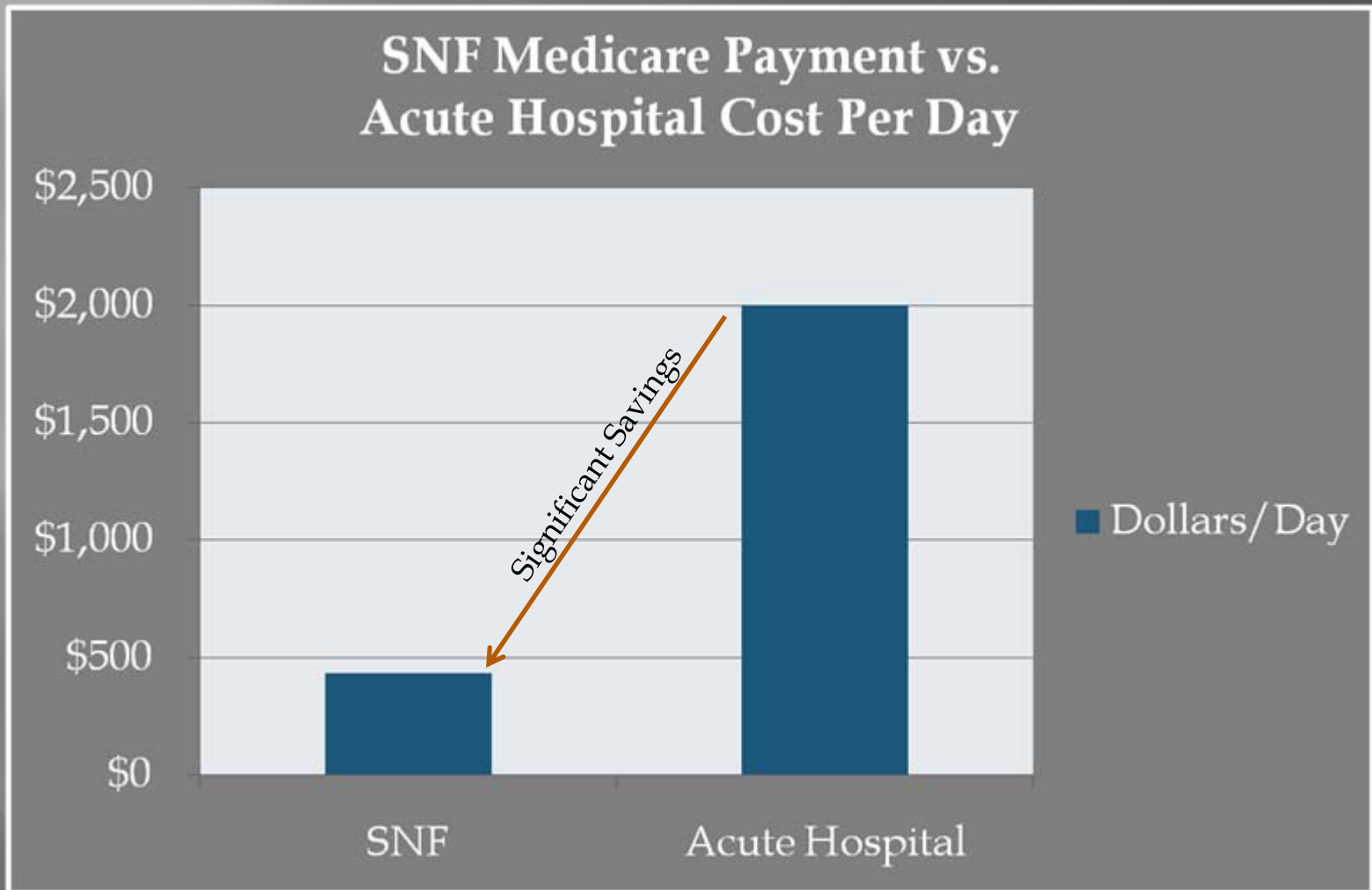
e.g. Durable Medical Equipment (DME)  
Home Health

# Low Cost/High Quality

## CMS Medicare Payments by Care Setting

Hospital Diagnosis	LTACH	IRF	SNF
Stroke	\$32,724	\$18,253	\$10,445
Hip fracture	\$27,497	\$14,117	\$11,265
Total hip replacement	\$26,315	\$11,918	\$8,399
Total knee replacement	\$22,703	\$9,722	\$5,244

# Control Health Care Costs



# Rehospitalization Rates

- ▣ Nearly one in five Medicare patients discharged from the hospital is readmitted within 30 days.
  - ≈ 2.6 million seniors
  - Cost to the system: \$26 billion annually



# SNFs are Working to Reduce Rehospitalizations

- ▣ AHCA is developing preventative strategies
- ▣ Hiring more nurse practitioners for weekends
- ▣ AHCA Member Examples:
  - From 2008-2010, Kindred Healthcare reduced rehospitalization rates after 30 days by 5.6%.
  - The Massachusetts Senior Care Association is working on a 3 state rollout of the INTERACT II program designed to help reduce rehospitalizations.

# Coordinated Post-Acute Care is Quality Care



# SNFs are Preparing for ACOs

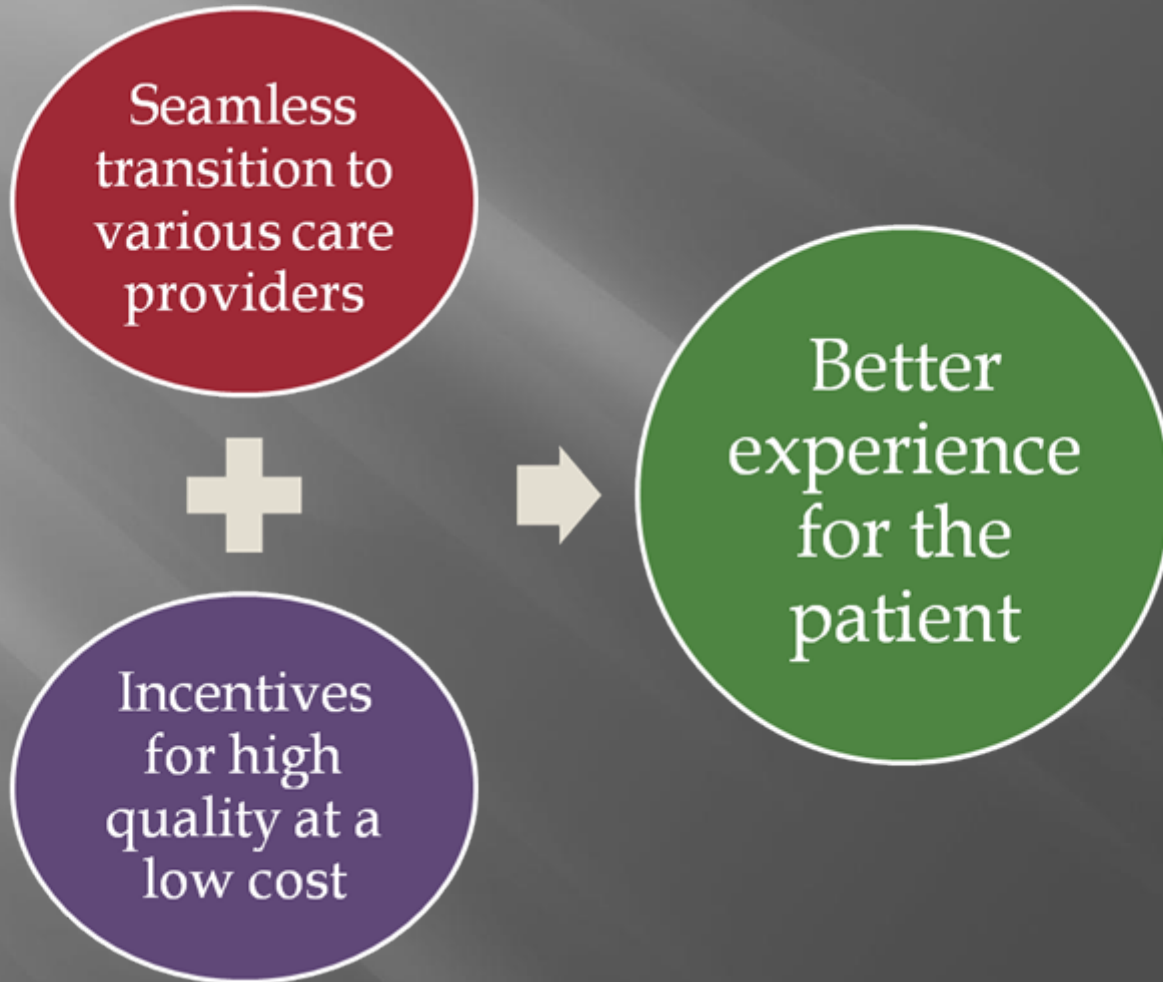
- ▣ AHCA has formally requested to be a part of ACOs through comments to CMS.
- ▣ Examples of current care coordination:
  - Genesis sponsors one of the few for-profit sponsored Program of All-Inclusive Care for the Elderly (PACE) programs – similar to ACOs - in Sharon Hill, PA.
  - Kindred has built a specific relationship with Norton Healthcare -1 of the 4 sites participating in the ACO demo project.
  - UHS-Pruitt has specific manuals directed to clinical pathways and hold weekly-monthly meetings about these pathways with hospitals. They say the key is data sharing.

# Challenges Moving Forward

- ▣ IT Development
  - Investment in expertise, resources
  - Increasing the use of electronic medical records in SNFs
- ▣ Legislative/Regulatory Opportunities
  - Elimination of Medicare 3-day stay
- ▣ Workforce Development
- ▣ Active Engagement in the Process

# The Opportunities Are Great

*A rational system should be:*



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**ncal**<sup>®</sup>

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