

Resource Guide

Cross-Sector Partnerships with Hospitals and Health Systems: A Guide for Community-Based Organizations

For hospitals, health systems and other health care providers, cross-sector partnerships are not only an effective tool for addressing social determinants of health (SDOH) and improving the health and well-being of individuals, but they can also be an effective strategy for achieving operational and financial improvements.

For hospital and health system providers participating in risk-based contracts, programs and initiatives, there are common challenges and areas for improvement that can be addressed by successful partnerships with other organizations. Community-based organizations (CBOs) seeking to build, sustain or grow partnerships with hospitals or health systems like these must understand:

- the challenges that these providers face,
- how those challenges affect them from a clinical, operational and financial standpoint,
- the pressures they face from various mandatory and voluntary health care reform programs, and
- the ways in which CBO partnerships can help improve performance and outcomes.

In this document, we will look at five common hospital challenges, explain the relevant health care policy reforms and their impact on hospital operations and effectiveness. We also provide ideas for identifying the hospitals that might benefit most from a partnership with qualified CBOs. We will also highlight some examples of existing partnerships that are already providing value for their CBO and health care provider partners—and for the populations they serve.



CHALLENGE #1:

Average Length of Stay / Throughput Issues

A challenge facing some hospitals occurs when patients remain in the hospital setting longer than is medically necessary, even when they could be discharged to lower care settings. The resulting lengths of stay present the following challenges for hospitals:

- 1. Throughput issues:** Patients with extended stays can create throughput issues, which occur when a hospital is at full capacity and does not have the space to admit new patients in need of acute-level care. As a result, these potential patients experience a long delay in care and the hospital may lose the accompanying reimbursement.
- 2. Limited reimbursement:** When patients remain in the hospital for longer stays and no reimbursement mechanism exists.
- 3. Penalties:** Hospitals participating in reform programs such as bundled payment programs and accountable care organizations may be penalized for unnecessary utilization for a defined patient population.

Understanding Relevant Reform Programs

- **Bundled Payment for Care Improvement (BPCI), BPCI Advanced, or Comprehensive Joint Replacement Program:** These bundled payment programs hold participants accountable for the costs associated with an episode of care for certain diagnoses. An episode of care includes a set of medical services provided to a patient for a specified condition within a defined period of time. Most bundled payments cover care that occurs during an inpatient stay and for up to 90 days after a patient has been discharged, including all post-acute care needs and readmissions. For detailed information about the bundled payment programs (including participation), visit the Centers for Medicare & Medicaid Services (CMS) Innovation Center website at innovation.cms.gov. Additional information can sometimes be found on the participant's website or within an annual report or news release.
- **Accountable Care Organizations (ACOs):** ACOs measure the quality and costs for an assigned beneficiary population, closely aligning provider incentives with those of health care payers, thereby delivering high-quality care and outcomes while managing costs. As a result, ACOs emphasize disease management and preventive care as a way of avoiding or limiting high-cost health care services, such as inpatient hospital stays. Medicare ACO programs include the **Medicare Shared Savings Program**ⁱ (which is most popular) and the **Next Generation ACO**.ⁱⁱ Many Medicare Advantage and commercial payer plans have also implemented ACO programs. In addition, some hospitals participate in a **Medicaid Managed Care ACO**.ⁱⁱⁱ

The CMS Innovation Center website can be used as a resource to find participants in Medicare ACOs. For others, a general online search may provide additional details. Individual ACO websites may provide details on their performance and outcomes.

In addition to these optional reform programs, hospitals are now required to participate in the **CMS Hospital Value-Based Purchasing Program (HVBP)**, which is designed to hold hospitals accountable for the costs associated with a Medicare beneficiary's episode of care. To lower costs, hospitals are incentivized to keep lengths of stay as short as is medically appropriate and to transition patients to the most cost-effective setting that corresponds to the level of care required for each patient.

The HVBP measures hospital performance in multiple quality domains or categories, including patient experience, efficiency, clinical outcomes and safety. Poor overall performance in these areas can place hospitals at risk for a penalty of up to two percent of their total base Medicare payment. The efficiency domain that factors into a provider's performance measures the hospital's Medicare Spend per Beneficiary (MSPB), which is the average cost for a Medicare patient's hospital inpatient stay, including costs that occur three days prior to the admission and 30 days after the stay. To keep this average low, providers must manage the entire care episode, which includes managing both the length of inpatient stays and use of high-cost post-acute care. This presents an opportunity for hospitals to partner with CBOs for services that manage an individual's care in the community, rather than in more costly care settings.

Medicare's Hospital Compare (www.medicare.gov/hospitalcompare/search.html) provides information on each hospital's MSPB performance in comparison to the national average. The American Hospital Directory (www.ahd.com), which profiles individual hospitals, provides limited data on a hospital's average length of stay for patients. However, the data only provides the average for a provider's Medicare population for designated conditions, so it does not provide insight on how a hospital's average length of stay compares to that of other payers, such as Medicaid or Medicare Advantage. Additional information on average length of stay can sometimes be found through a search of the hospital's annual report, online statistics provided via a website, or from previous presentations led by the provider. Data can also be purchased that provides average length-of-stay information, but it is important to note this data is often outdated.



How CBOs Can Help

If a hospital is at financial risk for performance, its leaders may be interested in exploring solutions that address common attributes of unnecessary lengths of stay. Partnerships with CBOs provide an opportunity to connect individuals with the support and services required to effectively transition them out of the hospital and into the community, when medically appropriate.

Case Study Highlight

A hospital was challenged with a very high average length of stay for their patients experiencing homelessness—an average of six weeks. To address the issue, the hospital partnered with a CBO that had experience in providing medical respite services and community-based care management services. Together, they developed a partnership to discharge this patient population, when medically appropriate, to a short-term (four-week) medical respite program managed by the CBO. Through this program, the CBO provides room and board and care management services, which includes connecting individuals to services needed beyond their respite stay, such as temporary and permanent housing services. As a result of this partnership, the hospital has experienced a two-week reduction in the average length of stay for the impacted population, with 30 percent of those served successfully transferring from the short-term respite program to permanent housing.

CHALLENGE #2:

Readmission Rates

Hospitals are increasingly held accountable for the rate of unnecessary readmissions (a hospital admission that occurs within 30-90 days of an inpatient discharge).

Understanding Relevant Reform Programs

- The **Hospital Readmission Reduction Program (HRRP)** is a mandatory CMS program that focuses on hospital readmission rates and results in a financial penalty for hospitals that perform poorly in this area. The program measures hospitals' readmission rates for key diagnoses for Medicare patients, including acute myocardial infarction, congestive heart failure, pneumonia, knee and hip joint replacement, chronic obstructive pulmonary disease, and cardiac artery bypass graft. Hospitals that have readmission rates higher than the adjusted average are susceptible to a penalty of up to three percent of their total base Medicare payment.
- There are numerous resources available to evaluate a hospital's performance in HRRP. Kaiser Health News^{iv} often provides an easy-to-use chart to see the incurred penalties for hospital providers.
- The **Hospital Value-Based Purchasing Program (HVBP)**, described earlier, also incentivizes hospitals to keep avoidable readmission rates down, as this is a direct cost contributing to MSPB.

For some, the financial risk associated with HRRP and HVBP is minimal, but the penalties of HRRP and HVBP can be substantial for others, serving as an incentive to drive readmission reduction initiatives. Participation in additional reform programs, such as the previously described bundled payment programs and ACOs, can provide an additional incentive and encourage providers to invest in solutions that lead to lowering readmission rates.

How CBOs Can Help

Readmissions often result from complications or miscommunications that occur when a patient is discharged into the community without the proper instruction or support. CBOs provide a host of services that bridge the gap between the time of the hospital discharge and the time when an individual is ready to return to the community and be fully independent. Services offered by CBOs include care coordination, home visits, meal delivery, falls prevention programs, transportation to medical appointments, and more. Partnerships between hospitals and CBOs to deliver services once a patient has been discharged from the hospital will increase the likelihood that an individual will receive the support required to avoid complications and remain healthy, thereby reducing the likelihood of a costly hospital readmission—and a readmission penalty for the hospital. There are many resources that demonstrate the potential impact of cross-sector partnerships on readmission reduction.^{v,vi}

Case Study Highlight

A hospital new to participating as a Medicare ACO quickly recognized that its success in the program could be hindered by the high readmission rates it was experiencing with their Medicare population, particularly among those with chronic conditions. Though hospital leadership recognized that they needed to address this issue, they were challenged by limited staff resources. To address the issue, the hospital developed a partnership with a CBO that provides community-based care management services, including access to a navigator who connects high-risk Medicare patients to the community services and resources they need, such as transportation services, meal delivery and/or assistive equipment. Not only has the CBO been able to better identify and manage the social needs of those touched by the service, it has also helped to decrease readmission rates and improve the satisfaction of those served—positioning the ACO to perform better within the ACO payment model.

CHALLENGE #3:

Unnecessary Health Care Utilization

Hospitals participating in mandatory and optional programs, including those that have entered into risk-based contracts with various payer types, may also be motivated to reduce health care utilization beyond readmissions (Challenge #2) and average length of stay (Challenge #1). In an effort to shift some focus from treatment to prevention, these hospitals often look to qualified CBOs to provide community support services and wellness programs.

Understanding Relevant Reform Programs

- With **Accountable Care Organizations** there is incentive to keep beneficiaries healthy, increasing the desire to use preventive and wellness services rather than more costly health care services.
- Similarly, bundled payment programs and the **Hospital Value-Based Purchasing Program** encourage hospitals to reduce costly post-acute care after a hospital stay. For example, following a hospital stay, a stay at a skilled nursing facility can sometimes be replaced with supportive services provided by CBOs in the community, positively contributing to hospital performance in these programs.

How CBOs Can Help

Addressing the social, environmental and behavioral aspects of well-being can have a great impact on overall health and health care outcomes when combined with preventative medical services. Partnering with CBOs to address the social determinants of health can provide hospitals with another avenue to keep individuals healthy in their communities, utilizing more preventative and wellness services rather than costly medical services. Multiple cross-sector partnerships that focus on addressing SDOH have demonstrated the potential to reduce expensive health care expenditures.^{vii}



Case Study Highlight

A health system participating as a Medicare ACO was looking for ways to improve its performance and recognized that it could reduce health care utilization by better identifying and addressing the social needs of individuals. However, a lack of staff resources and knowledge prevented the health system from effectively accomplishing this. As a result, the health system chose to launch a pilot with a CBO that had years of experience as a community-based care management provider. Through this partnership, the CBO provides eligible patients with an in-home assessment, a developed care plan, client and family education and resources, appointment support, in-home visits and support with referrals for additional service needs. Focused on reducing health care utilization, improving patient satisfaction, and reducing the burden on the ACO's care management staff, the pilot has seen early success and the health system and CBO are exploring ways to formalize the partnership.

CHALLENGE #4: Payer Mix

Hospitals can be challenged by the payer mix of their patient population and its impact on hospital utilization and reimbursement. Payer mix is the percentage of revenue coming from the various payer types— Medicare, Medicaid and commercial payers, as well as self-paying patients—each of which may reimburse a provider at a different rate for the same services. Payer mix is important because a higher percentage of low reimbursement patients (for example, Medicaid patients, for whom reimbursement is sometimes lower than the cost of care) can strain a hospital's financial position, and even threaten its long-term viability in the most extreme cases.

Understanding Relevant Reform Programs

Payer mix is not an issue directly tied to the performance of individual reform programs, as each of these programs is often specific to one payer population (i.e., Medicare or Medicaid beneficiaries). However, payer mix does become a concern for hospitals and health systems as they increasingly take on financial risk as a result of participation in reform programs. If hospitals perform poorly in the various programs, they encounter a reduction in revenue. Their payer mix becomes an important variable to monitor as they seek to find ways to improve their financial health.

While the American Hospital Directory (www.ahd.com) provides information on Medicare-specific cases, there are no established resources that provide payer mix information for all hospitals. However, a search of a hospital's annual report, published work and presentations, and organizational website can uncover details regarding payer mix. An [interactive dashboard](#)^{viii} for Medicare and Medicare Advantage plans from CMS also provides details on the number of beneficiaries per state or county, which might give some insight into the payer mix within a given market area.



How CBOs Can Help

For a hospital challenged by payer mix reimbursements, cross-sector partnerships may provide a way to better address the needs of individuals in high-risk, high-need populations, which account for a substantial amount of hospital costs but lower rates of reimbursement. By addressing an individual's social needs and moving them more efficiently throughout the health care continuum, and, when possible, into the community, hospitals are better positioned to achieve their desired payer mix, resulting in better financial and operational performance.

Case Study Highlight

A hospital was experiencing a throughput issue (see Challenge # 1) and found that the primary cause was that the Medicaid population that made up a large portion of their payer mix was remaining in the hospital much longer than medically necessary. This was because they were not healthy enough to return home unsupported, though not sick enough to remain in the hospital setting. They developed a community care network (CCN) to identify and partner with high-quality post-acute and community providers who could assist them in transitioning medically able patients out of the hospital by providing them with the appropriate support services necessary to meet their needs.

CHALLENGE #5: Patient Satisfaction/ Engagement

Faced with accelerating consolidation, increasing threats of financial penalties and declining incomes, hospitals are increasingly focused on preserving their market share as a means of maintaining healthy financial performance. A poor health care experience reduces the likelihood that a patient will return for treatment (when other options exist) and decreases their likelihood of recommending, rating or referring others to that provider. Hence, high patient satisfaction and strong engagement are priorities^{ix} for many hospital leaders.

Today, hospitals recognize that patient satisfaction extends beyond the inpatient experience, as unmet needs during and after discharge often color individual perceptions of the health care experience. Through partnerships, CBOs can assist hospitals with coordinating the transition process, supporting individuals as they recover after their hospital stay and in continuing patient engagement once individuals return to the community.

Understanding Relevant Reform Programs

- **Accountable Care Organizations** are required to measure patient experience as a measure of their performance quality, which in part determines their success in the program.
- **The Hospital Value-Based Purchasing Program** measures patient experience as one of the domains of the program, giving hospitals an incentive to focus on improving patient engagement and satisfaction in order to perform better in the HVBP program.

Many hospitals already have programs in place to gather their own patient satisfaction information, which may be found on their organizational website. Measures of patient satisfaction can also be found on the **CMS Hospital Compare** website (www.medicare.gov/hospitalcompare), which provides a Star Rating for hospitals across a number of factors, including patient satisfaction. *U.S. News & World Report* (<https://health.usnews.com/best-hospitals/search>) also provides profiles of individual hospitals and key information for each, including patient satisfaction.

How CBOs Can Help

Partnering with CBOs to better meet the needs of individuals can have a positive impact on their care satisfaction, health and well-being. The hospital's role in seamlessly connecting individuals to services that can meet their needs is likely to play a role when an individual considers their care experience.

Case Study Highlight

Patient satisfaction may not be the primary driver for pursuing partnerships, but it is often defined as an important goal and measured as an important outcome when evaluating the benefits and effectiveness of those partnerships.

For example, in the case study highlighted for Challenge #2, the ACO-CBO partnership monitored patient satisfaction and engagement, and initial results indicated a 90 percent engagement rate. The program highlighted as the case study in Challenge #3 also identified patient satisfaction as a priority measure to monitor.

YOUR NEXT STEPS

- Make the time to understand the reforms and other factors affecting providers in your area, starting with an understanding of the reform programs highlighted in this paper.
- Identify which providers in your area are most at risk, using the resources suggested in this paper and/or through your own knowledge of and research into your market.
- Determine which of the hospital challenges your CBO is best able to address, in partnership with local hospitals, health systems or other providers.
- Define your own value proposition to position your CBO as a viable and valuable partner for helping providers address these challenges, improve performance and deliver better outcomes in your community.

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- i. <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/about.html>
- ii. <https://innovation.cms.gov/initiatives/Next-Generation-ACO-Model/>
- iii. <https://www.naacos.com/medicaid-acos>
- iv. <https://khn.org/news/under-trump-hospitals-face-same-penalties-embraced-by-obama/>
- v. <http://alliance1.org/AsiCommon/Controls/BSA/Downloader.aspx?iDocumentStorageKey=7e39c7d6-7e0b-4532-9305-be96ac7a1b3a&iFileTypeCode=PDF&iFileName=Partnership%20for%20Healthy%20Outcomes%20Virginia%20Case%20Study>
- vi. <https://www.healthcarefinancenews.com/news/why-hospitals-should-align-aging-agencies-reduce-readmissions>
- vii. <https://www.modernhealthcare.com/article/20180402/NEWS/180409994>
- viii. <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Dashboard/Medicare-Enrollment/Enrollment%20Dashboard.html>
- ix. <https://www.acep-rso.org/the-fast-track/the-business-of-healthcare-how-patient-satisfaction-plays-a-role/>