



Creating Your Post-Acute Collaborative (PAC) Tip Sheet

Who should be included in your PAC?

Type of Organization	Decision-Making Staff Members
Skilled nursing facilities	Nursing Home administrators, Directors of nursing, Case managers
Home health agencies	Executive directors
Medical groups	Associated physicians
Community-based organizations (CBOs)	Care managers, directors

What data will be tracked?

State your facility’s goals to reduce avoidable hospital transfers, admissions, readmissions, and emergency department visits. Be prepared to collect:

- The average number of patients you send to post-acute partners.
- The percent of those transfers to post-acute that readmitted within in seven days.
- The percent of emergency department treated and released back to post-acute.
- The current 30-day readmission rate among those patients.
- Your facility’s goal to reduce preventable and unnecessary hospital transfers.
- Your facility’s goal related to length of stay.

Set clear expectations for your collaborative.

State your facility’s expectations from this collaborative. Be open to your partners’ goals and needs and adjust as needed.

- Set up a memorandum of agreement (MOA) or charter for participation.
- Establish meeting frequency and participation metrics.
- Establish a plan for data sharing (e.g., monthly, using a dashboard, sending a report to coordinator).
- Obtain a key point of contact for all preferred providers in the PAC.

Establish goals that will improve transitions of care with your partners.

Increase the skills and knowledge of your local partners to improve the overall quality of care in your community.

- Agree on a collective intervention to affect the community rate.
- Identify educational opportunities among your partners.
- Invite your Quality Improvement Organization (QIO) to facilitate the discussion on collaboration and share Medicare readmission data.