

# 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.