Door-to-Discharge Disposition: Why Post-Acute Care Transitions Are More Important Than Ever

2014 Fall Managed Care Forum

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Presentation Objectives

1. Understand the importance of post-acute care (PAC) services in treating major health episodes and managing chronic diseases to optimize health and patient independence within the context of healthcare reform and related current initiatives

2. Demonstrate the role of PAC services in reducing healthcare spending

3. Address the need for collaboration, coordination and communication among hospitals and PAC service providers in providing specialized and appropriate care along the continuum of care, thereby improving the healthcare delivery system
Post-Acute Care (PAC)

Post-acute care is the skilled nursing care and therapy typically furnished after an inpatient hospital stay. It is provided in a variety of settings, including skilled nursing facilities (SNFs), inpatient rehabilitation facilities (IRFs), long-term care hospitals (LTCHs), and in patients’ homes by home health agencies (HHAs). Often provided with the goal of shortening a patient’s hospital stay, post-acute care is just one component of a broad care delivery continuum.¹

¹ Statement by Jonathan Blum, Director, Center for Medicare Management on Post-Acute Care in the Medicare Program before the House Committee on Ways and Means Subcommittee on Health

Research

Studies have demonstrated that patients who receive PAC following a major medical event have improved clinical outcomes when compared to patients who are discharged to home without follow-up care, e.g.

> Compliance with post-acute rehabilitation guidelines was associated with improved patient outcomes/functional recovery in stroke patients ¹

Assessment Upon Discharge from Acute Care

> Patients have diverse healthcare needs, i.e., same discharge diagnosis may require different PAC services

> Patients should be assessed, considering
  – Clinical comorbidities
  – Complications
  – Functional status, cognitive ability
  – Post-hospital care required (facility, professional)
  – Family support
  – Home environment
  – Patient preferences
  – Insurance coverage (PAC services are covered by Medicare and other public and private payers) and patient’s financial capacities (Medicaid eligibility)

> Patients should be transitioned to the most appropriate PAC services available

Acute-Care Hospital and PAC provider Coordination is essential to improving Quality of Care and Reducing Spending

> Medicare has implemented penalties for hospital readmissions within 30 days of discharge [Patient Protection and Affordable Care Act (PPACA), FY 2012 IPPS]

> Medicare national readmission rate is approximately 20% within 30 days of discharge (34% within 90 days), with an estimated 76% of these being preventable ¹

> Medicare data indicates more than half of readmitted patients received no care or follow-up in the 30 days after initial hospitalization ¹

> Interventions targeted toward PAC transitions can reduce admission rates by 1/3 ² as well as unnecessary use of the ED


In 2013 CMS Issued Guidance for Transition Planning/Community Care Transitions (i.e., hospital discharge planning)

- Medicare discharge planning is a Condition of Participation for hospitals
- Discharge planning process must be available to all patients (not only Medicare)
- Detailed role/functions in transition of patients from hospital to other care settings, including home
- Transition planning to improve the quality of care for patients and reduces chances of readmissions
- May also include outpatient observation patients (SDS, ED) with complex medical needs
- Hospitals must know capabilities/capacities of facilities to which they refer patients
- Patient and family/patient representative involvement; team approach

PPACA Has Established Transitional Care Programs and Services

- To improve the quality of care
- To reduce healthcare costs
- To assist hospitalized patients with complex chronic conditions transfer from one level of care to another in a safe and timely manner
- To reduce avoidable hospital readmissions
Community-Based Care Transitions Program [PPACA, Section 3026]

> Provides $500M from 2011 to 2015 to health systems/community organizations that provide at least one transitional care intervention to high-risk Medicare beneficiaries, e.g.,
  – Initiation of services no later than 24 hours prior to patients' hospital discharges
  – Timely post-discharge follow-up services to patients and family caregivers
  – Assistance to patients and post-acute/outpatient providers
  – Assessment and active engagement of patients and family caregivers through self-management support
  – Comprehensive medication review and management

Medicare and Medicaid Innovation Within CMS [PPACA, Section 3021]

> Creates a Center for Medicare and Medicaid Innovation (CMI) to test innovative payment and service delivery models to reduce program expenditures while preserving or enhancing the quality of care

> Models must address a defined population for which there are deficits in care leading to poor clinical outcomes, or potentially avoidable expenditures

> Appropriates $10B for FY 2011 – 2019 and each subsequent ten-year period starting with 2020
Additional Programs That Support Care Transitions

> Medicare Shared Savings Programs [PPACA, Section 3022]
  – Medicare ACOs to submit performance data addressing care transitions across healthcare settings

> Health Homes [PPACA, Section 2703] – designed to provide comprehensive care management, including transitional care, to patients with chronic conditions

> Bundled Payments [PPACA, Section 3023] tests integrated, episode-based payments and care delivery models including transitional care

PAC: Role in Reducing Healthcare Costs

> Lower costs per-patient-day (relative to inpatient acute care)
> Reduces avoidable hospital readmissions
> Avoids unnecessary ED care
> Delivers medically appropriate care along the continuum of care
  (i.e., “providing the right care, at the right time, in the right place”)
> Improves the quality of healthcare outcomes
Providers: PAC Requirements and Opportunities

- Care coordination processes
- Collaborations between hospitals and healthcare providers
- Regulatory compliance
- New technological infrastructures to support PAC transition interventions
- New service opportunities
- Changing reimbursement

Post-Acute Care Coordination Processes

- Designed to prevent readmissions, bridge gaps in care
- CMS initiatives
  - Bundled Payments for Care Improvement (BPCI) – PAC marketplace
    » Retrospective Acute care Hospital Stay plus Post-Acute Care Model 2
    » Retrospective Post-Acute Care Only Model 3
  - Hospital Readmissions Reduction Program, effective October 1, 2012:
    Readmission penalties/payment adjustments for readmissions for selected diagnoses within 30 days
  - PPACA-mandated multiple-provider approvals to ensure that patients have legitimate need for services (i.e., minimize medically unnecessary care)
Collaborations Between Hospitals and PAC Providers

> Reasons for collaboration: Hospital discharge planning requirements, readmission penalties, ACOs

> PAC facilities concerned with patients discharged to their facilities with care needs that exceed their capacity

> Hospitals concerned with PAC providers inappropriately sending patients to ED

Collaborations Between Hospitals and Healthcare Providers, Cont.

> Follow-up on post-discharge transition and care
  – CMMI’s Community-Based Care Transitions Program (CCTP) – models for improving care transitions from hospital to other settings, reducing readmissions for high-risk Medicare beneficiaries
    » Community Based Organizations (CBOs) are paid an all-inclusive rate per discharge based on cost-of-care transition services at patient level for 180-day period

  – Dual Eligible Programs
    » Duals: complex health needs, high-cost beneficiaries
    » Test financial models to help states improve quality, coordinate care, improve care delivery; share in lower costs
    » Reduce preventable inpatient hospitalizations among residents of SNFs by providing needed treatment
    » Two models with shared savings
      1. Capitated model: Agreement between state, CMS, MCO
      2. Managed FFS model: Agreement between state and CMS
Example: Health System Partnership with PAC Providers

> North Shore LIJ and PAC non-system sub-acute partners

> Selection criteria
  – Quality metrics: Nurse staffing ratios, Medicare’s Nursing Home Compare star ratings
  – Geographic proximity to system hospitals
  – Referral patterns

> Joint quality initiative: Heart failure patients at partnering SNFs receive similar protocol-driven care/treatment in SNF as in hospital

Example: Health System Partnership with PAC Providers, Cont.

> Focus: Safety, quality and efficiency of care transitions

> Results
  – Reduced readmissions
    » Standardized treatment protocol for SNF patients with heart failure reduced the heart failure re-hospitalization rate within the SNF affiliate network ~6% in 2010 to 2% in 2012
    » Improved communication/collaboration reduced all-cause readmission rate within the network from 13% in 2010 to 7.5% in 2012
  – Decreased PAC costs
  – Improved quality of care
    » 2008-2010: Increased Medical Orders for Life-Sustaining Treatment by 40 percentage points, from 10% to 50% of patients
Example: Health System Partnership with PAC Providers, Cont.

> Reporting (monthly)
  ¬ LTC mortality rate
  ¬ LTC hospitalization index
  ¬ Total readmission rate within 30 days
  ¬ Total readmission rate within 72 hours

Regulatory Compliance

> Inpatient rehabilitation facilities (higher acuity than SNFs):
The “75% Rule” distinguishes IRFs from general acute hospitals; to participate in Medicare the Rule requires that a certain percentage of IRF patients fall within 13 diagnostic categories, i.e., the Rule limits the number/types of IRF patients who are not within the 13 categories, including cardiac, pulmonary, cancer, pain, and joint replacement patients
Regulatory Compliance, Cont.

- Increased quality reporting requirements
  - IRF: Inpatient Rehabilitation Facility-Patient Assessment Instrument (IRF-PAI)
  - SNF: Minimum Data Set (MDS)
  - Hospice: Quality Assurance/Performance Improvement (QAPI)
  - HHA: Outcomes and Assessment Information Set (OASIS); challenge to HHA as care is not easily monitored

- Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014

- Requires post-acute care (PAC) providers to report standardized patient assessment data, data on quality measures, and data on resource use and other measures;
  - Require the data to be interoperable to allow for its exchange among PAC and other providers to give them access to longitudinal information so as to facilitate coordinated care and improve Medicare beneficiary outcomes; and
  - Modifies PAC assessment instruments applicable to PAC providers for the submission of standardized patient assessment data on such providers and enable assessment data comparison across all such providers.
Regulatory Compliance, Cont.

> Regulation and reporting requirements increase PAC providers overhead, increase need for outsourcing to quality and outcomes measurement companies, require more provider infrastructure and processes, and decrease employee productivity in the pursuit of increasing quality.

New Technological Infrastructures to Support PAC Transition Interventions

> Use of assistive technologies can result in
  - Fewer hospitalizations and ED visits
  - Improved health and outcomes
  - Increased patient satisfaction
  - Improved quality of life
  - Reduced costs of care

> Center for Technology and Aging Tech4Impact Diffusion Grants Program
  - Expands use of technologies for improving PAC transitions and reduce avoidable rehospitalizations
New Technological Infrastructures to Support PAC Transition Interventions, Cont.

> Applications: Examples ¹

- Medication adherence: Medication reminders and dispensers
- Medication reconciliation: Medication list software
- Remote patient monitoring: Home diagnostic devices
- Personal health information: Problem detection algorithms
- Social support: Social media
- Remote training and supervision: Videoconferencing

¹ CTA Technologies for Improving Post-Acute Care Transitions, Position Paper, September 2010, Discussion Draft

New Service Opportunities

> HHA expand service offerings in assisted living facilities and patient homes, i.e., “healthcare at home” – strengthen transitional care linkages, lower costs

> Expanded transitional care serving broad spectrum of patient needs in the home (e.g., mobile diagnostics, home monitoring of vitals, mobile EMR, patient education, nutritional support)
New Service Opportunities, Cont.

> Physician-led PAC management services
  - Post-discharge monitoring of care and treatment, triage as needed, for 30 days

> Consolidated services along the continuum of care
  - Partnering opportunities with health systems, ACOs

> PAC transportation

The Future of Reimbursement

> Provider scrutiny from regulators regarding profitability, e.g.,
  - In 2010, SNF and HHA generated 18-20% Medicare profit margins, inpatient facilities lost approximately 5% in margin on aggregate Medicare reimbursement

> Changing reimbursement methodologies, e.g.,
  - Sequestration cut of 2% for Medicare FFS claims after April 1, 2013
  - Home healthcare: CMS/PPACA proposed rebasing reimbursement rates and methodologies to align payments with cost (14% cut over 4 years)
  - SNF: As of October 1, 2011, average 11.1% reimbursement cut; changes in Medicare billing rules for individual patient therapy care
  - Hospice: CMS/PPACA Demonstration program to cover concurrent curative care (paid at FFS) and palliative care ($400 per beneficiary/month)

> Financial risk for population health

1 MedPac, Report to Congress: Medicare Payment Policy, March 2012
In Summary

>
The aging population will increase demand for post-acute care services

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Growth in PAC spending makes controlling post-acute spending a focus for CMS

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Successful healthcare reform will address
  – Care management
  – Alignment of payment with costs
  – Provider incentives for
    » Early intervention
    » Coordination of care
    » Managing patient compliance
    » Care in the most efficient setting
    » Reduced inpatient readmissions
  – Accountability for patient outcomes

In Summary Cont.

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Effective programmatic interventions address PAC as part of the broad continuum of care, e.g.,
  – Medicare shared-savings
  – Bundled payments
  – Community-based Care Transitions

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Provider-enabling technologies (e.g., mobile diagnostics, patient-monitoring technologies) will support moving care delivery down the continuum

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Providing PAC services and/or partnering with PAC providers will provide business opportunities for strategically-minded healthcare systems moving toward assuming the financial risk of managing population health
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