Continuing the Journey:
The Post-Acute Care Patient Experience

California Hospital Volunteer Leadership Conference
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Why Post-Acute Care?

Many hospital patients utilize at least one post acute care service.

The outcome and success of an individual’s acute medical care is often dependent on effective and appropriate post acute care.

To succeed clinically and financially under health care reform, acute care providers must partner with post acute providers.
“Post-Acute Care” includes several specific provider groups.

Additional services (medical and other) are used by patients discharged from acute care.
Major Post Acute Care Provider Groups:

- Inpatient Rehabilitation Facilities (IRFs)
- Long Term Acute Care Hospitals (LTCHs)
- Skilled Nursing Facilities (SNFs)
- Home Health Agencies
Post-Acute Care Services

Major post-acute care provider groups are defined and differentiated by:

• Facility requirements
• Program requirements
• Patient characteristics

Each PAC service has a specific Medicare PPS system.
Inpatient Rehabilitation Facility (IRF)

- May be a free-standing hospital or unit in a larger hospital.
- Provides specialized level of care including medical management and intensive therapy for persons who have suffered a disabling injury or illness, for example stroke or orthopedic surgery.
- Average length of stay 2-3 weeks.
- Reimbursed on case rate, based on patient diagnosis and functional independence.
Long Term Acute Care Hospital (LTCH)

- May be free standing or established as a “hospital within a hospital” (HwH).
- Provide extended care to patients with very complex medical and rehabilitation needs, for example ventilator-dependent, complex wound care.
- Average length of stay > 25 days.
- 2 - 3 weeks.
- Reimbursed on case rate, based on DRG.
Skilled Nursing Facility (SNF)

• May be free-standing/community-based or distinct part of hospital.
• May provide short term transitional care or long-term residential care.
• Serve patients who meet specific “skilled” criteria.
• In CA, may include sub acute care unit.
• Reimbursed on per diem rate.
Hospital Based SNFs

- Licensed as a distinct part (DP) of the acute care hospital.
- Typically have higher staffing, better outcomes than FS SNFs: Often treat patients of greater complexity, higher acuity.
- Frequently only option for patients not accepted by other (FS) SNFs.
- Medi-Cal reimbursement for DP SNFs is different from that of FS SNFs.
- Many CA DP NFs have closed in recent years.
Home Health Agencies (HHA)

May be independent or affiliated with hospital or health system.

Provide medical and therapeutic services to home-bound individuals.

Reimbursed for episode of care, based on patient clinical characteristics.
# Current Medicare Payment

<table>
<thead>
<tr>
<th>Feature</th>
<th>Skilled Nursing Facilities (SNF-PPS)</th>
<th>Inpatient Rehabilitation Facilities (IRF-PPS)</th>
<th>Long-term Care Hospitals (LTCH-PPS)</th>
<th>Home Health Agencies (HHA-PPS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unit Basis</td>
<td>Per diem</td>
<td>Per case/per hospitalization</td>
<td>Per case/per hospitalization</td>
<td>Per 60-day episode of care</td>
</tr>
<tr>
<td>Case-mix adjuster</td>
<td>Resource Utilization Groups (RUGs)</td>
<td>Case Mix Groups (CMG)</td>
<td>Diagnosis –Related Groups specific to LTCH patients (LTMS-DRG)</td>
<td>Home Health Resource Groups (HHRGs)</td>
</tr>
<tr>
<td>No. of case-mix groups</td>
<td>66</td>
<td>92 CMGs x 4 comorbidity “tiers”= 368 groups</td>
<td>540</td>
<td>153</td>
</tr>
<tr>
<td>Input document/ information Source</td>
<td>Minimum Data Set (MDS)</td>
<td>Patient Assessment Instrument (IRF-PAI)</td>
<td>ICD-9-CM codes</td>
<td>Outcomes &amp; Assessment Information Set (OASIS)</td>
</tr>
</tbody>
</table>
Other PAC Services

Additional medical services may be utilized by patients after discharge from acute care.

- Hospices
- Adult Day Health Centers (ADHC)/Community Based Adult Services (CBAS)
- Program of All-Inclusive Care for the Elderly (PACE)
- Outpatient medical and therapy services
- Hospital based clinics providing primary care
Case management is a collaborative process that includes the assessment, planning and coordination of options and services to meet a patient’s medical care needs. Effective case management utilizes available resources to achieve high-quality and cost-effective outcomes.
Case Management

*Discharge planning*: provide patient and family support and information to assist transition to post acute care.

*Utilization Review*: Monitor the appropriateness, necessity and quality of health care services; communicate with payers.

*Care Coordination*: provide coordination of medical and social services to manage transitions of care, support chronic care management, etc.
Many hospital patients are discharged to post-acute care

Over 40% of Medicare patients are discharged to at least one post-acute service

Source: Gage, et al. Examining post-acute relationships in an integrated hospital system, ASPE, 2009
Many patients utilize more than one level of post-acute care

Post-acute care utilization has grown significantly

Medicare FFS expenditures in billions

- 2003: $34.1 (Post-Acute $98.4, Acute $98.4)
- 2007: $48.2 (Post-Acute $106.8, Acute $106.8)
- 2011: $60.3 (Post-Acute $116.7, Acute $116.7)

Source: CMS.
The growth in post-acute care utilization continues

Source: CMS Office of the Actuary.
Utilization of post-acute care varies widely by region.

Utilization of the various levels of post-acute care also differs widely by region.

Patients with similar diagnoses/characteristics may be admitted to different levels of care.
Post-acute care affects episode of care payment & costs

Total Medicare episode payment by first setting for post-discharge care, 30-day fixed-length episode, major joint procedure (MS-DRG 470), 2007-2009

Patient functional ability affects care costs

Distribution of episodes & average Medicare episode payment by functional ability score for 30-day fixed-length episodes (2007-2009)

Source: Dobson/DaVanzo analysis of research-identifiable 5 percent SAF for all sites of service, 2007-2009.
Post-Acute Care & Hospital Readmissions

Percent of 30-day fixed-length episodes with readmissions by first setting of post-discharge care

Sources: RTI International and Cain Brothers’ Analysis.
Post-acute care & hospital readmissions

The highest percentage of readmissions comes from patients who did NOT receive post-acute care

Percent of readmissions by source, 30-day fixed length episodes, 2007-2009

Patient functional ability affects care costs

Distribution of episodes & average Medicare episode payment by functional ability score for 30-day fixed-length episodes (2007-2009)

Source: Dobson/DaVanzo analysis of research-identifiable 5 percent SAF for all sites of service, 2007-2009.
Impact of Transition Care on Readmissions

Percent of Patients with Re-hospitalization

<table>
<thead>
<tr>
<th>Time Period</th>
<th>Patient Who Did Not Receive Transition Care</th>
<th>Patient Who Received Transition Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Within 30 Days</td>
<td>11.9%</td>
<td>8.3%</td>
</tr>
<tr>
<td>Within 90 Days</td>
<td>22.5%</td>
<td>16.7%</td>
</tr>
<tr>
<td>Within 180 Days</td>
<td>30.7%</td>
<td>25.6%</td>
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The Affordable Care Act (ACA) of 2010 initiates comprehensive and far-reaching changes to health care service delivery:

- Coverage
- Payment policies
- Delivery system reforms
Coverage

The ACA results in significantly expanded coverage: many more individuals have access to health care insurance, and fewer individuals will be uninsured.

The implications for access to services and impact on hospitals and other health care providers is not yet clear.
Payment Policies

The ACA implements several payment policy changes with significant implications for hospitals and health care providers.

- Productivity adjustments/Rate reductions
- Quality Reporting Program (QRP)
- Hospital Readmissions Reduction Program (HRRP)
- Hospital Consumer Assessment of Health Providers and Systems (HCAHPS)
Delivery System Reforms

Several components of the ACA will result in far changes in our delivery system

• Accountable Care Organizations
• “Bundled” payment
• Demonstration programs
HCR Changes Incentives

Current Health System
• ↑ procedures = ↑ revenue
• payment depends on site
• promotes “silos of care”
• promotes “serial” care
• limited attention to outcome
• emphasizes institutional care

Health Care Reform
• ↑ procedures = ↑ cost
• payment depends on patient
• ↑ coordination of care
• improved care transitions
• ↑ attention to outcome
• promotes community care
Health Care Reform will significantly change reimbursement incentives.

Acute care providers will need to work closely with post-acute care services and providers.

Post-acute providers will be challenged to demonstrate value to acute care providers and other stakeholders.
Implications for Hospitals

Medicare (and other) reimbursement will be based on patient characteristics – not provider type.

Payment will be tied to outcomes, quality – not quantity.

Health systems will manage to cost – not revenue.
# Implications for Hospitals

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<tr>
<th>When</th>
<th>Financial Incentive</th>
<th>PAC Service Characteristic</th>
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<tbody>
<tr>
<td>Pre-2013</td>
<td>LOS reduction</td>
<td>Quick Patient Transfer</td>
</tr>
<tr>
<td>Present</td>
<td>LOS reduction <em>Plus</em> avoid readmission penalty</td>
<td>Quick patient transfer, low readmission rate</td>
</tr>
<tr>
<td>Future (ACO’s, Bundling)</td>
<td>LOS management, maintenance of quality of care, overall cost control</td>
<td>Timely patient transfer, low readmission rate, good quality performance, positive patient satisfaction, cost effectiveness, LOS management</td>
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Health care reform expands the focus of payment & policy

**Future Focus Areas**

**Current Focus Areas**

- Ambulatory, Primary & Chronic Care
- Ambulatory Specialty Care

- Inpatient Care

- Long-Term Care Hospital
- Inpatient Rehabilitation Facility
- Skilled Nursing Facility
- Home Health Care
- Hospice
Implications for Hospitals

Acute hospitals will develop, acquire, partner with more post-acute and home and community based services.

Hospitals will place greater emphasis on management of transitions of care and on care coordination before, during and after hospitalization.
The increased focus on outcomes of care and patient satisfaction will have significant implications for care delivery and the patient experience, and provides new opportunities for volunteer services.
Implications for Volunteer Services

The ongoing implementation of health care reform will result in greater opportunities for volunteer services.

- Patient experience of care
- End of life care
- Support for functional independence/ADL
- Community support
- Advocacy/"Navigation"
Reimbursement will be affected by provider’s performance on quality indicators, including patient satisfaction.

Patient satisfaction is closely related to patient experience/perception, not solely clinical outcome.

*Volunteer roles* — patient visitation, care support.
End of Life Care

Over 25% of Medicare expenditures are spent in the last 6 months of life. Impact on quality and outcomes are questionable.

Hospice services can provide patient-centered care and improve quality of life.

*Volunteer roles* — patient visitation, pastoral care.
Rehabilitation Support

There will be a greater demand for programs and services that support in individual’s ability to achieve and maintain functional independence, including mobility and self-care.

*Volunteer roles* — therapy support activities, exercise, activities of daily living support.
Community Support

HCR will support the development and implementation of new models of community support, to assist individuals to remain in the community.

*Volunteer roles* — “check-in” and visitation, transportation, support for home management and self-care.
Advocacy & Navigation

Patients/consumers will continue to have numerous choices for health care coverage and health care providers. Health care providers will seek to partner with patients and consumers. There will be an increased need for information and support in making care decision.

*Volunteer roles* — facilitation of communication and navigation of care, ombuds programs.
Thank You!

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