Post-Acute Care and Bundled Payments: Why Is This Important to You?

Part 1 in a Two-Part Webinar Series

Louise Bryde, RN, BSN, MHA
Carla Brock Wilber, DNP, RN, NE-BC
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NATIONAL RURAL HEALTH RESOURCE CENTER

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Learning Objectives

- ✓ Understand the types of post-acute care
- ✓ Recognize the relationship between transitions of care and hospital readmissions
- ✓ Become familiar with the IMPACT Act and its implications
- ✓ Identify risk factors for readmissions
- ✓ Examine utilization, cost and quality in post-acute care

What Is Post-Acute Care?

Post-Acute Care Lexicon

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Acronym	Term	Relative Cost
IRF	Inpatient Rehabilitation Facility	$$$$
SNF	Skilled Nursing Facility	$$$
LTAC/LTACH	Long-Term Acute Care/Long-Term Acute Care Hospital	$$$
HHA	Home Health Agency	$$

Challenges in Administering PAC Services

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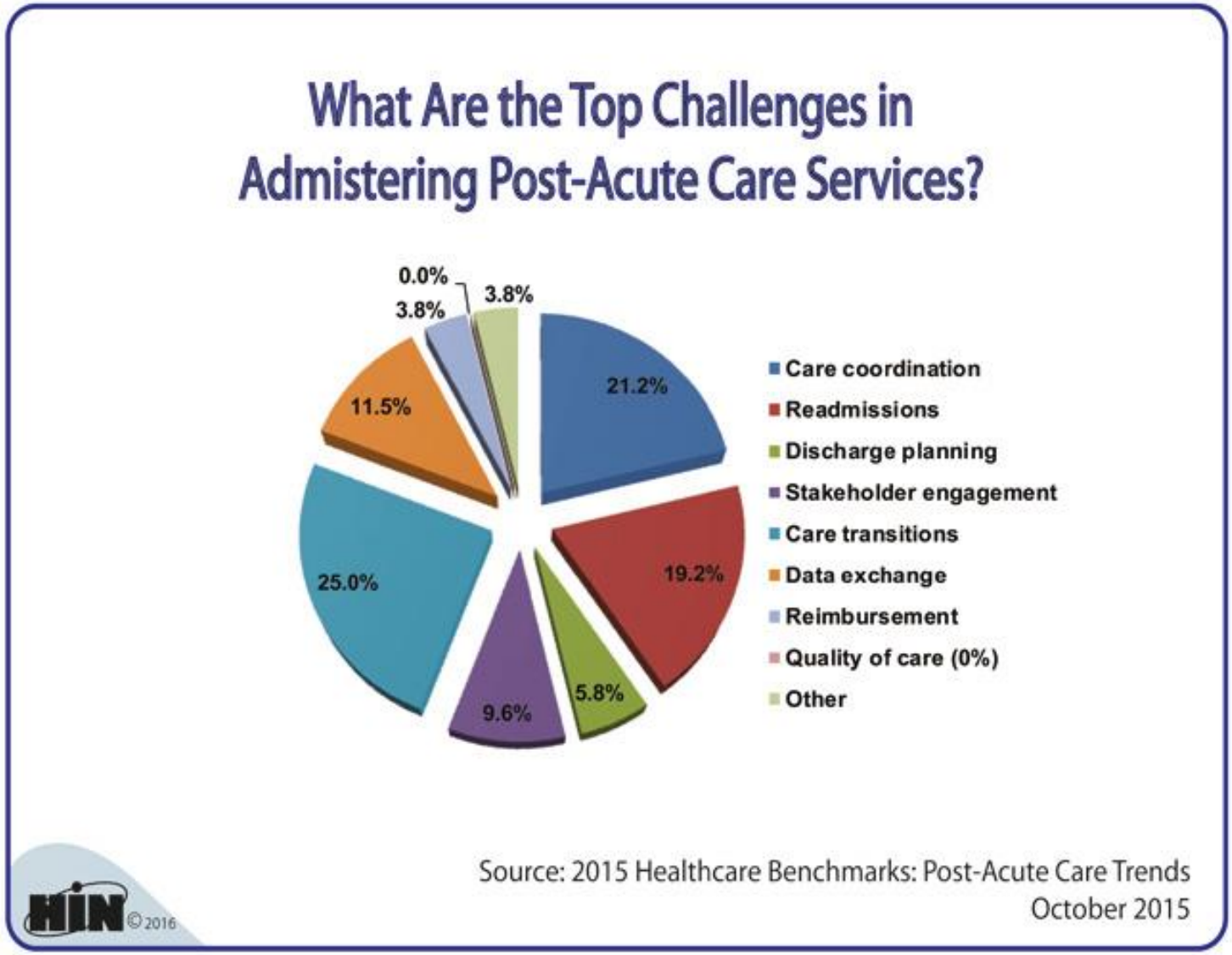

Why Focus on Post-Acute Care?

Utilization, Cost & Quality

Post-Acute Care Utilization Overview

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90% increase in post-acute care utilization from 2002 to 2012

64% of Medicare patients readmitted after an inpatient stay received no post-acute care

35% of Medicare patients receive post-acute care

Source: HealthLeaders Media Webcast: How Ascension Senior Living Creates Successful Postacute Care Partnerships, December 7, 2015

Critical Transitions of Care

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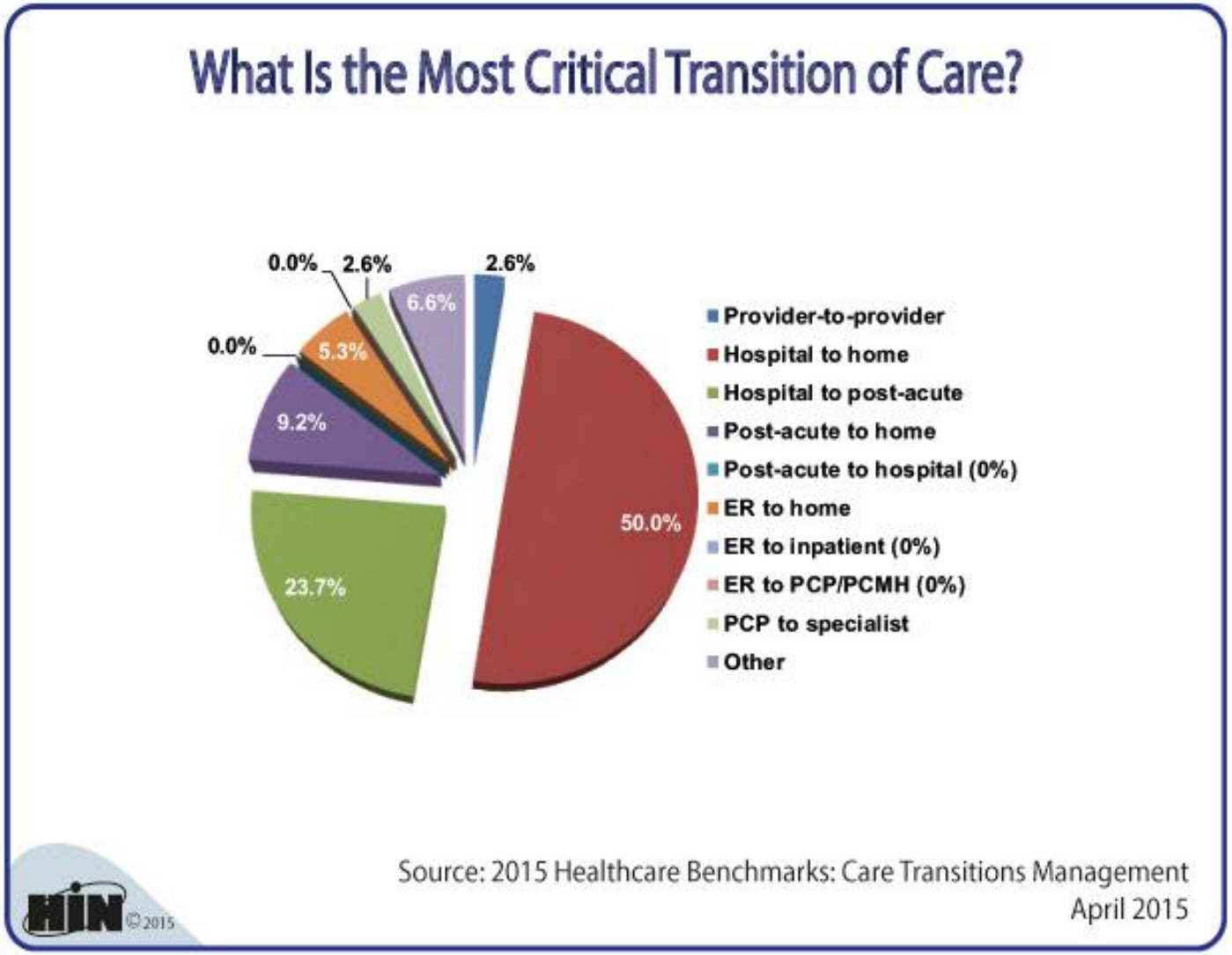
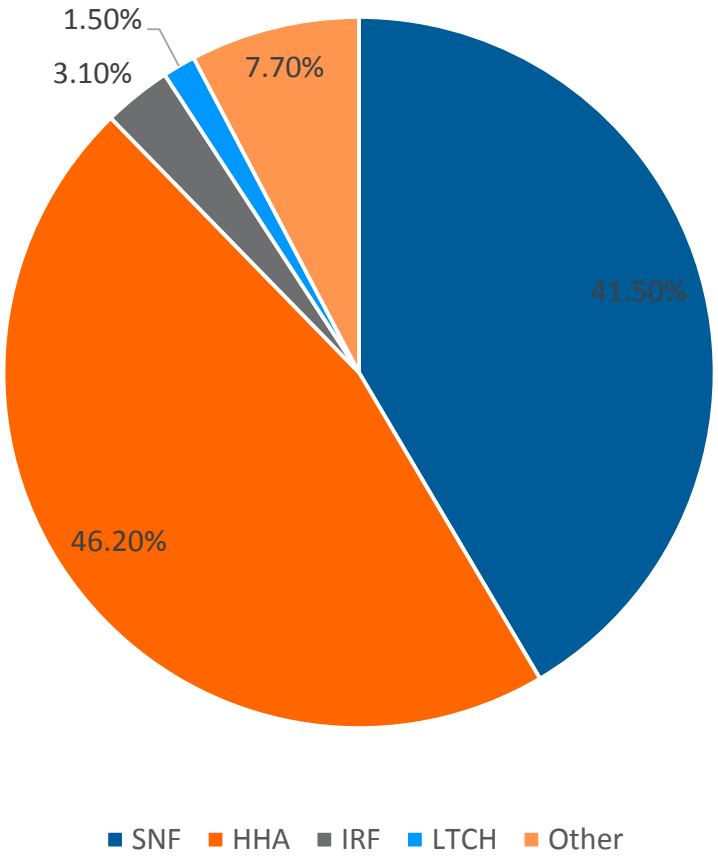


PAC Discharge Trends



Source: HIN 2015 Post-Acute Care Trends Survey, July 2015

Why Focus on Post-Acute Care?
Utilization, Cost & Quality

PAC Cost and Quality Concerns

- Hospital readmission penalties and CMS and Commercial Bundled Payment Initiatives have increased focus and concern about the cost and quality of PAC.
- The President's budget for past three years has proposed to bundle 50% of PAC payments by 2020*, with a goal to reduce health care spending.
- Under Bundled Payment models, an entity receives a single payment from a payer that covers all related services needed to treat a patient for a given condition or episode of care.

* Source: U.S. Department of Health & Human Services. Fiscal Years 2014-2016 Budget in Brief publications.

Costs of Post-Acute Care

Passage of the ACA in 2010 heightened focus on the Triple Aim of improving patient experience of care, improving population health, and reducing per capita costs of health care

An Institute of Medicine report in 2013 identified PAC as the source of **73% of the variation** in health care spending, significantly increasing attention to the post-acute sector

Estimated that as many as 43% of Medicare FFS Beneficiaries are discharged to one of the Medicare-recognized post-acute settings: SNFS, LTACs, IRFs, Home Health*

Between 2001 and 2012, program payments to PAC providers doubled to $59 billion

*Source: Health Dimension Group 2014

Medicare Spending on PAC by Sector

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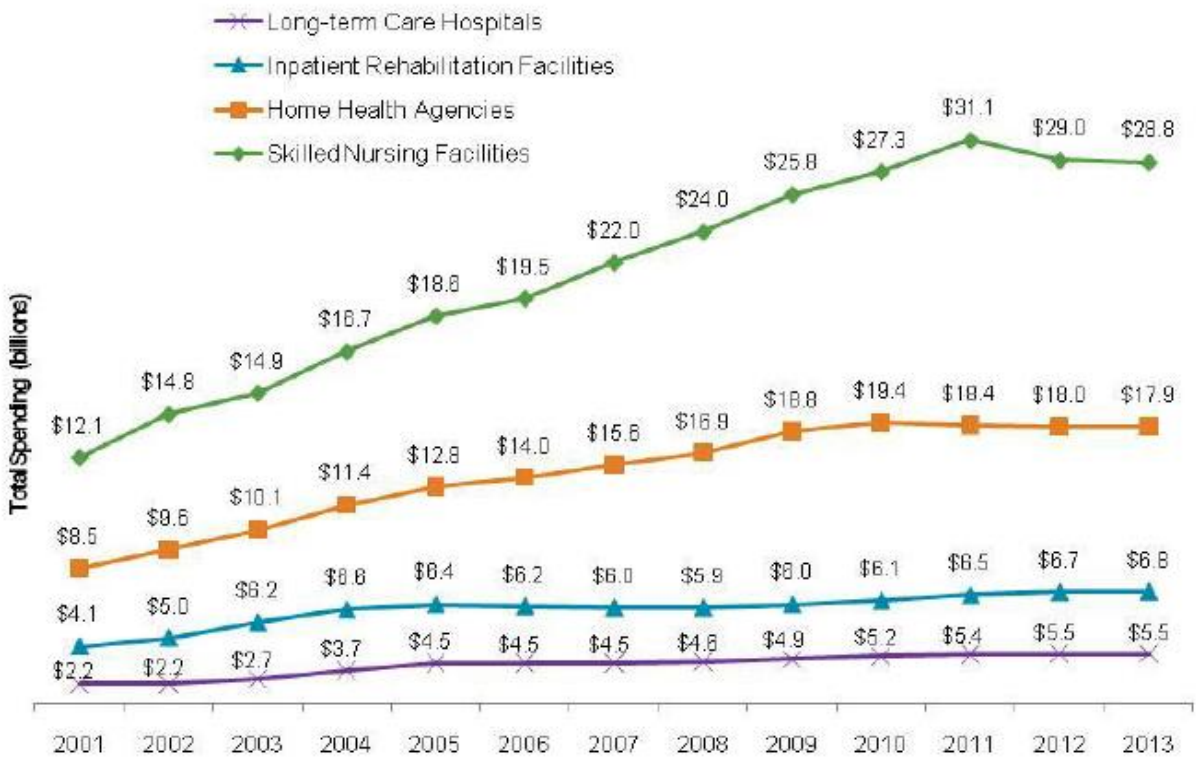
Chart 9: Medicare Spending on PAC by Sector



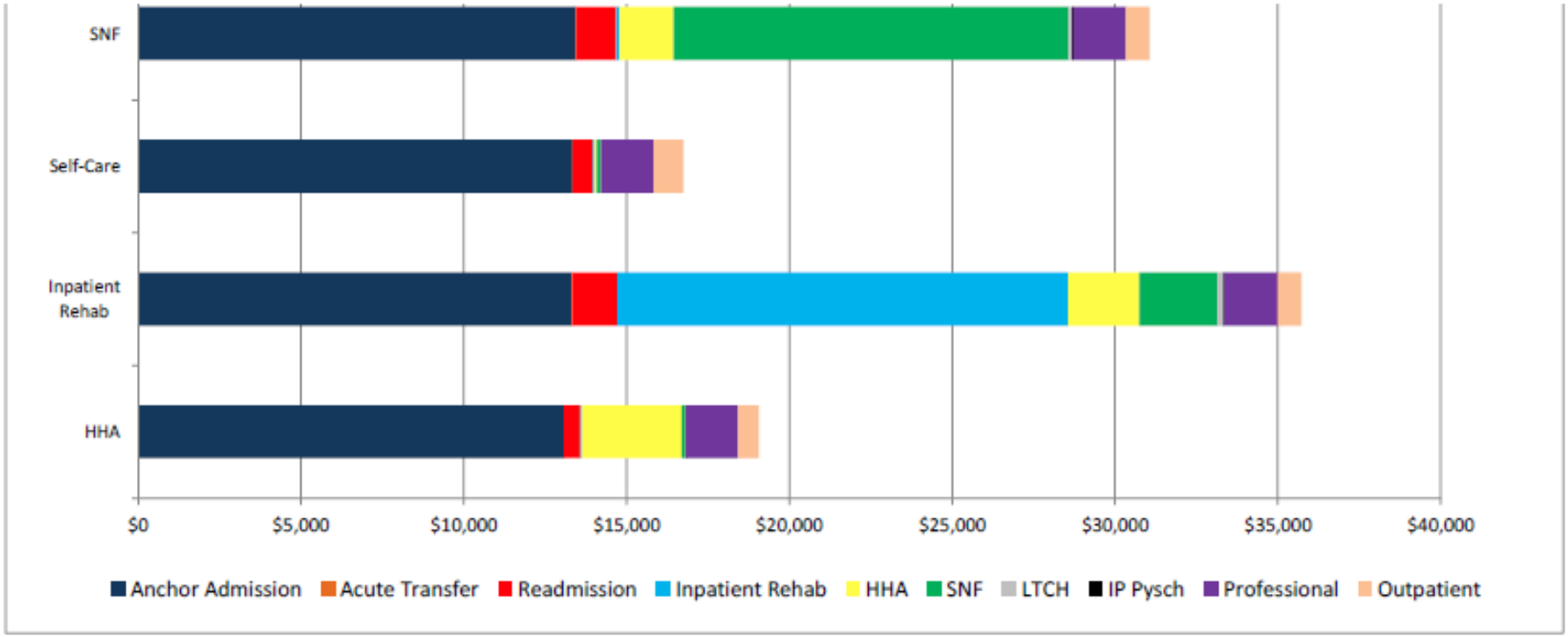
Source: Miller, M. Medicare PAC Reforms. *U.S. Congress House Subcommittee on Health: Committee on Energy and Commerce.* 16 April 2015.

Average Episode Spending

Further analyses have demonstrated significant differences in cost related to the initial post-acute setting of care following hospitalization.

Exhibit 2—Average Episode Spending by First PAC Setting

DRG 470



Source: DataGen Healthcare Analytics

Why Focus on Post-Acute Care?

Utilization, Cost & Quality

The IMPACT Act of 2014

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- Required domains and sample metrics
  - Patient assessment
    - Needs special services
    - Cognitive function
  - Quality measures
    - Skin integrity changes
    - Medication reconciliation
  - Resource use measures
    - Medicare spending per beneficiary
    - Rate of discharge to community

Standardized data reporting

- Three stated purposes
  - Compare quality across PAC settings
  - Inform hospital discharge planning
  - Create foundation for future PAC payment reform

To guide patient placement

To meet CMS requirements, hospitals and PAC providers must incorporate PAC quality and resource use data into discharge planning by 1/1/2016

Source: HealthLeaders Media Webcast: How Ascension Senior Living Creates Successful Postacute Care Partnerships, December 7, 2015

The IMPACT Act of 2014: Implementation Timeline

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Sector	Report Standardized Patient Assessments	Report Additional Quality Measures	Report Resource Use Measures
LTACH	10/1/2018	• 10/1/2016 (skin integrity, major falls) • 10/1/2018 (functional status, medication reconciliation, transfer of health information)	10/1/2016
IRF	10/1/2018	• 10/1/2016 (functional status, skin integrity, major falls) • 10/1/2018 (functional status, transfer of health information)	10/1/2016
SNF	10/1/2018	• 10/1/2016 (functional status, skin integrity, major falls) • 10/1/2018 (functional status, transfer of health information)	10/1/2016
HHA	1/1/2019	• 1/1/2017 (skin integrity, medication reconciliation) • 1/1/2019 (functional status, major falls,	10/1/2017

The IMPACT Act of 2014

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- Quality measure variability across skilled nursing facility (SNF) providers

Quality Measure (Risk-Adjusted)	25th percentile	Mean	75th percentile
Patients discharged to the community	29.2%	37.5%	46.6%
Potentially avoidable rehospitalizations during SNF stay	8.0%	11.1%	13.9%
Potentially avoidable rehospitalizations within 30 days of SNF stay	3.4%	5.5%	7.2%
Average mobility improvement across three mobility ADLs	35.6%	43.6%	52.5%
No decline in mobility during SNF stay	82.7%	87.2%	92.9%

Source: Medicare Payment Advisory Commission "Report to the Congress: Medicare Payment Policy" March 2015 via HealthLeaders Media Webcast "How Ascension Senior Living Creates Successful Postacute Care Partnerships"

Nursing Home Compare Metrics

From CMS: Nursing Home Compare allows consumers to compare information about nursing homes. It contains quality of care and staffing information for all 15,000 plus Medicare- and Medicaid-participating nursing homes.

Nursing Home Compare includes information on:

- 5-star quality ratings of overall and individual star performance on health inspections, quality measures, and hours of care provided per resident by staff performing nursing care tasks.
- Health and fire-safety inspections with detailed and summary information about deficiencies found during the 3 most recent comprehensive inspections (conducted annually) and the last 3 years of complaint investigations. Learn more about the nursing home certification process - Opens in a new window.
- Nursing home staffing information about the number of registered nurses, licensed practical or vocational nurses, physical therapists and nursing assistants in each nursing home.
- A set of quality measures that describe the quality of care in nursing homes including % of residents with pressure sore, % of residents with urinary incontinence and more.
- Penalties against a nursing home.

Source: CMS.gov

Readmissions Overview

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In 2013, there were about 500,000 readmissions totaling $7B in hospital costs for four high-volume conditions: AMI, CHF, COPD, and pneumonia

Readmissions for these four conditions cost Medicare $5.2B in 2013

From 2009 to 2013, the readmission rate for stays covered by Medicare decreased by 13 percent for AMI, by 7 percent each for CHF and COPD, and by 6 percent for pneumonia

Hospitals risk losing 1.5% of their Medicare reimbursements in Fiscal Year 2015 if they don't show simultaneous improvements in both process of care measures and patient experience. By 2017, that looming cut will grow to 2%, which equates to millions of dollars for an average hospital.

Readmissions are a significant portion of Medicare spending—37 percent of total Medicare spending is for inpatient care, and 18 percent of all inpatient admissions paid by Medicare are readmitted within 30 days, accounting for $15 billion in costs annually.

Pneumonia is responsible for an estimated $6 billion in direct costs each year in the U.S.

Source: AHRQ Healthcare Cost and Utilization Project Statistical Brief #196

Why Do We Measure Readmissions?

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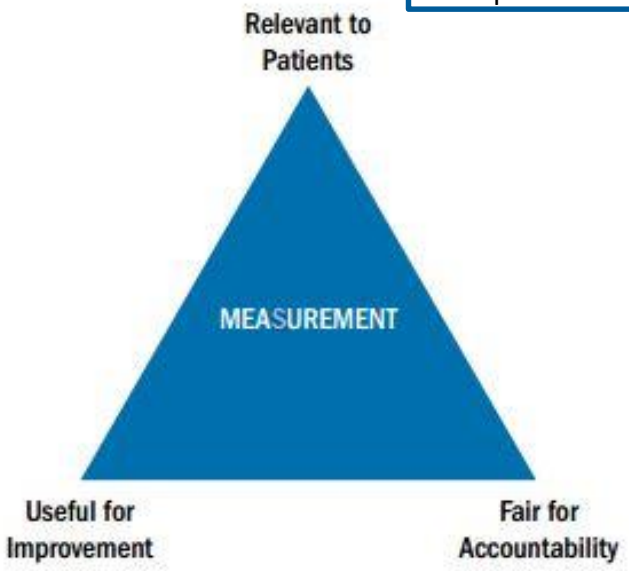
- Poorly coordinated care leaves patients isolated, confused, and at risk
- Medicare's current readmissions metric (30 days and 3 conditions) does not capture patient experience



- Hospitals need evidence base to measure success of care coordination efforts

- Holding hospitals financially accountable for readmissions is a step in the right direction…but the Medicare readmissions penalty has many issues

Risk Factors for Readmission: The 8 P's

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1.Problems with medications: Patients with **polypharmacy** — i.e. ≥10 routine medications — or who are on high-risk medications including anticoagulants (e.g. warfarin, heparin, Factor Xa or thrombin inhibitors), antiplatelet agents in combination (e.g. aspirin and clopidogrel), insulin, oral hypoglycemic agents, digoxin, and narcotics.

2. Psychological: Patients who screen positive for depression or who have a history of depression. You may also choose to include anxiety and substance abuse in this screening.

3. Principal diagnosis: Patients with a principal diagnosis or reason for hospitalization related to cancer, stroke, diabetic complications, COPD, or heart failure.

4. Physical limitations: Patients with frailty, deconditioning, or other physical limitations that impair or limit their ability to significantly participate in their own care (e.g. perform activities of daily living, medication administration, and participation in post-hospital care).

5. Poor health literacy: Patients who are unable to demonstrate adequate understanding of their care plan as demonstrated by their inability to complete "Teach Back" successfully (See "Teach Back Process").

6. Poor social support: The absence of a reliable caregiver to assist with the discharge process and to assist with care after the patient is discharged. This P also captures the concept of social isolation.

7. Prior hospitalization: Unplanned hospitalization in the six months prior to this hospitalization.

8. Palliative care: When thinking about this patient, would you be *surprised* if the patient died within a year? Does this patient have an advanced or progressive serious illness? This risk factor would be triggered if you answered no to the first or yes to the second question

Source: Society for Hospital Medicine Project BOOST Implementation Toolkit
http://www.hospitalmedicine.org/Web/Quality_Innovation/Implementation_Toolkits/Project_BOOST/Web/Quality___Innovation/Implementation_Toolkit/Boost/BOOST_Intervention/Tools/Risk_Assessment.aspx

Readmission Financial Penalties

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Financial Year	2013	2015	2013	2013	2017	2017	2015
Condition	**AMI 30-Day Readmission**	**COPD 30-Day Readmission**	**HF 30-Day Readmission**	**Pneumonia 30-Day Readmission**	**Stroke 30-Day Readmission**	**CABG 30-Day Readmission**	**THA/TKA 30-Day Readmission**
National Readmission Rate	17.0%	20.2%	22.0%	16.9%	12.7%	14.9%	4.8%
Multiplier (1/national rate)	5.89	4.94	4.54	5.90	7.87	6.69	20.63
Admission WT	2.2819	1.1807	1.3485	1.2489	2.0864	5.2348	2.1692
Std Admissions at avg CMI (1.6987)*	8.0	3.5	3.6	4.4	9.8	20.9	26.7
Penalty per readmission at base rate of $6,212*	$83,449	$36,262	$38,064	$45,801	$101,984	$217,609	$277,949

Table 1: National relative readmission penalty by condition (*CMS IPPS Final rule 2016)

Source: QualityNet and various CMS HRRP appendixes obtainable from the IPPS final rule home page

Source: *Increasingly disproportionate penalties in the Medicare Hospital Readmission Reduction Program (HRRP), March 18th, 2016* By Richard Fuller, MS, Norbert Goldfield, MD, 3M Inside Angle, 3/18/2016
http://www.3mhisinsideangle.com/blog-post/increasingly-disproportionate-penalties-in-the-medicare-hospital-readmission-reduction-program-hrrp/

Why the Concern?

- Current study shows that 7% of acute care hospitals currently have higher than expected readmission rates.
- Avoidable readmissions may result from:
  - an adverse event that occurred during the initial admission

    OR
  - as a result of inappropriate or lack of follow-up care coordination following discharge
  - Avoidable hospital readmissions are often considered as "indicators of poor care or missed opportunities to better coordinate care"

Source: www.amerinet-gpo.com

Why the Concern?

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- Of readmissions after a heart failure hospitalization, **87.5 percent were readmitted once**, 9.7 percent were readmitted twice and 2.8 percent were readmitted three or more times.

- Of readmissions after an acute myocardial infarction hospitalization, **97.4 percent were readmitted once,** 2.4 percent were readmitted twice and 0.2 percent were readmitted three or more times.

- Of readmissions after a pneumonia hospitalization, **95.1 percent were readmitted once,** 4.3 percent were readmitted twice and 0.6 percent were readmitted three or more times.

Source: http://www.beckershospitalreview.com/quality/20-statistics-on-hospital-readmissions.html

Potential Negative Impact of Readmissions

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- Decreased margin:
  - Hospitals are denied payment for readmissions
  - PPS pay a penalty if readmission rate is above the accepted rate: 3% for 2015 and beyond (penalty = decreased % of Medicare payment to the hospital)
  - Increased cost to manage care, which is an issue with DRG payment, bundled payment, capitated models or ACO payment mechanism

Potential Negative Impact of Readmissions

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- Can be very disruptive to patients and family, effecting patient engagement and HCAHPS outcome
- More chances of increased mortality rate which not only effects families but also impacts the revenue under hospital value based purchasing (HVBP) due to penalty above accepted rate
- Publically reported - decreased utilization – poor image
- Less desirable partner for affiliation

Interact 4.0

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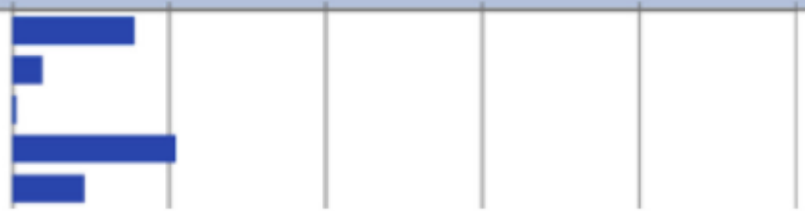
INTERACT Version 3.0 Tool

Actions Taken to Evaluate and Manage the Change in Condition

From: 4/1/2013 To: 3/31/2014

Interventions

	N	%
New medication(s)	753	16%
IV or SubQ fluids	182	4%
Increase oral fluids	18	0%
Oxygen	1012	21%
Other	442	9%



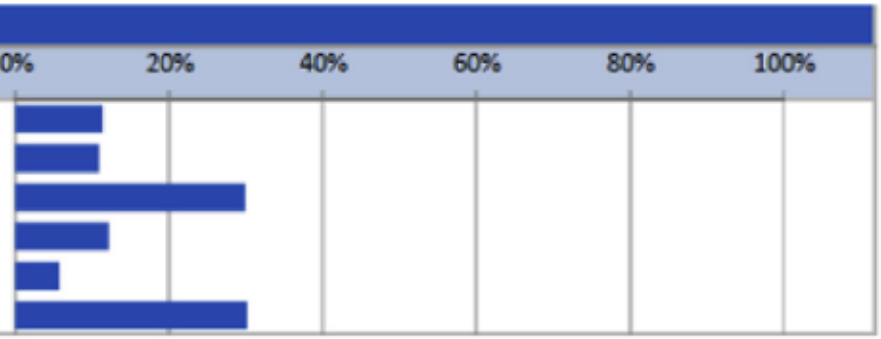
INTERACT Version 3.0 Tool

Hospital Transfer Information

From: 4/1/2013 To: 3/31/2014

Length of stay prior to hospital transfer

	N	%
2 days or less	551	11%
3-6 days	524	11%
7-29 days	1450	30%
30 to 59 days	590	12%
60 to 89 days	277	6%
90 days or more	1464	30%



Root Cause Analyses of Transfers of Skilled Nursing Facility Patients to Acute Hospitals: Lessons Learned for Reducing Unnecessary Hospitalizations
Joseph G. Ouslander MD,*, Ilkin Naharci MD, Gabriella Engstrom PhD, RN,
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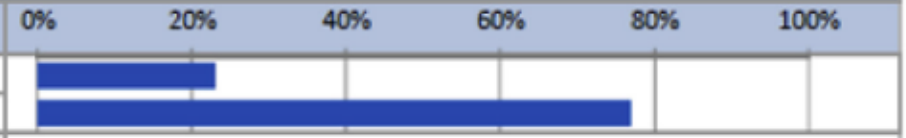
Opportunities for Improvement

From: 4/1/2013 To: 3/31/2014

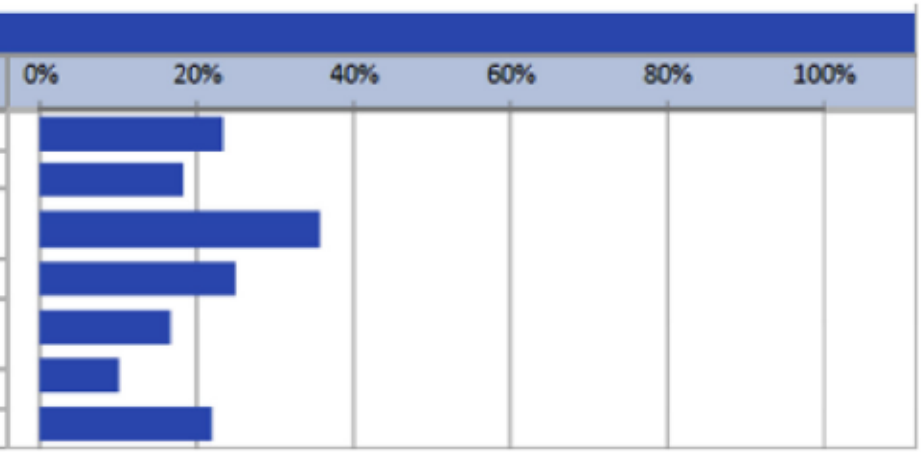
Transfer Rated as Preventable

	N	%
Yes	1044	23%
No	3483	77%
Total	4527	100%



Opportunities for Improvement

	N	%
Changes could have been detected earlier	243	23%
Communication could have been better	190	18%
Condition might have been managed in NH w/available resources	372	36%
Resources not available to manage the change	260	25%
Earlier discussion of preferences with resident/family	173	17%
ACP could have been in place earlier	105	10%
Other	228	22%



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Conclusion and Next Steps

- Please join us for Part 2 of this webinar series on July 19th, 2016
- In the upcoming webinar, we will discuss emerging alternative reimbursement methodologies- bundled payments and the new Comprehensive Care for Joint Replacement (CJR) Model

Questions and Discussion

Thank you