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

Part 1 in a Two-Part Webinar Series

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July 12, 2016
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
# Post-Acute Care Lexicon

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Term</th>
<th>Relative Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>IRF</td>
<td>Inpatient Rehabilitation Facility</td>
<td>$$$$$</td>
</tr>
<tr>
<td>SNF</td>
<td>Skilled Nursing Facility</td>
<td>$$</td>
</tr>
<tr>
<td>LTAC/LTACH</td>
<td>Long-Term Acute Care/Long-Term Acute Care Hospital</td>
<td>$$</td>
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<tr>
<td>HHA</td>
<td>Home Health Agency</td>
<td>$$</td>
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</table>
Challenges in Administering PAC Services

What Are the Top Challenges in Administering Post-Acute Care Services?

- Care coordination: 21.2%
- Care transitions: 19.2%
- Data exchange: 11.5%
- Discharge planning: 5.8%
- Readmissions: 3.8%
- Stakeholder engagement: 3.8%
- Quality of care (0%)
- Other: 0.0%

Source: 2015 Healthcare Benchmarks: Post-Acute Care Trends
October 2015
Why Focus on Post-Acute Care?

Utilization, Cost & Quality
Post-Acute Care Utilization Overview

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

What Is the Most Critical Transition of Care?

Source: 2015 Healthcare Benchmarks: Care Transitions Management
April 2015
PAC Discharge Trends

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.

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

Chart 9: Medicare Spending on PAC by Sector

Further analyses have demonstrated significant differences in cost related to the initial post-acute setting of care following hospitalization.
Why Focus on Post-Acute Care?
Utilization, Cost & Quality
The IMPACT Act of 2014

• 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

|--------|----------------------------------------|-----------------------------------|-----------------------------|
| 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, transfer of health information) | 10/1/2017 |
The IMPACT Act of 2014

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

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

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

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?

• 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

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”](http://www.hospitalmedicine.org/Web/Quality_Innovation/Implementation_Toolkits/Project_BOOST/Web/Quality_Innovation/Implementation_Toolkit/Boost/BOOST_Interaction/Tools/Risk_Assessment.aspx)).

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
## Readmission Financial Penalties

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<tbody>
<tr>
<td>AMI 30-Day Readmission</td>
<td>2013</td>
<td>17.0%</td>
<td>20.2%</td>
<td>22.0%</td>
<td>16.9%</td>
<td>12.7%</td>
<td>14.9%</td>
<td>4.8%</td>
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<tr>
<td>COPD 30-Day Readmission</td>
<td></td>
<td>5.89</td>
<td>4.94</td>
<td>4.54</td>
<td>5.90</td>
<td>7.87</td>
<td>6.69</td>
<td>20.63</td>
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<tr>
<td>HF 30-Day Readmission</td>
<td></td>
<td>8.0</td>
<td>3.5</td>
<td>3.6</td>
<td>4.4</td>
<td>9.8</td>
<td>20.9</td>
<td>26.7</td>
</tr>
<tr>
<td>Pneumonia 30-Day Readmission</td>
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<tr>
<td>Stroke 30-Day Readmission</td>
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<tr>
<td>CABG 30-Day Readmission</td>
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<tr>
<td>THA/TKA 30-Day Readmission</td>
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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

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?

- 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.

Potential Negative Impact of Readmissions

- 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

- 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

Actions Taken to Evaluate and Manage the Change in Condition

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

<table>
<thead>
<tr>
<th>Interventions</th>
<th>N</th>
<th>%</th>
<th>0%</th>
<th>20%</th>
<th>40%</th>
<th>60%</th>
<th>80%</th>
<th>100%</th>
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<tr>
<td>New medication(s)</td>
<td>753</td>
<td>16%</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>IV or SubQ fluids</td>
<td>182</td>
<td>4%</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Increase oral fluids</td>
<td>18</td>
<td>0%</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Oxygen</td>
<td>1012</td>
<td>21%</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Other</td>
<td>442</td>
<td>9%</td>
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Hospital Transfer Information

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

<table>
<thead>
<tr>
<th>Length of stay prior to hospital transfer</th>
<th>N</th>
<th>%</th>
<th>0%</th>
<th>20%</th>
<th>40%</th>
<th>60%</th>
<th>80%</th>
<th>100%</th>
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<tr>
<td>2 days or less</td>
<td>551</td>
<td>11%</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>3-6 days</td>
<td>524</td>
<td>11%</td>
<td></td>
<td></td>
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<tr>
<td>7-29 days</td>
<td>1450</td>
<td>30%</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>30 to 59 days</td>
<td>590</td>
<td>12%</td>
<td></td>
<td></td>
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<tr>
<td>60 to 89 days</td>
<td>277</td>
<td>6%</td>
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<tr>
<td>90 days or more</td>
<td>1464</td>
<td>30%</td>
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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, Jill Shutes GNP, David G. Wolf PhD, CNHA, CALA, CAS, Graig Alpert BS, Carolina Rojido MD, Ruth Tappen EdD, RN, FAAN, David Newman PhD

JAMDA 17 (2016) 256-262 via interact2.net
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* Corresponding author.

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### Opportunities for Improvement

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

<table>
<thead>
<tr>
<th>Transfer Rated as Preventable</th>
<th>N</th>
<th>%</th>
<th>0%</th>
<th>20%</th>
<th>40%</th>
<th>60%</th>
<th>80%</th>
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<tr>
<td>Yes</td>
<td>1044</td>
<td>23%</td>
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<td></td>
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<tr>
<td>No</td>
<td>3483</td>
<td>77%</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Total</td>
<td>4527</td>
<td>100%</td>
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#### Opportunities for Improvement

<table>
<thead>
<tr>
<th>Change in Care</th>
<th>N</th>
<th>%</th>
<th>0%</th>
<th>20%</th>
<th>40%</th>
<th>60%</th>
<th>80%</th>
<th>100%</th>
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<tbody>
<tr>
<td>Changes could have been detected earlier</td>
<td>243</td>
<td>23%</td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Communication could have been better</td>
<td>190</td>
<td>18%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Condition might have been managed in NH w/available resources</td>
<td>372</td>
<td>36%</td>
<td></td>
<td></td>
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<tr>
<td>Resources not available to manage the change</td>
<td>260</td>
<td>25%</td>
<td></td>
<td></td>
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<tr>
<td>Earlier discussion of preferences with resident/family</td>
<td>173</td>
<td>17%</td>
<td></td>
<td></td>
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<tr>
<td>ACP could have been in place earlier</td>
<td>105</td>
<td>10%</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Other</td>
<td>228</td>
<td>22%</td>
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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