Session #W39:

Hospital Care Transitions and the Impact on Reducing Avoidable Readmissions

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Objectives:

- To gain a deeper understanding of Readmission penalties and current strategies being used by hospitals to mitigate these penalties.
- To understand the ideal care transition and how optimizing care transitions can impact readmissions.
- To gain insight into how to partner with Acute Care hospitals and generate more referrals to your facility.

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Disclosure of Commercial Interests

I have commercial interests in the following organization(s):

Employer: Reliant Post-Acute Care Solutions
Title: Chief Medical Officer

Reliant PACS provides Post-Acute Care Network solutions to hospitals and health care systems by implementing clinical teams and an IT platform in a dedicated, narrow network of skilled nursing facilities partnered with the hospital.

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Agenda

- Why all the fuss about readmissions?
- Importance of care transitions
  - Impacts on outcomes and readmissions
  - What does the "ideal transition" look like?
  - Role of the post-acute provider
- Hospital/ post-acute partnerships
- Other strategies for preventing readmissions

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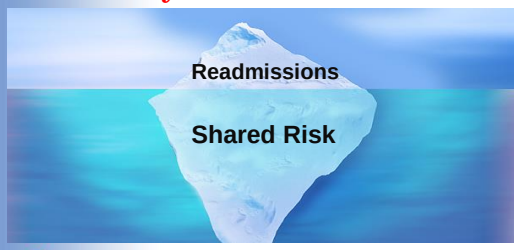
Why all the fuss…?



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Reducing High Cost of Readmissions: A National Focus

- A CMS st… tal admissio… g Facility (SNF) or … ve been avoided.
  - Respo… ing) expend…
  - In turn… tely $227 millio… lministered to mor… ates.

Significant Readmission Challenges for Post-Acute Care	
22.4%	Medicare post-acute care episodes with at least one readmission
121%	Average increase in Medicare post-acute care costs when an episode contains at least one readmission

Source: Advisory Board

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Even the Best are Struggling

30 Day Readmission Rate			
	U.S. News Best Hospitals	The Rest	P-Value
AMI	28.3%	24.9%	0.47
CHF	30.9%	26.5%	<0.001
PN	27.3%	21.7%	<0.001
30 Day Mortality Rate			
	U.S. News Best Hospitals	The Rest	P-Value
AMI	11.4%	21.2%	<0.001
CHF	8.1%	12.0%	<0.001
PN	10.4%	12.8%	<0.001

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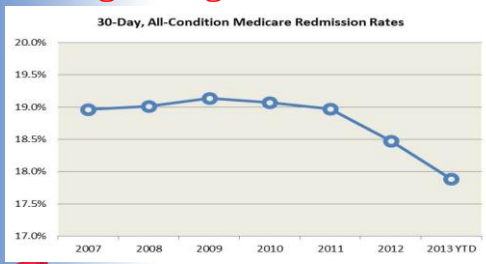
Beginning to See Results



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Drivers

- Medicare spend (2012):
  - $62 Billion in post-acute services
  - $17 Billion in readmissions costs
- Medicare's Value-Based Purchasing initiatives:
  - P4P (Pay for Performance)
  - Medical episodes – UTI, Cellulitis, GI Hemorrhage
  - Surgical episodes – THR, TKR, Lumbar fusion

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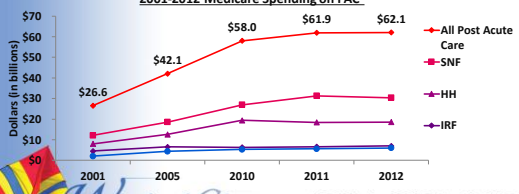
PAC Growing in Size/Importance

By the Numbers …..

- Four of every 10 Medicare patients nationwide are discharged to a PAC setting.
- Post -acute care creating significant variation in the quality and medical spend associated with care episodes -- **40% of the variation in Medicare beneficiary spend.**[1]

2001-2012 Medicare Spending on PAC[2]



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[1]Institute of Medicine. Interim report of the Committee on Geographic Variation in Health Care Spending and Promotion of High-Value Health Care: preliminary committee observations, March 2013; [2]Source: Med Pac *Data Book: Health care spending and the Medicare program*, June 2013

The Value Equation

$$\text{VALUE} = \frac{\text{QUALITY}}{\text{COST}}$$

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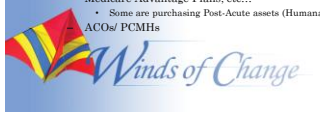
Clear movement toward episode-based payments:

- CMS/ HHS announced in early February 2015 that:
  - By 2017 - 30% of Medicare payments will be according to alternative payment methodologies
  - By 2018 – 50%
- Bundled Payment for Care Improvement (BPCI) Initiative
  - Enrollment re-opened - now at 6500 providers
  - 179 MS-DRG's grouped into 48 bundles
  - Models of bundling:
    - Model 2 – Acute care + post-acute (30/60/90)
    - Model 3 – Post-acute only
    - Model 4 – Acute care only
  - Initiated through "Convener"
- Population Health Management
  - Medicare Advantage Plans, etc…
    - Some are purchasing Post-Acute assets (Humana)
  - ACOs/ PCMHs



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It's not just the Payors…

- Patient-led/ focused organizations:
  - AARP, IHI
- Employers:
  - Leapfrog – focused on increasing quality while lowering employer healthcare expenditures
  - Wal-Mart incentives for spine and cardiac procedures

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Hospital Concerns

- Risk without control
- Fragmentation of post-acute world
  - Disparate clinical and operational platforms
- Large variations in cost and quality of care
  - IOM Study – 73% of variation in Medicare spending is due to utilization of post-acute services[11]

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Care Transitions and Readmissions

- More than 5 million individuals transition from hospitals to SNFs annually
- Poor coordination across care settings too often results in re-hospitalizations
- 2011 – SNFs transferred 25% of their Medicare residents (3.3 million people) to hospitals
- Medicare spent $14.3B on hospital stays for SNF residents (33% more than average Medicare hospitalization)

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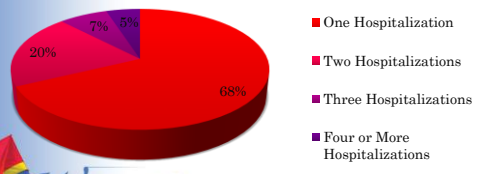
Care Transitions and Readmissions

Number of Hospitalizations Experienced by Hospitalized Medicare Residents Who Resided in Nursing Homes in FY 2011



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Readmissions Rates Affected By:

- Health literacy
  - Fundamental, scientific, civic and cultural
- Visual or cognitive impairment
- Functional status
- Language barriers
- Community-level factors - social support
- Hospitals unjustly penalized when their patient population is:
  - More chronically ill
  - Lower socioeconomic status

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"Post Hospital Syndrome [7]"

- Acquired, transient period of vulnerability related to:
  - adaptive changes related to illness
  - physiological stress
  - effects of lingering illness
- Impaired defenses
- Depleted reserves
- Patients are affected by:
  - Sleep disturbances
  - Nutrition issues
  - Pain
  - Emotional challenges
  - Medications altering cognition
  - Deconditioning

"Try to get some rest. I'll be in every few minutes to make sure you don't."

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ID of High Risk Patients

LACE Tool [5]

- Length of stay
- Acuity of illness (Charlson score)
- Comorbidities
- Emergency Dept. visits

HOSPITAL Score [6]

- Hemoglobin at discharge,
- Oncology service discharge
- Sodium level at discharge,
- Procedure during the index admission,
- Index Type of admission,
- Admissions (#) during the last 12 months
- Length of stay

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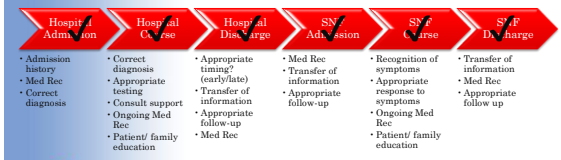
Care Continuum



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Care Transitions and Outcomes

- Poorly handled care transitions can lead to:
  - SNF confusion about patient's condition and appropriate care
  - Duplicative testing (costs)
  - Inconsistent patient monitoring
  - Medication errors
  - Delays in care or diagnosis
  - Lack of follow-through on referrals
- Failures create concerns around patient safety, quality of care, and patient health concerns that can lead to readmissions and negative outcomes

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The Ideal Transition

- 2009 - Transitions of Care Consensus Policy Statement - J Gen Int Med[9]
  - Accountability
  - Communication
  - Timely information exchange
  - Involvement of patient/ family
  - Coordination of care
  - Medical home or coordination clinician
  - National standards
  - Metrics around quality and accountability

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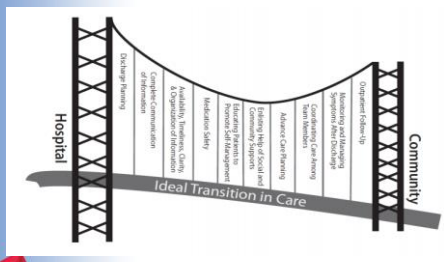
The Ideal Transition



Burke, R. 2013 JHM

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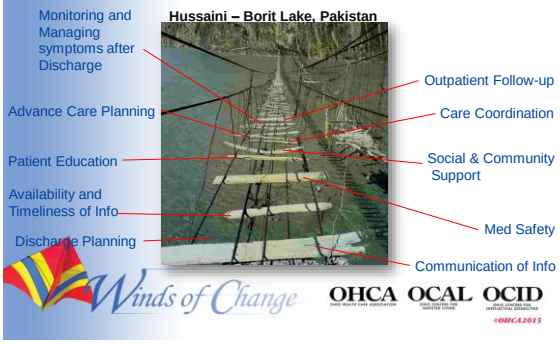
The Patient's Perspective



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Creating Successful Care Transitions

- Understand mutual inter-dependence between care settings
- Co-design processes that increase communication and transfer of important information
- Move from site-specific model of care to patient-centered model of care

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Communication and Care Transitions

- Clear and direct communication of treatment plans and follow-up expectations
- Two-way communication with opportunities for clarification and feedback
- Discharge information available to SNF prior to transfer
- Information access via EMR, phone, HIPAA-compliant communication methods
- Inadequate discharge information leads to delays, increased staff stress, frustrated patients and families

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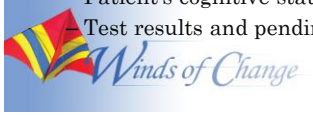
Transfer of Clinical Information

- Minimal data elements that should be part of the transfer record:
  - Principle diagnosis and problem list
  - Medication list
  - Transferring physician's name/ institution and contact information
  - Patient's cognitive status
  - Test results and pending results



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Additional Elements for "Ideal Transition" Record

- Emergency plan and contact number/person
- Treatment and diagnostic plan
- Prognosis and goals of care
- Advance directives, power of attorney
- Planned interventions, DME requirements, wound care, etc…
- Families should understand and be encouraged to participate in development of transition record

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Patient/Family Education

- Lack of understanding about a care transition can cause anxiety for patients and families
- Providers should:
  - Identify expectations about short/ long term clinical outcomes
  - Discuss desires regarding advance directives
  - Evaluate patient's and family's understanding of overall care plan
  - Ensure patient and family understand who is responsible for care plan and how to contact them

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Hospital/Post-Acute Partnerships

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What do Hospitals Want?

- Clinical Integration
  - Commonality of clinical protocols
  - IT interfaces (EHR)
  - Competency to accept higher acuity patients
- Partners who understand and potentially share their risk (ACO's, Bundles)
  - Readmissions
  - Returns to ED
- Transfer of Information
  - Prevent POA's from becoming HAC's

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What are Hospitals Doing?

- Analyzing historical data
- Gathering concurrent data
- Evaluating sources of readmissions and routes of discharge
- Engaging community providers and resources
- Ensuring that patient is placed in lowest <u>appropriate</u> acuity level setting (lower cost)
- Building Post-Acute Care Networks

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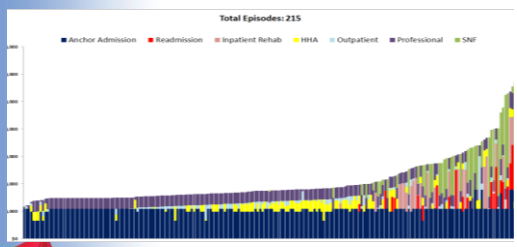
Data Samples



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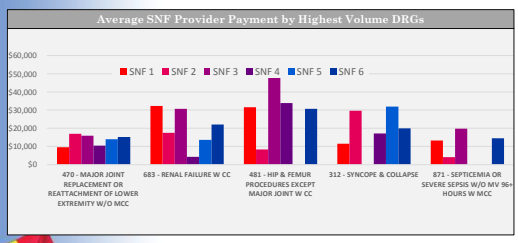
Data Samples



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Outside the Box

- Pressure to engage those providing post-acute care in community
- Doesn't work without the outpatient providers engaged/ aligned

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Own it or Influence it

- Engage:
  - Post-Acute Care Network providers
  - Physicians
  - Midlevel providers
  - Nursing home / LTAC administrators
  - Third-party payors
  - Home care/ Home health
  - Community resources
  - Patients and families

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Own it or Influence it

Engage | Entice

- Entice:
  - Incentives (ACO/ PCMH)
  - Referral patterns
  - PAC QI projects
  - "Network" inclusion

Employ | Educate

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Own it or Influence it

- Educate:
  - PCPs
    - Declining professional society membership
    - Losing touch with the care of acutely ill hospitalized patients
  - Need tools to be successful
    - Clinical protocols – disease specific (CHF, AMI, PNA)
    - Post-discharge visit checklists

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Own it or Influence it

- Employ:
  - Buy post-acute assets – SNF's, HH, etc…
  - Extend hospitalist group(s) to post-acute care facilities:
    - Dedicated resources?
    - Rotations?
  - Align with hospital-affiliated/ employed outpatient providers

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Vendors or Partners

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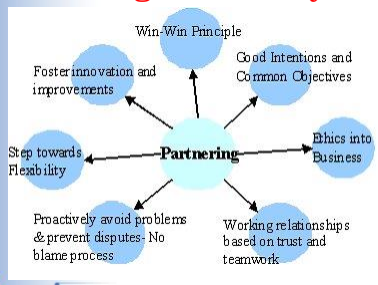
Partnering is the Way to Go



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Be a Partner

- Increased relevance
- Increased revenue (volume, risk based payments)
- Better outcomes for patients
- Improved community reputation
- Increased referrals
- "Part of the solution"

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Other Strategies for Success in Risk Planning

- Improve staff clinical skills/ capabilities
  - Engagement/ Availability of MDs, NPs, PAs
    - "Send the patient to the ER" can't be the kneejerk response
  - Nursing competencies
  - Availability of ancillary services – respiratory therapy, etc..
- Tools to decrease variation in care
  - Clinical protocols/ pathways
  - Order sets
- Data tracking/ reporting

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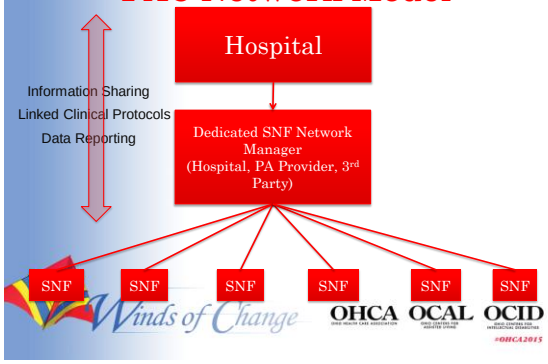
PAC Network Model



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More Relevance = More Referrals

- Relevance is directly related to your ability to mitigate hospital's risk
- Incumbent on SNFs to demonstrate value

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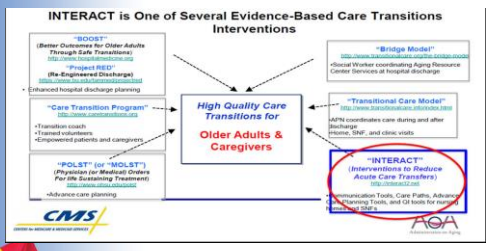
Resources/Toolkits



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Summary

- Readmission rates are the tip of the iceberg
- Novel payment methodologies are inevitable and driving need for better alignment
- Effective care transitions are essential in preventing readmissions
- Partnering with acute care is the way to go
- Develop or utilize existing tools to guide care and reduce variation in your facilities
- PACNets are coming…

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