POST-ACUTE CARE REFORM: WHAT SHOULD PROVIDERS KNOW?

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Geriatrics Grand Rounds
December 3, 2015

I have no conflicts of interest to declare.

LEARNING OBJECTIVES

- List the four most important influences on PAC that spurred reform
- Identify how PAC is used, and how quality and outcomes are measured for PAC
- Describe reforms to PAC as a result of recent legislation
- Discuss implications of these reforms
OUTLINE

Historical influences
- Hospital payment reform
- The “hospitalist movement”
- Growth in older adult populations
- Consolidation and profits of PAC providers

Current state
- Who gets PAC
- How PAC is paid for
- PAC quality measurement
- Outcomes of PAC

Future reforms
- Who gets PAC
- Payment reform
- Quality measurement of PAC
- How to improve outcomes

HISTORICAL INFLUENCES

Hospital payment reform
The “hospitalist movement”
Growth in older adult populations
Consolidation and profit of PAC providers
HOSPITAL PAYMENT REFORM

- 1983: Medicare changes from FFS to PPS

"QUICKER AND SICKER" HOSPITAL DISCHARGES

Top: Burke et al, *JAMA IM* 2015
Right: Burke et al, *Med Care* 2015
START OF HOSPITALISTS


HOSPITALISTS >> GERIATRICIANS

Hospitalists in United States, 2014 44,000

Geriatricians in United States, 2014 7,400

Sources: Society of Hospital Medicine/AAMC, American Geriatrics Society
HOSPITALISTS ARE NOT PAC EXPERTS

Brief Report

Do Internal Medicine Residents Know Enough About Skilled Nursing Facilities To Orchestrate a Good Care Transition?

Katherine T. Ward MDa,b, Michelle S. Eslami MD, Maristela B. Garcia MDb, Heather E. McCreath PhD

Overall score: 5 of 10

Examples:

• Services not available at a SNF 22% correct
• Patient not appropriate for SNF transfer 45% correct
• Staffing at a SNF 67% correct

“SILVER TSUNAMI”

Figure 1-1. Population Aged 65 and Over: 1900 to 2050

PAC PROVIDER PROFIT

- 95% free-standing, 70% for-profit, 72% urban
- ~15,000 providers across the USA, stable ~10 years

Chart 8-5. Freestanding SNF Medicare margins remain high despite reductions in payments

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<tbody>
<tr>
<td>All</td>
<td>17.5%</td>
<td>13.8%</td>
<td>12.8%</td>
<td>16.7%</td>
<td>19.4%</td>
<td>14.0%</td>
<td>13.1%</td>
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<tr>
<td>Rural</td>
<td>20.3</td>
<td>16.1</td>
<td>13.5</td>
<td>17.9</td>
<td>19.4</td>
<td>13.0</td>
<td>12.1</td>
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<tr>
<td>Urban</td>
<td>16.9</td>
<td>13.3</td>
<td>12.7</td>
<td>16.4</td>
<td>19.4</td>
<td>14.2</td>
<td>13.3</td>
</tr>
<tr>
<td>Nonprofit</td>
<td>9.1</td>
<td>3.8</td>
<td>3.2</td>
<td>7.2</td>
<td>10.8</td>
<td>5.7</td>
<td>5.0</td>
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<tr>
<td>For profit</td>
<td>19.4</td>
<td>16.1</td>
<td>16.1</td>
<td>19.0</td>
<td>21.5</td>
<td>16.2</td>
<td>15.3</td>
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Source: MedPAC, June 2015 Data Book

PAC PROVIDER CONSOLIDATION

- Kindred  $4.1 billion  310 facilities
- Golden Living $2.6 billion  344 facilities
- Genesis $2.2 billion  232 facilities

Source: Modern Healthcare, 9/2009
CURRENT STATE

Who gets PAC
How PAC is paid for
PAC quality measurement
Outcomes of PAC
PATIENT SELECTION – JOINT REPLACEMENT

POST-ACUTE CARE COSTS

MedPAC Data Book, June 2015
REGIONAL VARIABILITY

Variation in Health Care Spending: Target Decision Making, Not Geography – IOM 2013

QUALITY MEASUREMENT

- “5-star” rating system
- On-site inspections
  - How many deficiencies, how severe, how long to fix
  - Scaled by state
- Quality measures – taken from MDS
  - Short-stay: pressure ulcers, mod-severe pain, antipsychotics
  - Long stay: more help with ADLs, restraints, catheters/CAUTIs, falls
- Staffing levels (reported, not tied to payrolls….yet)
  - Total nursing hours per resident day (RN+LPN+nurse aide)
  - RN hours per resident day
  - Adjusted for case-mix (observed/expected)

- Not specific to SNFs
- Payment not tied to patient needs, quality, or outcomes
OUTCOMES

- Readmission rates
- Community discharge rates
- Recovery of function

READMISSIONS

[Graph showing percentage of readmissions from PAC facility by post-hospital day]
COMMUNITY DISCHARGE RATES

Kramer et al. Community Discharge and Rehospitalization Rates, April 2013.

READMISSIONS AND COMMUNITY DISCHARGE RATES ARE CONNECTED

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Adjusted OR (95% CI)</th>
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<tbody>
<tr>
<td>Living in community</td>
<td>0.52 (0.44-0.62)</td>
</tr>
<tr>
<td>Different living situations, &gt;2 versus 2 or less</td>
<td>13.15 (4.86-35.58)</td>
</tr>
<tr>
<td>Mortality (30 days)</td>
<td>2.01 (1.60-2.54)</td>
</tr>
<tr>
<td>Mortality (100 days)</td>
<td>3.79 (3.13-4.59)</td>
</tr>
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</table>

Burke et al, JAMDA 2015
READMISSION RISK FACTORS

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Hazard ratio (95% CI)</th>
</tr>
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<tbody>
<tr>
<td>Functional status</td>
<td></td>
</tr>
<tr>
<td>Low vs. high</td>
<td>4.78 (3.22-7.10)</td>
</tr>
<tr>
<td>Moderate vs. high</td>
<td>2.79 (1.87-4.15)</td>
</tr>
<tr>
<td>Number of physician visits (&gt;1 vs. 0)</td>
<td>1.82 (1.50-2.21)</td>
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<tr>
<td>Intravenous medications</td>
<td>1.63 (1.39-1.92)</td>
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<tr>
<td>Ownership (for-profit vs. non-profit)</td>
<td>1.43 (1.21-1.69)</td>
</tr>
<tr>
<td>Index hospital length of stay (log-transformed)</td>
<td>1.41 (1.28-1.56)</td>
</tr>
<tr>
<td>Heart failure primary diagnosis</td>
<td>1.40 (1.06-1.84)</td>
</tr>
<tr>
<td>Size of facility (&gt;100 beds vs. 100 beds or less)</td>
<td>1.35 (1.19-1.53)</td>
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<tr>
<td>Previous admissions in last 6 months (per admission)</td>
<td>1.25 (1.16-1.35)</td>
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FUTURE REFORMS

- Who gets PAC
- Payment reform
- Quality measurement
- How to improve outcomes
SOLUTION TO ALL: CARE TOOL?

- CARE tool
  - Patient selection
    - Match patient needs to PAC type (if any)
  - Payment reform
    - Provide “site-neutral” payment depending on patient needs, not care provided
  - Quality measurement
    - Longitudinal assessment of patients
    - Outcome assessment across different PAC delivery options


DERIVATION OF CARE TOOL

- Inputs
  - Stakeholders, technical expert panels convened by RTI
  - Kramer et al., 2006 Recommendations for a Uniform Patient Assessment for Post-Acute Care
  - Pilot tests

- Outputs
  - 5 domains: Medical/clinical complexity, Physical/Cognitive function (2), Social Supports, “Transition items”
  - ? Items – 23 pages long
CARE TOOL TESTING

- **Feasibility testing**
  - Significant missing data
  - Improved functional status measures using Item Response
  - Avg reported time to complete: 30-60 mins

- **Reliability testing**
  - “Traditional” IRR – 2 evaluators in same setting with same pt
    - Only 17% had kappas <0.70
  - “Video” IRR – 2 evaluators in different settings, standardized pt
    - More than 70% agreement in nearly all items
    - Varied by who completed assessment

- **Testing for payment**
  - Could predict discharge destination, intensity of therapy, costs, and to some extent outcome with CARE tool
  - “The implication is that choosing the models with the best explanatory power is allowing the past to drive the future”

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CARE TOOL

III. Current Medical Information (cont.)

<table>
<thead>
<tr>
<th>Major Treatments</th>
<th>Used at Any Time During Stay</th>
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<tbody>
<tr>
<td>D.</td>
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<tr>
<td>Discharged With:</td>
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<tr>
<td>D1a.</td>
<td>D1b.</td>
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<tr>
<td>D2a.</td>
<td>D2b.</td>
</tr>
<tr>
<td>D5a.</td>
<td>D5b.</td>
</tr>
<tr>
<td>D6a.</td>
<td>D6b.</td>
</tr>
<tr>
<td>D8a.</td>
<td>D8b.</td>
</tr>
<tr>
<td>D9a.</td>
<td>D9b.</td>
</tr>
<tr>
<td>D10a.</td>
<td>D10b.</td>
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</table>
| D12a.            | D12b.                       | D12. High O2 Concentration Delivery System with FiO2 > 40%

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*Which of the following treatments did the patient receive a) at the time of discharge or b) at any time during their admission?*
PAYMENT REFORM

Post-Acute Care — The Next Frontier for Controlling Medicare Spending
Robert Mechanic, M.B.A.

Post-Acute Care Reform — Beyond the ACA
D. Clay Ackerly, M.D., and David C. Grabowski, Ph.D.

In Race for Medicare Dollars, Nursing Home Care May Lag
By Katie Thomas April 14, 2015
The New York Times

PAYMENT REFORMS

- “Site-neutral” payments
  - Using the Continuity Assessment Record and Evaluation (CARE) tool
  - HHC may be excluded
  - 2016 - Initial report on demonstration project due
  - 2018 - CARE tool must be rolled out nationwide
  - 2020 - Final proposal for system for site-neutral payment due

- Goal: choose the best site for the patient regardless of reimbursement, allow better comparisons

Deficit Reduction Act, 2005
Improving Medicare Post-Acute Care Transformation (IMPACT) Act, 2014
PAYMENT REFORMS

- Bundled Payment for Care Improvement (BPCI) - CMMI demonstration
  - 1 of 4 models “bundles” acute hospital + post-acute stay (up to 90 days)
  - 24 hospital-SNF groups participating, starting with one dx (joint replacement, mostly)
  - Found:
    - decreased hospital LOS
    - major decrease in SNF use and increase in HHC
    - Increased ED visits

- Value-based purchasing
  - Medicare Spending Per Beneficiary (MSPB)
    - Bundles 3 days prior to admission to 30 days post-discharge
    - Outliers are penalized

Affordable Care Act (ACA), 2010

PAYMENT AND QUALITY

- Payment based on quality
  - New standardized quality metrics for all PAC (none finalized):
    - Admission/discharge functional assessment and care plan that addresses function
    - New or worsened pressure ulcers
    - Falls with major injury
    - Required to start reporting in 2018

- Penalties for potentially preventable readmissions
  - Public reporting by 10/17, but no agreed-upon measure
  - Penalties begin 2019 (SNFs)
  - 5-star ratings not associated with 30-day readmission rates (Neuman et al, JAMA 2014)

IMPACT Act, 2014
Protecting Access to Medicare (PAMA) Act, 2014
IMPLICATIONS

- “Integrated post-acute care”
- How to choose a partner(s)?
  - Practical challenges in integration
- “Nudging” patients to choose a preferred partner
  - Pointing to publically-available information
  - Preserving choice
- How do we measure quality – what measures are linked with outcomes?

IMPLICATIONS

- Is it valid?
- Who is responsible/has the knowledge?
- How to implement?
- What about patients who don’t fit?
  - SNF but low rehab potential
  - Care availability (rural patients)
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  - SNF but low rehab potential
  - Care availability (rural patients)

IMPROVING VALUE IN PAC

- Improve patient assessment and inform decisions
  - Better prognostic tools
  - Better assessment tools – needs and risk factors for AEs
  - Need the “expected” for observed vs. expected
- Improve care processes
  - Particularly around transitions – mismatch of needs/resources
  - Need process measures linked with outcomes for quality measurement
    - Identify high and low performers
  - How to partner with SNFs?
    - What to do if vertical integration is not an option
    - Testing interventions, including implementation strategies
CONTACT

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- Thank you: Eric Coleman, Robert Schwartz, Cari Levy, Michael Ho, Adit Ginde

- National Health Policy Forum – “Medicare’s Post-Acute Care Payment: An Updated Review of the Issues and Policy Proposals” – Sally Coberly, PhD