



INTEGRATING ACUTE TO POST-ACUTE CARE SETTINGS: WHERE DO WE GO FROM HERE?

HEALTHCARE LANDSCAPE
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WHAT IS POST-ACUTE CARE?

...what comes after an acute care stay

Goals are to expedite the recovery process, ease patients' transition back into the community, and restore patients to maximum possible level of functioning

- Inpatient rehabilitation facilities (IRFs)
- Skilled nursing facilities (SNFs)
- Long-term acute care hospitals (LTACs)
- Home health agencies (HHAs)
- Continuing care retirement facilities (CCRCs)



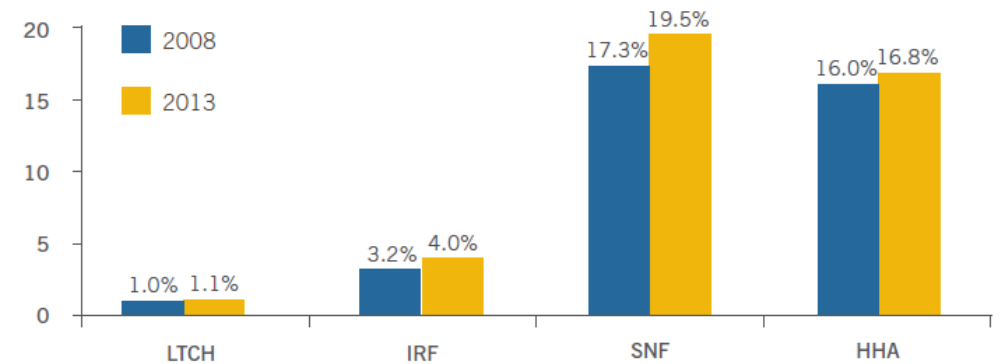
POST-ACUTE CARE: A SECTOR ON THE RISE

Tremendous growth in utilization

- 1/3 of Medicare beneficiaries following acute care hospital discharge
- Rapid growth area in Medicare
- Stems from the introduction of Medicare's acute care hospital inpatient prospective payment system (PPS)
 - Hospitals discharging “quicker and sicker”
 - “Substitutability” touted across settings

The percentage of Medicare beneficiaries discharged from a hospital to a PAC setting increased between 2008 and 2013.

Chart 1: Patients Discharged from Hospital to PAC Setting, 2008 and 2013



Sources: Medicare Payment Advisory Commission. (June 2008). *A Data Book: Health Care Spending and the Medicare Program*. Washington, DC. Medicare Payment Advisory Commission. (2015). *March Report to the Congress: Medicare Payment Policy*. Washington, DC.

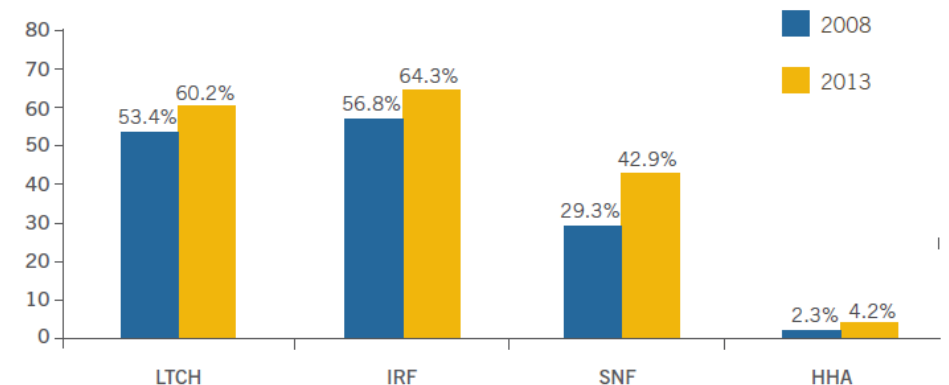
POST-ACUTE CARE: A SECTOR OF SILOS

As individual PPSs and specific regulations were introduced for each post-acute setting, this reinforced the “siloeing” of post-acute care

- Competing for the same patients and conditions due to “substitutability”
- Different histories, philosophies, restrictions, and assessment tools
- Lack of cooperation, coordination
- Continual competition, redundancy
- Difficulty comparing settings

A majority of patients admitted to PAC are later transferred to a second PAC setting.

Chart 2: Percent of Patients that Progress to a Second PAC Setting, from Initial PAC Setting, 2008 and 2013



Sources: Medicare Payment Advisory Commission. (June 2008). *A Data Book: Health Care Spending and the Medicare Program*. Washington, DC. Medicare Payment Advisory Commission. (2015). *March Report to the Congress: Medicare Payment Policy*. Washington, DC.

POST-ACUTE CARE: A WORK IN PROGRESS

Value-based care efforts prompting deeper consideration of PAC relationships

Bundled payment projects leading to questions of PAC integration

Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014

- Prompted by “growing concerns over the rapid growth and wide variation in Medicare’s PAC spending and the lack of uniform patient assessments to gauge quality” (Carter, Garrett, & Wissoker, 2016)
- Aims to eliminate the siloed nature of post-acute care and standardize assessments across post-acute care settings
- Calls for recommendations to develop and implement a unified payment system for Medicare post-acute care



POST-ACUTE CARE: A WORK IN PROGRESS

Strengthening Post-Acute Partnerships 8 Factors for Success

To improve patient outcomes, connect patients to the right post-acute care

How to Build a Successful Acute/Post-Acute Care Continuum

Hospitals are forming networks with post-acute care and continuing care partners to ensure quality across the continuum.

With shared interests in reducing readmission rates and associated Medicare payment penalties, hospitals and skilled nursing facilities are in the vanguard of an evolutionary movement.

8 Steps Hospitals Can Take to Collaborate With Post-acute Care Facilities, Improve Community Health

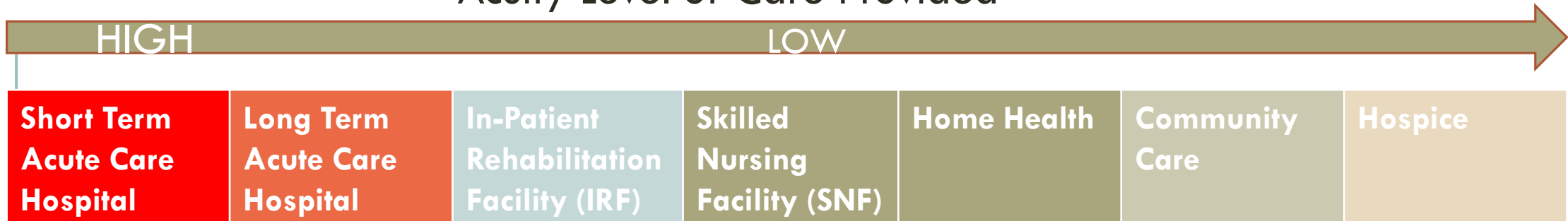
Interfacility relationships can stand to be formalized so that hospital administrators can keep better track of patients throughout the continuum of care. Here are ways hospitals can work to strengthen those bonds.

Managing post-acute care in the 21st century

Why Post-Acute Care Partners Are Critical to Hospitals' Future

Downstream providers will have a growing effect on health systems' reputation and bottom line.

Acuity Level of Care Provided



Key Descriptions

- Short-Term Acute Care Hospital - STACHs are licensed as acute care hospitals. is a level of health care where a patient receives active but short-term treatment for a severe injury or episode of illness, an urgent medical condition, or during recovery from surgery – usually < 5 days.
- Long-Term Acute Care Hospitals – LTACHs are licensed as acute care hospital. LTACHS provide care for patients with serious medical problems that require intense, special treatment for an extended period of time – usually 20-30 days. These patients are among the sickest of patients with multiple co-morbidities and limitations with their Activities of Daily Living. With extensive medical and rehabilitative care required, this patient population represents a small subset of medically complex patients with multiple acute or chronic conditions and/or critical or catastrophic illnesses, such as organ failure, burn trauma, large wounds or mechanical ventilation weaning failure.
- Inpatient Rehabilitation Hospitals - freestanding and managed hospital-based Acute Rehabilitation Units offer full-time rehabilitation, interdisciplinary care management and 24-hour physician-supported medical care to facilitate rapid recovery and return home.
- Skilled Nursing Facility - Skilled nursing staff consisting of RNs, LPNs, and certified nurses' aides (CNAs) are available to provide 24-hour medical attention. Skilled nursing facilities are commonly used for short-term rehabilitative stays.
- Home Health – medical care and services for people who are homebound and can avoid admission to a hospital or nursing home and provide continuing rehabilitation and nursing care to a patient after a stay in another care setting.
- Community Care - delivers needed assistance with daily living activities for Medicaid beneficiaries, low-income individuals and families who want support to provide non-skilled care for a loved one. Services are funded by MCOs for Medicaid and Texas HHSC for additional services supplemented by Title XX programs.
- Hospice - supportive care to people in the final phase of a terminal illness and focus on comfort and quality of life, rather than cure.

POST-ACUTE SETTINGS: IRF

Inpatient Rehabilitation Facilities (IRFs)

- Freestanding rehabilitation hospitals and rehabilitation units within acute care hospitals
- Provide therapeutic and rehabilitative services to restore maximum level of functioning to patients suffering recent disability due to illness or accident
 - *Stroke, spinal cord injury, traumatic brain injury, amputation, hip fracture, etc.*
- Patients receive 3 hours of intense rehabilitation services per day
- Length-of-stay averages roughly 12 days



POST-ACUTE SETTINGS: SNF

Skilled Nursing Facilities (SNFs)

- Provide full range of clinical long-term care services
 - *Skilled nursing care to rehabilitation to assistance with all ADLs*
 - *Rehabilitation an important component of skilled care, as well as therapeutic diets and nutritional supplements*
- Patients qualify for Resource Utilization Groups (RUGs), which vary in the amount of therapy minutes patients receive each week
- Length-of-stay averages roughly 28 days

POST-ACUTE SETTINGS: LTAC

Long-Term Acute Care Hospitals (LTACs/LTACHs/LTCHs)

- Specialty care hospitals that may be freestanding or “hospitals within hospitals”
- Provide concentrated care for patients suffering from comorbidities and conditions that are expensive and complex to manage
 - *Mechanical ventilator weaning, complex wound care, respiratory and cardiac failure, septicemia, etc.*
- Medicare requires an average length-of-stay of at least 25 days

POST-ACUTE SETTINGS: HHA

Home Health Agencies (HHAs)

- Agencies providing health care services by health care professionals in patients' homes
 - *Nursing care, rehabilitative therapy, medical supplies and equipment, etc.*
- Patients must have a physician-reviewed plan of treatment and require intermittent or part-time skilled nursing and/or rehabilitative therapy

POST-ACUTE SETTINGS: CCRC

Continuing Care Retirement Communities (CCRCs)

- Provide “one-stop shopping” for residents
 - *Retirement living*
 - *Personal care*
 - *Nursing care*
- Campuses allow for “aging in place”
 - *Independent living*
 - *Assisted living*
 - *Skilled nursing*

WHY THIS MATTERS...

“Let’s make sure patients go to the right place to get the right care...”

- What happens when patients are sent to an inappropriate setting for post-acute care?
- How are we doing with recent efforts to improve post-acute care?
- Are we making progress in improving the care that patients receive after their hospital stay?
- Does this really make a difference for acute care hospitals?

LET'S HEAR FROM OUR PANEL...



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