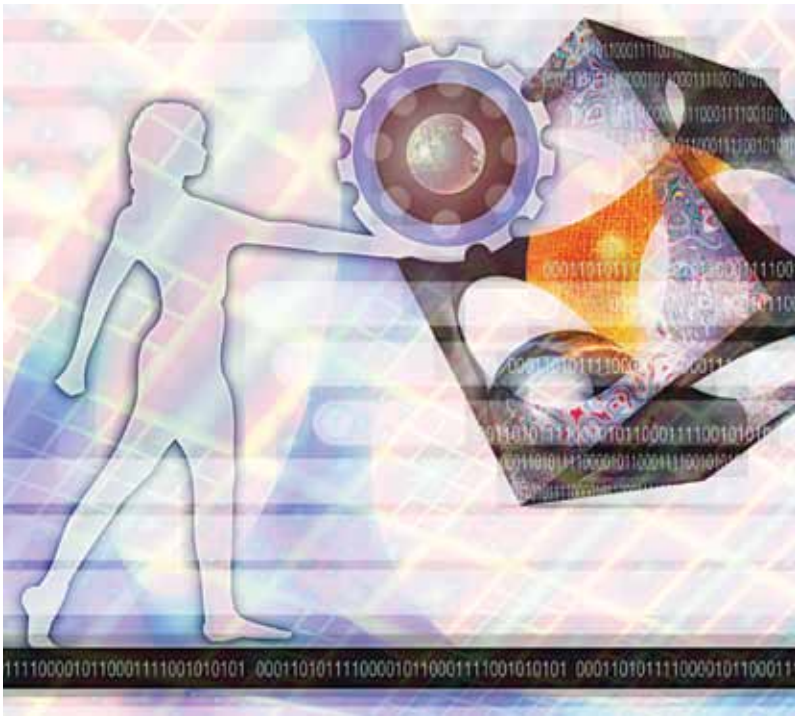
ROUNDTABLE

Postacute Care and the Care Continuum

Hospitals and health systems increasingly must work with providers across the continuum of care to meet the demands of value-based purchasing, reduced reimbursements, new payment structures, and readmissions penalties. Postacute care is the subject of increased interest and focus because it holds the dual promise of improved clinical care and cost containment. Many healthcare providers are purchasing or partnering with a range of postacute facilities such as long-term acute care hospitals, inpatient rehabilitation facilities, and skilled nursing facilities, as well as home- and community-based services such as home health and hospice care. Important structural and financial questions remain to be resolved as well as the identification of partners that integrate postacute care plans across the care continuum.



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SHUTTERSTOCK

Roundtable Highlights

HEALTHLEADERS: *At what stage is each of your organizations in postacute care strategy?*

MIKE BOWERS: California is unique both from an operating perspective as well as from a regulatory standpoint. My hospitals are right in the heart of the Central Valley area, and so our struggles or issues are very different compared to other markets in the state.

Our focus in our market is really figuring out what the fragmentation or gaps look like, both from a quality and an accessibility standpoint, and then determining how and who we partner with. We have good home health providers. Our own home health and hospice programs do very well from the quality aspect, but my biggest issue and concern is the other attachment points along that postacute side. We have very poor skilled nursing in the community, and a marginal-quality outcome rehab hospital. We do not have an immediate postacute higher-acuity option like an LTACH [long-term acute care hospital]. If you need that level of care in the market, you have to either go into L.A. or to the Bay Area, so we're working on a strategy to partner with a provider who will put an LTACH in one of our hospitals.

We're also partnering with some FQHCs [federally qualified health centers] in the community for unassigned patients, and we've been looking at establishing a community care clinic and as well adding more resources for the discharge process to better support assignment of patients across the postacute care continuum.

MARK NESSEL: In New Jersey we have similar challenges. We do have an LTACH that's part of our hospital. We have acute rehab within our hospital. Those really don't present any problem. Actually, the patient flow in transitions works very well.

We're working on [what happens] when [patients] get out in the community. There are socioeconomic issues.

We have a large cardiology program we're working on with a long-term care facility. We have 50 employed cardiologists, and they're in a comanagement model, which really drives the innovation. Their metrics are around quality. They have been willing to be much more proactive in looking at the postacute care world. Since we're not at risk, it's hard to get people excited about that.

The second thing we've done is study the results from one of our long-term care facilities. We're working with three, but a nurse practitioner did a very specific study around one. We've gone out to them and said, "We are willing to work with your cardiac patients, but we need a subsidy because we can't legally do that without a subsidy." They've been willing to subsidize it. The nurse practitioners come in twice a week. They first identify every patient that has a cardiac condition, and they follow them. Then a cardiologist goes to the facility twice a month and reviews all the records.

In the first year, they had 212 patients identified, and 45 of them were readmitted. In the year we just finished, with this program they had 18 out of 173. They've actually cut the readmissions from 20% to 10%.

This facility, we're actually driving their metrics. We're pretty excited about that because we see that as we go into these shared savings programs, we're actually going to be sought out for our cardiology program because we're going to have these connections out into the community.

PAMELA DUNCAN: Our community in the Northwest Triad region of North Carolina has one of the highest readmission rates in the state. Wake Forest Baptist Health, Forsyth Medical Center, and community agencies were leaders in the community to work with the Carolinas Center for Medical Excellence under the CMS 10th Scope of Work to conduct a communitywide root cause analysis of the readmission issue. It is noteworthy to mention that the coleaders of this effort, Wake Forest Baptist Health and Forsyth Medical Center, are the predominant health systems in the community and are fiercely competitive within this healthcare provider market. The root cause analysis process and the associated community engagement activities shifted the focus from competition to collaboration, which not only improved collaboration among the health systems, but also led to the development of the Northwest Triad Coalition for Improved Care Coordination. This coalition engages medical and social services to improve care transitions. The root cause analysis also informed WFBH's strategic priorities for the integration of postacute services.

Leslie Boney
Vice President of
Postacute Development
Community Hospital Corporation

For example, our root cause analysis revealed that home health providers had the highest rates of 30-day readmissions. Our frequently admitted patients have very high levels of acuity, multiple complex comorbidities, residences in socioeconomically challenged areas of the community, and have Medicare and Medicaid as their most likely form of health insurance. The challenges with the readmissions attributed to home health offered opportunities for better management by the health system as well as by home health. We subsequently decided that

we would develop a joint venture with a home health enterprise where we can manage our patients seamlessly from the hospital to home health.

Within the model of care developed by the joint venture, patients may be seen by home health within 24 to 48 hours of hospital discharge. However, even with a more timely response on the behalf of home health, there are often medical and social challenges or functional declines that patients face during this tenuous transition. These challenges are often complicated due to the probability of the patient being unable to access his or her primary care physician due to scheduling constraints. The inability of home health to communicate with the primary care provider or the hospitalist who may have rotated off of the patient's discharging service also presents a barrier. Without reestablishing a strong connection among the key medical providers, home health often decides to send the patient to the emergency department when issues arise within the home environment. We have developed a different model of home health where our home health team has immediate access to a WFBH physician who is also the home health medical director. In addition, this WFBH physician leads a multidisciplinary team of hospital-based and home health providers that has virtual rounds twice a week to review patients with multiple comorbidities and at high risk of readmission.

Mike Bowers, FACHE
Vice President &
Chief Operating Officer
Mercy Hospitals of Bakersfield

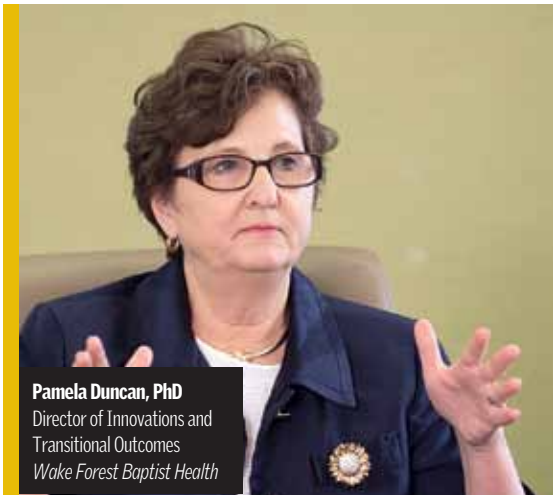
The current challenge is to move the current focus from home health and hospital engagement toward the achievement of the long-term goal, which is to strengthen the model of collaboration with primary care. Our goal is to get the patient and home health providers engaged as soon as possible with a trusted primary care provider. We are continuing to learn more about the challenges in relation to operations and implementation that exist and serve as impediments toward achieving this goal.

TIM KIRBY: With the Dallas market, we have no certificate of need. We have lots of skilled nursing and home health and LTACHs, heavily overutilized. If you look at the Medicare data and you look at the average cost on the CMI [case-mix index]–adjusted basis, the Dallas market is about $2,000 over the national average. All of that $2,000 is in postacute care with about two-thirds of it being home health. That's the market situation that we're starting with. That situation had us focusing on what happened outside of our hospital.

One of the things we had to start doing very early on was capturing where we were sending people. In early 2012, we realized this was an issue, and we started putting a focus in our hospitals on capturing that data as well as capturing data for when people came back. We would just code they came from home health or they came from skilled nursing. So we had the list of some of these providers, and we sent out a request for information with a lot of questions to these skilled nursing and home health [providers] that we used a lot and asked for self-reported information. Then we went to those that responded to us, and we went back to some that were getting referrals, and we said, "You didn't respond to us. Give us your information if you would like to be part of our emerging network."

From that we had a group of maybe 60 skilled nursing facilities that we invited to a skilled nursing summit. We did some work with them and came up with what we think is our beginning set of metrics that we're going to use.

We now have our preferred group of about 20 SNFs to start off with, and we have those that didn't make the cut. We've had a follow-up meeting with the ones that made the cut to begin refining it even more, and we invited those that didn't make the cut to a separate meeting to say, "How can we help you raise your standards and your quality so that you can be a part of this?"



Pamela Duncan, PhD
Director of Innovations and
Transitional Outcomes
Wake Forest Baptist Health

We shared the same type [of] questionnaires with home health providers. We had our first home health summit in November 2013, and we're still working on what's going to be the preferred group versus the non-preferred home health group.

Our legal counsel has approved a letter to give to the patient that lists our preferred network: "You've got a choice of whoever you want, but here's why we would think these might be a good choice for you to use."

We've also coordinated with, and we meet regularly with, the people that lead our in-house care management teams, and people from our ACO [accountable care organization] have been meeting regularly to work on transitions, identify patients that are in the hospital, and get them synched up before things go wrong.

LESLIE BONEY: Community Hospital Corporation is already focusing on both acute as well as postacute care services from a consulting, management, and ownership perspective. Our

strategy is to meet the need in the community in working with our hospital partners. What we're trying to do is to educate those who may have been running an LTACH how to do that better or differently for financial success ... and keeping the continuum of care in mind, to ensure patients receive the right care in the right place at the right time. Key to their financial success is the clinical criteria for appropriate admission—and, of course, managing the patient over a defined period of time. Our unique model can offer financial savings for traditional hospitals which have not been adequately reimbursed to care for the patient who requires an extended acute hospitalization. It may be challenging to navigate the specific rules for LTACHs, as well as the new [SGR Reform Act of 2013] law, but there are several benefits to operating and integrating an LTACH, and that's what we help our hospital partners with. It's also important to modify a strategy over time as an acute-care hospital changes strategy, and as the population and health needs in a community also change.

HEALTHLEADERS: *Have home health and skilled nursing facilities been receptive to improving their quality and transparency in order to be considered a preferred provider?*

KIRBY: Right now, we're finding they're very receptive because it's a competition. Who's going to get the volume and who's going to survive? It might be different if there were only three skilled nursing facilities, but there are hundreds in the marketplace and we find enough of them are stepping up and saying we want to be part of this, we want referrals to come to us, we are willing to work on being a different kind of system in the organization.

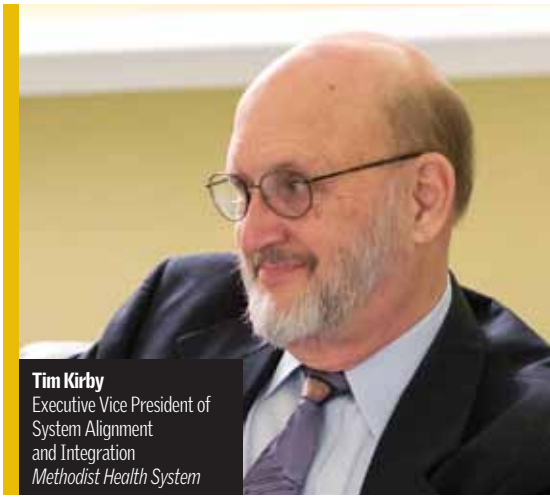
DUNCAN: It is quite different in Texas than in North Carolina because we're a certificate of need state. We are sometimes limited in the number of skilled nursing facilities that will serve the more complex patients. It's all very regional, but our nursing home providers are truly interested in improving care and collaborating, so they are definitely coming to the table.

BONEY: What we have seen is that people really want to provide good care. Some key challenges with home health or skilled nursing are cost reimbursement structure; it costs a lot of money to reengineer. Where is that money to reengineer coming from? Some systems have it better than others. It all goes back to volume. You can't make money in home health if you don't have a certain volume, and you also can't deal with the quality structure or even the purchasing power if you don't have good infrastructure. So for these little mom-and-pop shops who don't have that, it becomes more and more of a challenge. It is fine for us to say "give me this data," but that's a big shift to them and their infrastructure to provide this data quickly. You've got to bring all these larger enterprises together who can do major purchasing and create an infrastructure to manage the quality.

BOWERS: I agree, and it becomes a compounded problem because it's location, location, location. The integration needed to sustain quality and access is going to create a new cost shift that may not be sustainable in smaller markets and as well will drive competition within bigger markets. It's getting more complicated very, very quickly.

HEALTHLEADERS: *Postacute providers, such as LTACHs and SNFs, are emerging as critical partners to keep readmissions down. What are the challenges this presents under current healthcare reform?*

BOWERS: There has to be some incentive behind it—both for the traditional acute providers and the postacute providers. We know we will see a decline in reimbursement in the acute setting, and there's not necessarily any incentive on the back end or downstream in the care continuum that will be increased enough to support the added cost of caring for the added acuity, or the integration to support access to the



Tim Kirby
Executive Vice President of System Alignment and Integration
Methodist Health System

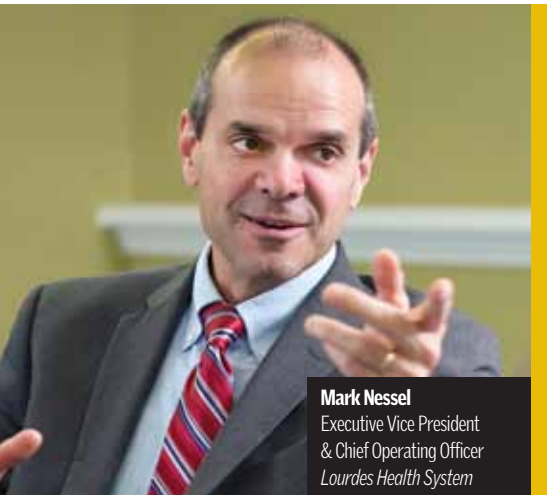
right care in the right place, or the IT structures that will be needed to share information across that continuum. The acute side is going to be looked upon as the integrator, and there's a cost element to that that in some markets is going to be unsustainable. The barrier to entry will be too high for many to support the quality needs and infrastructure to really address population health management effectively.

NESSEL: We just finished our strategic plan, and our goal is to be a population manager as opposed to a health system. The change is good for us. We've already made that distinction that we are not going to live and die by the bricks of the hospital. Once you've made that decision, it changes where your resources and capital go.

KIRBY: I have experience in retail, grocery, and banking. They went through massive structural changes: consolidation. That's what is going to have to happen in healthcare with all these little skilled nursing facilities and mom-and-pop home health providers. Having been in the grocery business years ago and seen how things evolved, you used to have the grocery store and the drug store and the hardware store, etc. They reengineered all of that into one kind of facility. That's what healthcare needs. We've got to reengineer all of these separate silos into something that's more connected.

BONEY: One thing to understand about postacute care is that there is a path of recovery. If you don't get patients "rehabbed" to the level of enough mobility so they can move about and not fall as well as manage their healthcare, then it's just the start of a vicious cycle.

The biggest challenge when we bill with this elderly population is to understand that we're not about the episode of 30-day care; we're about the trajectory of recovery as well as the course toward decline. We have to understand this decline as well, because when we go to palliative and hospice care, in reality,



Mark Nessel
Executive Vice President
& Chief Operating Officer
Lourdes Health System

if you present to a hospital with end-stage congestive heart failure, COPD, and renal disease, your probability of dying is much higher than if you have stage four lung cancer.

But because the patients have lived so long with these chronic diseases, the physicians, the patients, and their families are not really quite ready to believe this reality, so that no matter how many more readmissions I have to the hospital, it's not going to change my trajectory. They would be better served with palliative and hospice care in the home rather than to keep coming back to the hospital.

BOWERS: I think there's also a big piece of it dependent upon accessibility. There is going to have to be sort of a mind shift in who can provide those resources and not have care be just dependent upon the MD or the DO in order for new structures to be sustainable. It has to include the nurse practitioner, it has to involve the PA [physician assistant], it has to be the physical therapist or the pharmacist—those that have the license and the ability to more easily integrate into the new care models at a lower cost. Because there are not enough rules and regulations allowing other providers to have greater roles that can be extended to that postacute care setting at a lower cost, we're dependent on some element that has been and is continued to be driven from the fee-for-service on the MD side of it.

When I look at, on some level, the impact on a patient's health, first it is really influenced by four factors. One, it is genetics. Two, it's the environment in which we live. Three, it's the lifestyle in which we live in that environment, and four, it's the healthcare network that exists around the first three. Somehow the healthcare network and lifestyle have to begin to merge at a greater rate, and to be able to do that you have to have the accessibility.

So again, it's a cost shift. Who picks up that tab to be able to do that integration?

KIRBY: We work with an agency here in town called the Senior Source. They have a senior sitter program where an elderly person in fairly good health and without a job is paid a minimal amount of money and lunch to be the caretaker.

We have also been working with the city of Dallas fire and rescue department, who is making lots of unneeded runs on people and bringing them to our hospital. But in Texas, under the direction of doctors' orders, a paramedic can do things that nurses and other people can't.

We're looking at how can we use the fire and rescue people when they go out on some of these calls so they don't have to bring that person back.

DUNCAN: One thing that we are beginning in the Northwest Triad region of North Carolina, which has been highly successful in Memphis, is to mobilize churches in the community in order for health systems and other community organizations to partner with them on the journey of health and healing. The movement that has begun in North Carolina is called FaithHealthNC. So, how do you get churches mobilized to bring the needed food, transportation, and to assist residents by taking this on as their mission within their own communities? That's really important in socioeconomically disadvantaged communities.

As I've mentioned, what we found when we did our root cause analysis while also being aware that we have a large Medicare/Medicaid dual-eligible population, we identified one large nursing home that had the biggest bounce-backs of this population. Everybody says, "That is a terrible nursing home," but in reality, it was dealing with very socially complex patients. No one else would take them. They were patients who didn't have good, healthy lifestyles before or may have had dysfunctional relationships.

We decided that that it was a part of our mission—to work with that nursing home to take our geriatrician and nurse practitioner staff in there and really walk the journey with them. A few of the patients also receive support from a chaplain from our Division of Faith and Health Ministries because a lot of the issues that contribute to ED visits are people "wanting"—they're tired of sitting in the nursing home. They don't like the food. They want more attention. So if individuals that can relate to them and are a part of their community can join their journey, [then] that may help.

BONEY: I think we have to consider we're pushing very sick patients out into the postacute side—the LTACH, the skilled nursing facility, and the home health providers. There is a major shift to reduce services in those areas. You're really shifting the acuity of your patient with complex medical and social issues to new environments.

We are going to have to build more systematic collaborative partnerships that would help us financially in our organizations as well as contribute to overall quality of care.

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