Transitions Through the Care Continuum: Discussions on Barriers to Patient Care, Communications, and Advocacy

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Disclosure Slide

- I have no financial disclosures

Post-Hospital Space

- Return to Usual Home
  - Private Primary Care Clinician
- Skilled Nursing Facility
- Rehabilitation Hospital
- Long-Term Acute Care Hospital
- Home Health
- Hospice

Post-Hospital Space

- Non-Medicare Home Health
- Private Assistance
- Family Assistance
- Change in Home Environment
  - Assisted Living
  - Home of a Family Member

Economic Forces that Have Shaped the Transitional Space

Hospital

- 1965 Medicare Act
- 1983 Diagnostic Related Groups for Medicare
- 1988 DRGs for Everyone
- 1990's Hospitals, HMOs…Learn that keeping a patient in the hospital is not a great thing for them financially

Skilled Nursing Facility

- 1986 — IOM study noting Nursing Home Abuse & Neglect
- 1987 — Nursing Home Care Act in the Omnibus Act of 1987 'Second most regulated industry next to nuclear power plants'
- 1990-97 — Golden Years
- 1996 — Minimum Data Set = 350 data points about each resident on the 5th, 14th, 30th and q 30 days for subacute patients
- 1997 — Resource Utilization Group (RUG) which are 66 levels of care that correlate to a revenue for the nursing home

Home Health

- 1999 OASIS data set (Outcome and Assessment Information Set)
- 2000 Case Mix Payment in 60 day episodes of care and are paid prospectively. There are 153 case-mix groups.

Hospice

- Four Levels of Care (routine home, respite inpatient, acute inpatient, and continuous care)
- Average daily reimbursement is $150/day

Burdens of the Clinician

- Reimbursements neutral
- Burden of maintaining an office
- Burden of documentation
  - How many EHRs can you possibly learn?
- Burden of Regulation
- Burden of Travel

Clinician Economic Timeline

- 1995-96 Hospitalist Programs
- 2000-05 Now We Are Three
  - Hospitalist
  - Nursing Home Specialist (SNFist)
  - Primary Care Clinician
- 2017 Further Specialization
  - Nocturnalists, Admissionalists, Intensivists
  - Subacute vs. Long-term Care

Why are Hospitalist Programs Successful?

- Hospitals
  - Shorter lengths of stays
  - The Medical improvements that go along with that
    - Infection, function, adverse effects
- Hospitalists
  - Higher income than typical primary care physician
- Primary Care Clinician
  - Economies of scale

Barriers to the Care of the Patient in Transition

- Patient Information
  - Multiple EHRs that do not talk to each other
- Multiple take-offs and landings for the patient
- Difficulty in intervening with the primary care physician

Models of Care in the Transition Space

- Some primary care clinicians in this space
- Primary Care Groups that have a presence in the nursing home
- Dedicated practices in skilled nursing facilities
- Hospitalist groups that refer to themselves in SNFs

More Regulation with ACA

- Payment Regulations with 30 day Readmission Penalty = 3%
  - CHF, Pneumonia, COPD, Hip and Knee Replacement
- Quality Regulations with Penalties = 1%
  - Measures of bloodstream infections in patients with central lines; urinary-tract infections for catheterized patients; surgical-site infections; and a composite score of eight quality measures, such as pressure ulcers and sepsis

Table 1: The first five years of the Hospital Readmission Reduction Program

Year penalties applied	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Performance (measurement) period	June 2008-July 2011	June 2009-July 2012	June 2010-July 2013	June 2011-July 2014	June 2012-July 2015
Diagnoses of initial hospitalization	Heart attack Heart failure Pneumonia	Heart attack Heart failure Pneumonia	Heart attack Heart failure Pneumonia COPD Hip or knee replacement	Heart attack Heart failure Pneumonia COPD Hip or knee replacement	Heart attack Heart failure Pneumonia (expanded)* COPD Hip or knee replacementCABG
Penalties: Percentage reduction in base payments on all Medicare inpatient admissions					
Maximum rate of penalty	1%	2%	3%	3%	3%
Average hospital payment adjustment (among all hospitals)	-0.27%	-0.25%	-0.49%	-0.48%	-0.58%
Average hospital penalty (among penalized hospitals only)	-0.42%	-0.38%	-0.63%	-0.61%	-0.74%
Percent of hospitals penalized	64%	66%	78%	78%	79%
Percent of hospitals at max penalty	8%	0.6%	1.2%	1.1%	1.8%
CMS estimate of total penalties	$290 million	$227 million	$428 million	$420 million	$528 million

Hospitals with Coercive Influence

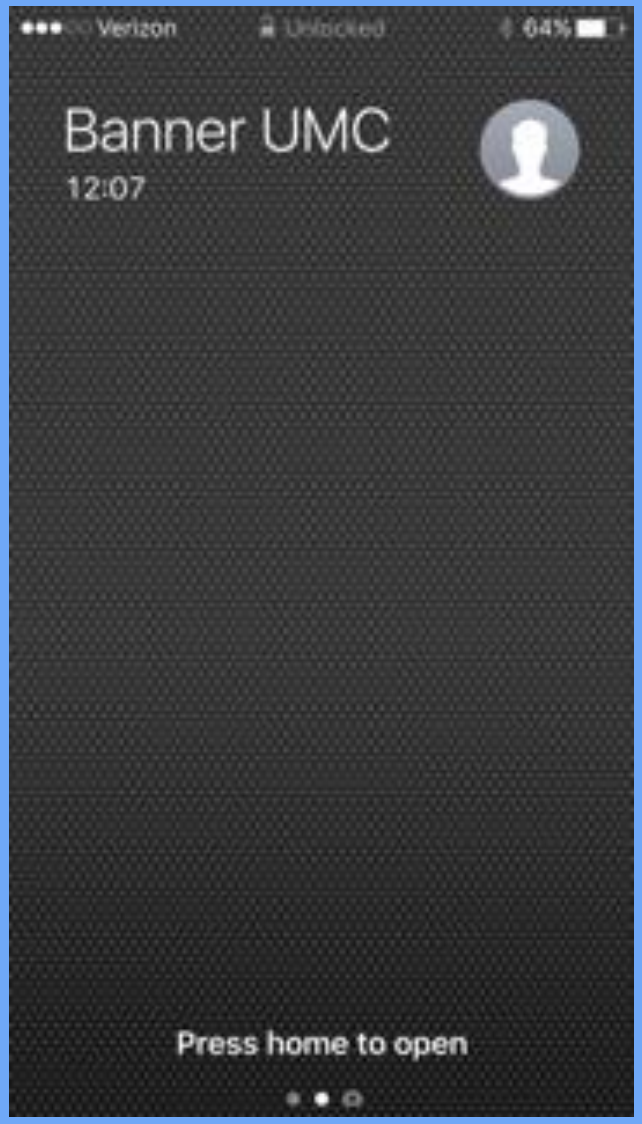
- Hospitals making demands of skilled nursing facilities on the return to hospital rates when patients are discharged from the hospital in 3+ something days.
- Hospitals are setting the tone for the entire downstream
  - They consider themselves the gatekeepers
  - They have the penalties
  - They have the resources to monitor
  - They are the most monitored

Pause for a Moment

- Patient that went to the hospital
- Cared for by a hospitalist(s) unfamiliar with the patient and the primary care physician
- Who writes for discharge based upon needs of the patient
- To another healthcare entity (SNF, HH, Hospice) often with little input by the primary care physician, the patient, or the family
- Goal by the hospital to limit the length of stay

Practicing in the SNF

- Rarely get a phone call from the hospitalist
- Average 50 pages, mostly useless, of hospital records
- Average discontinue three medications
- Nurses sign out to each other, but somehow clinicians do not
- Left with decisions about isolation, ordering bloodwork, wound care, etc.
- ~25% patients have no primary care clinician
- Try to make phone at least two phone calls a day
- Discharge patient with our notes
- Attempting to follow the patient with a least one visit after discharge into their homes


Verizon
Unlocked
64%
Banner UMC
12:07
Press home to open

Further Changes are Coming!

Bundled Payments for Care Improvement (BPCI)

- Programs started in 2013
- Past was quantity over quality
- The bundled payment encourages cooperation between all providers of care across the continuum


KINGSMILL
MEDIUM
50/50

What will BPCI Cover?

- Acute myocardial infarction
- Amputation
- Atherosclerosis
- Automatic implantable cardiac defibrillator generator or lead
- Back and neck except spinal fusion
- Cardiac arrhythmia Cardiac defibrillator
- Cardiac valve
- Cellulitis
- Cervical spinal fusion
- Chest pain

What will BPCI Cover?

- Chronic obstructive pulmonary disease, bronchitis/asthma
- Combined anterior posterior spinal fusion
- Complex non-Cervical spinal fusion
- Congestive heart failure
- Coronary artery bypass graft surgery
- Diabetes
- Esophagitis, gastroenteritis and other digestive disorders
- Double joint replacement of the lower extremity
- Fractures femur and hip/pelvis
- Gastrointestinal hemorrhage
- Gastrointestinal obstruction

What will BPCI Cover?

- Hip and femur procedures except major joint
- Lower extremity and humerus procedure except hip, foot, femur
- Major bowel Major cardiovascular procedure
- Major joint replacement of the lower extremity
- Major joint replacement of upper extremity
- Medical non-infectious orthopedic
- Medical peripheral vascular disorders
- Nutritional and metabolic disorders
- Other knee procedures
- Other respiratory
- Other vascular surgery
- Pacemaker
- Pacemaker Device replacement or revision

What will BPCI Cover?

- Percutaneous coronary intervention
- Red blood cell disorders
- Removal of orthopedic devices
- Renal failure
- Revision of the hip or knee
- Sepsis
- Simple pneumonia and respiratory infections
- Spinal fusion (non-Cervical)
- Stroke
- Syncope and collapse
- Transient ischemia
- Urinary tract infection

How do BPCIs Work?

- The ‘owner’ of the Bundle is called the Convener
- A set price for the cost of care for a specific disease
- Over the Course of ~90 days, charges accumulate in an imaginary bucket
- The accumulated charges are compared to the cost set by CMS
  - If less, Convener earns money
  - If more, Convener pays money

Positive Aspects of BPCI

- Saves CMS $
- ~~Encourages~~ Forces collaboration among entities across the continuum
- Removes some of the heavy handedness of the upstream partners (hospital)
- Discharge with a purpose in mind other than just getting the patient out of the hospital, or Skilled Nursing Facility, etc.

Negative Aspects of BPCI

- Even less control by the patient
- Less control by the primary care physician
- Commitments and relationships that are inflexible

How will Valued-Based Payments Affect the Healthcare Landscape?

- There is not going to be room for everyone as entities align
- Less indiscriminate choices within the healthcare continuum
- ‘Forced’ interconnectedness of the EHR
- Telemedicine will finally be a tool in connecting patients to their physicians, nurses, caregivers
- Care Navigators will be a necessary (finally!) part of any collaborative experience

Rise of Transitionalists

- The new systems will demand a different approach to the care of the patient that will require not just the care of the patient in the hospital or the skilled nursing facility (rehabilitation hospital, LTAC) but also for the rest of the 90 days of their 'illness'
  - home health
  - hospice
  - health management
- Who will be the clinician for the other ~60 days?
- The Transitionalist will be the clinician behind a consortium of connected healthcare entities tied together by quality and financial ties

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