Transitioning Patients Within Post-Acute Care:

It's Time to Ensure the Best Care in the Best Setting for All

Traditionally, most coordinated patient care transitions have occurred between acute and post-acute settings. Getting a patient out of the hospital and into a skilled nursing facility (SNF) or back at home has been the primary goal. However, change is in the air when it comes to continuity of care.

Today, forward-thinking post-acute care (PAC) providers are increasingly focused on care transitions within PAC. Imagine moving a home health patient to hospice at just the right time to obtain the greatest outcome from that care transition. As an industry goal, patient-centered care transitions deserve to be at the top of the list.

While patients - and their caregivers - should always be the primary beneficiaries of intra-PAC transitions, others involved in the care continuum can also gain from expanding this practice. Enterprise providers with financial stakes across multiple post-acute service lines, such as skilled nursing, personal home care, home health, rehabilitative services, infusion clinics, and hospice, should prosper if they "own" more of the patient care market continuum. It may be time to explore a new business model for intra-PAC transitions.

The Stakes are Higher Every Day

According to its latest projections, the U.S. Census Bureau says there will be 77.0 million people aged 65 and older by 2034, outnumbering children under 18 for the first time. When all baby boomers have reached age 65 in 2030, older Americans will account for 21 percent of our population, versus 15 percent a couple of years ago.[1] CMS predicts that national health spending will grow 5.5 percent per year on average between 2018 and 2027, to nearly $6.0 trillion!

With all the new Medicare enrollees, Medicare spending will also increase, by an estimated average of 7.6 percent per year.[2] The bottom line: the cost to care for our aging population, whether in acute or post-acute settings, will be an astronomical burden if changes aren't implemented.

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COVID-19 has further upped the ante. How much higher will these statistics go? Perhaps COVID-19 will provide an impetus towards more intra-PAC transitions. According to Anne Tumlinson, CEO of research and advisory services firm ATI Advisory, while partnerships across providers are challenging to implement, post-acute providers are increasingly motivated to work together to decrease hospital readmissions.[3] She sees potential for the CARES (Coronavirus Aid, Relief, and Economic Security) Act to affect future policy.

"With respect to post-acute care, the CARES Act makes it easier and more streamlined to refer and activate service in different settings. Hospitals can make quick decisions and send patients off without taking the time to determine if they're qualified for the service. Once the chaos in the delivery system settles down, it will be interesting to see if some of the pre-CARES Act barriers are permanently removed."

We're not where we should be in delivering high-value experiences for patients. Getting providers to work together on a regular basis, from acute to post-acute, or between post-acute services, would enable better performance on quality measures. Plus, the institution of cross-setting payment systems would help improve coordination of care – and outcomes – across all transitions.

PAC Incentives and Education Still Elusive

There's evidence that regulatory factors are starting to have an impact on the continuity of care. CMS and other payers are beginning to motivate the post-acute sector to join value-based contracts and move towards a unified payment system. Contributor Dan Mendelson writes in Forbes that post-acute care is poised to experience "some of the greatest changes it's seen in decades."[4]

"Post-acute providers are invaluable partners to hospital systems. Acute care facilities are being incentivized to move their patients to lower-cost, clinically appropriate care settings, and post-acute care providers are vital clinical and operational collaborators that can reduce preventable re-admissions and ensure the health and well-being of patients with complex needs."

Mr. Mendelson also notes that more seniors are choosing Medicare Advantage (MA) plans, which are bound to propel care delivery and payment reforms. He sees post-acute care providers offering chronic condition management, preventative health initiatives and care coordination programs that support MA performance. In addition, post-acute providers are being held more accountable:

"CMS is also rolling out value-based purchasing (VBP) models across the post-acute sector, further solidifying the link between payments and performance on hospital readmission rates and other key measures." Will this create a new market vertical for those that fall out to engage?

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"The MA plans, the hospital health systems or ACOs, who are either in charge of the payment or the patient movement, or both, aren't collaborating with SNFs or home health in any deliberate way. So the post-acute care provider may find it difficult to realize a return when it invests in technology to manage those transitions," Ms. Tumlinson points out.

Some post-acute providers don't even know what technology they need. And it's often frustrating for them to get cooperation from the acute care sector. Will smaller facilities merge into larger systems possessing the technology and analytics to move the market's needle?

Financial Considerations Remain

There are also financial considerations in preparing for intra-PAC transitions, something which Jackie Dukes, vice president of innovation and efficiency for CommonSpirit Health at Home, says cannot be overlooked.[5]

"Large, multi-site or multi-state agencies are much better suited to investigate and adopt the technologies that will lead to good intra-PAC transitions. Small independent post-acute providers, perhaps with only one or two locations, just can't afford to implement technologies if they're not going to be reimbursed for the care they provide. As an industry, we need to advocate for the use of that technology – whether you're big or small – across the board."

Sandra Schrauf, senior vice president of innovations for Amedisys, agrees that payment reform has not kept up with rewarding absolute best practices, offering the examples that palliative care and home safety assessments are not covered by many plans.[6] However, she says post-acute providers are being more thoughtful about utilization management, which is fundamental to making the right transitions. Ms. Schrauf is convinced that intra-PAC transitions offer financial benefits, and mitigate risk, if they're done correctly.

"For example, a patient in a post-acute facility could be transitioned to safe care in a home environment, providing financial relief to a plan and potentially to a patient. Caregivers often see quick increases in functionality and improvements in their well-being when patients are back in a familiar and safe home environment. Getting that right can be incredibly important."

What About Technology?

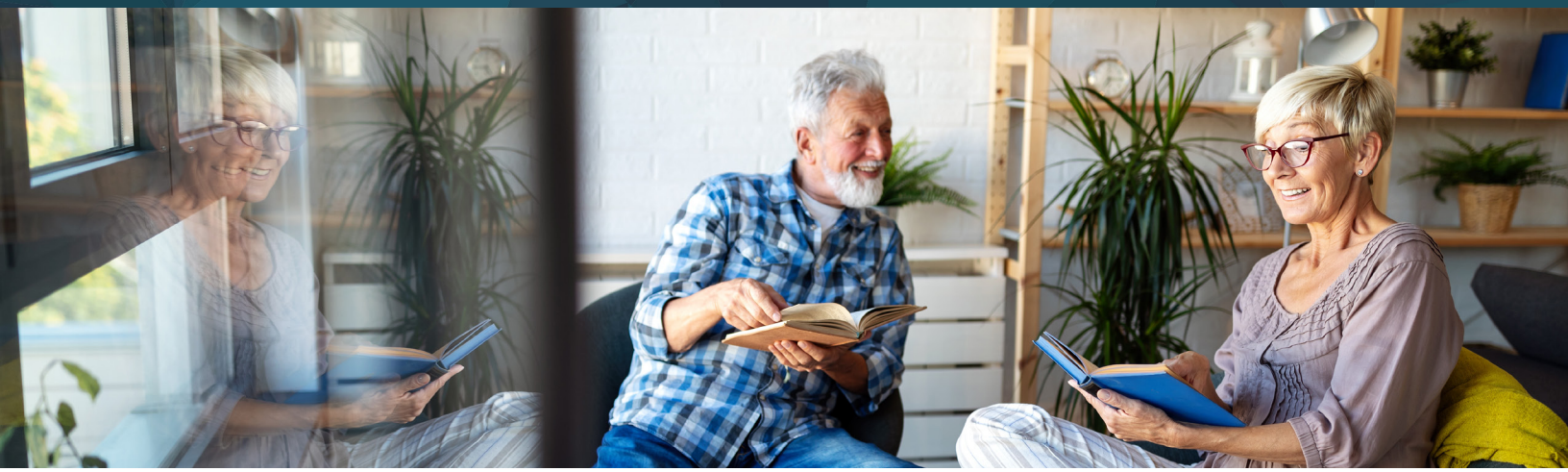
CMS has set its sights on getting post-acute providers to adopt electronic health records (EHRs), now that they're widely used in the acute care sector. Besides the lack of federal incentives, interoperability has been the biggest stumbling block to smooth intra-PAC transitions for post-acute care providers.

Thankfully, action is well underway on the connectivity front. Two not-for-profit organizations, Carequality and CommonWell Health Alliance, are active proponents of seamless health data exchange. And Robert Samples, senior program manager for ESAC, Inc., - which is participating in the PACIO Project – is working to extend interoperability in both the acute and post-acute care spaces.[7]

"There are still a lot of challenges, even within organizations where doctors are using one EHR and the hospital is using a different one. Some organizations have multiple EHRs within their own groups that can't talk to one another. So we're really looking forward to FHIR, which would allow servers to talk to one another – between EHRs, between the government and providers, and between providers and patients. "

FHIR (Fast Healthcare Interoperability Resources) is an exchange platform that describes how health data should be structured and exchanged in any use case. It's designed to be very flexible, so a truly interoperable data platform could potentially be deployed worldwide in every healthcare setting.

"It tries to be descriptive, rather than prescriptive, and very easy to use," notes Mr. Samples. "Plus, multiple implementation guides will help meet specific needs. The 'F' in FHIR means 'fast,' and I've never seen developers and even non-technical folks be able to pick up a specification and make it work as quickly as they can with FHIR."



With FHIR still in its infancy, Mr. Samples sees interest, testing and implementation growing among post-acute care vendors…but it won't be obvious to users in the PAC community.

"If we as standards developers are doing it right, providers should never even know they've adopted FHIR. We want it to provide a platform in between what the provider is doing and whoever might need to access that data, so the users never really see much of a change. Being able to seamlessly transfer information between care settings, and querying back and forth, is of utmost importance when it comes to patient care and safety. We need to put the patient at the center of their data, the way things are documented and communicated, so they can take more control of their own care."

So How Are PAC Providers Responding?

It's never too soon to begin preparing for the inevitable – and some post-acute care providers are already positioning themselves to lead the way in intra-PAC transitions. They're:

- diversifying their services, to offer a greater variety of post-acute options while increasing revenue;
- identifying the post-acute sites with the highest quality care ratings as reference points when it's time to transition a patient;
- measuring their own performance against the upcoming value-based criteria.

PAC agencies are also identifying the resources they need to make transitions go smoothly, for both the patients and the providers. Ms. Dukes says there's one key ingredient to successful transitions.

"Technology is the lynchpin to making it all work. There's more demand for interoperability, to ease that transition. Whether it's in another true healthcare facility, like a SNF, or keeping patients' families in the loop, you also need technology to support communication. The options out there are amazing now, like telehealth. The pandemic has really highlighted the need for easy-to-use, widespread, and connected types of technology. I'm curious to see if that continues once the public health emergency is over." Ms. Schrauf echoes the significance of technology in moving towards more and better intra-PAC transitions.

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"Technology now plays an important role, and will play an increasingly important one, in helping to identify the right setting of care. We're seeing more connectivity established across different settings of care, offering broader availability of care transition information. That's going to allow more graceful care coordination and more timely insight into patients as they enter and exit different parts of the care continuum. We'll be able to intervene more quickly and keep them stable and comfortable while easing the burden on the healthcare system."

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So as a post-acute care provider, how are you organizing your technology resources to execute an intra-PAC transition strategy? You should look for solutions that help you:

- ***Better manage your organization***
- ***Improve communications***
- ***Increase interoperability***

Trending Towards Better Transitions

All the pieces for intra-PAC transitions are not in place yet, with providers on different systems and EHRs not talking to each other. But the post-acute industry is moving in the right direction, with new interface capabilities for sending referrals and increased ability to share documentation via health information exchanges.

"Ideally, you want to ensure a smooth transition for that patient without repetition. Having the technology to move all their information quickly, easily and accurately across sites of care without continually retelling their story is the goal," says Ms. Dukes. "When all these settings of care are able to talk to each other, support each other, facilitate that information flow – from basic demographics to primary diagnosis to medication list – it will have a huge impact on patient well-being, let alone outcomes."

Ms. Dukes uses her late mother, who was hospitalized with cancer, as an example. Her mother was sent home, with a discharge summary that she understood perfectly when sitting in her hospital room. Then as soon as she got home, she went to take her blood pressure medication. Ms. Dukes stopped her, reminding her that although

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she had had high blood pressure for 30 years, she now had low blood pressure due to her disease process. So in that transition, her mother did not fully understand the impact of what had happened to her in the hospital setting and how it affected her medication regimen going forward in her home.

Besides the need for technology advancements, Ms. Dukes sees that COVID-19 has highlighted the pros and cons of the different sites of care.

"It has exposed both the strengths and weaknesses of all the sites of care. It's shown that the patient must be at the center, and that a more conscious decision is needed to find the appropriate setting for each patient. From a health standpoint, the hospital is not necessarily the place where everyone should be, even sick people. SNFs have their role, home health has its role, hospice has its role. We need to find the site of care that's best for each patient, and make it seamless to move them there."

Ms. Schrauf says home health, hospice and personal care provider Amedisys is already guided by a similar philosophy.

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"We want to make sure that every patient is getting the right care at the right time that's appropriate for them. We think of that both within episodes of care, and longitudinally across different settings of care. Within episodes, we're using tools to drive care planning and ensure the right mix of therapies, skills and visits are occurring, and to look at hospitalization and mortality risks and level of functionality and support systems for each patient. We're continuously monitoring the health and status of our patients, to optimize their care both within episodes and transitioning from one setting to another."

Bottom Line, It's All About the Patients

Whether you're already successfully managing intra-PAC transitions, just beginning to make them, or still thinking about it, the practice must always revolve around what's best for each patient. Also, with the increase in healthcare consumerism, people of all ages are becoming more interested, capable and adamant about being in charge of their health journey.

Anne Tumlinson best sums it up: "We still have a ways to go before we're optimally using each one of the settings. Post-acute providers must do a better job of helping patients make decisions based on what the patients need, as opposed to what the post-acute providers have always done based on financial incentives and other factors."

How does your organization put the needs of its patients first in identifying the most appropriate setting of care at any point in time? Perhaps the right intra-PAC transitions are a part of the answer.

Sources

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[5] Phone interview conducted with Jackie Dukes May 13, 2020

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