Post–Acute Care Reform: Implications and Opportunities for Hospitalists

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Nearly all practicing hospitalists have firsthand experience discharging patients to post–acute care (PAC), which is provided by inpatient rehabilitation facilities, skilled nursing facilities, or home healthcare providers. Many may not know that PAC is poised to undergo transformative change, spurred by recent legislation resulting in a range of reforms. These reforms have the potential to fundamentally reshape the relationship between hospitals and PAC providers. They have important implications for hospitalists and will open up opportunities for hospitalists to improve healthcare value. In this article, the authors explore the reasons for PAC reform and the scope of the reforms. Then they describe the implications for hospitalists and hospitalists' opportunities to Choose Wisely and improve healthcare value for the rapidly growing number of vulnerable older adults transitioning to PAC after hospital discharge. *Journal of Hospital Medicine* 2017;12:46-51. © 2017 Society of Hospital Medicine

The landscape of post–acute care (PAC), which is predominantly provided by inpatient rehabilitation facilities (IRFs), skilled nursing facilities (SNFs), and home healthcare (HHC) providers, is rapidly changing. As hospitalizations shorten, PAC utilization is rising, resulting in rapidly increasing costs.[1-5] However, patient outcomes in PAC are characterized by high rates of readmission and low rates of return to the community.[6,7] Emerging evidence suggests these outcomes could be substantially improved through use of better in-hospital and transitional care processes.[8-10]

Legislators took notice of the spiraling costs, potential quality concerns, and undesirable patient outcomes in PAC. Provisions in the Patient Protection and Affordable Care Act of 2010 (ACA), the Protecting Access to Medicare Act of 2014 (PAMA), and the Improving Medicare Post–Acute Care Transformation (IMPACT) Act of 2014 affect patient selection, payment, and quality measurement in PAC. As older adults are increasingly being cared for by hospitalists,[11] hospitalists must be aware of the implications of these reforms.

IMPLICATIONS FOR HOSPITALISTS

Choosing Patients Wisely for PAC

Because PAC-related decision making is not standardized, referral rates vary significantly.[12] The variability in PAC use accounts for 79% of all regional variation in Medicare spending in the United States.[13,14] Compared with other physicians, hospitalists are more likely to use PAC[15] but typically receive little exposure to PAC during training.[16]

The IMPACT Act proposes 2 major changes to patient selection: a uniform assessment tool for patients being discharged to PAC and "site-neutral" payments for PAC. Starting in 2018, the Continuity Assessment Record and Evaluation (CARE) tool must be completed before a hospital discharge in order to better match PAC resources to patient needs. The current 26-page CARE tool includes questions about demographics and home support, medical complexity, physical function, cognitive status, and "transition items," including discharge plans and advance directives. In pilot testing, significant amounts of missing data and average completion times of up to 60 minutes raised concerns about feasibility.[17] CARE tool assessments accurately predicted what form of PAC patients actually received, but further testing is planned to validate whether the type of PAC selected was optimal for patient outcomes.. A plan for using CARE tool assessments to determine site-neutral payments is due to Congress by 2020. In the site-neutral payment system, the PAC provider will be reimbursed according to patient needs (identified by the CARE tool), regardless of PAC setting—a radical change from the current system, in which IRF, SNF, and HHC episodes show major differences in median costs (Table 1).[18]

Hospitalists may be concerned that use of the CARE tool will supplant clinical judgment about patients' PAC needs. The burden of completing the CARE tool could inadvertently reduce the amount of attention hospitalists give to other aspects of a safe discharge rather than lead to the improvement desired.[19-21] Hospitalists will benefit from developing interdisciplinary, iterative workflows to complete the tool, improving accuracy and reducing the burden.

A potential unintended consequence of the site-neutral payment system may be increased difficulty discharging elderly patients who have limited rehabilitation potential but are lacking sufficient social support to return home. In the current system, these patients are commonly discharged to SNFs as a bridge to long-term nursing home care. Hospitalists will need to become increasingly familiar with novel al-

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TABLE 1. Overview of Most Common Post–Acute Care Options[18]

	Inpatient Rehabilitation Facility	Skilled Nursing Facility	Home Healthcare Provider
Eligibility	Preceding hospital stay not required, but patient without preceding stay responsible for more cost	Preceding 3-night hospital stay required within 30 days of SNF admission	Preceding hospital stay not required
	Patient requires and can tolerate ≥3 hours of therapy 5 days per week	Patient must have daily skilled nursing or therapy need	Patient must be "homebound" and require intermittent nursing care or therapy
	More than 60% of IRF patients must fit into 1 of 13 proscribed diagnostic categories (eg, stroke)	Many facilities also provide long-term nursing home care, which patients may transition into if they do not rehabilitate successfully	Home healthcare is disbursed in 60-day "episodes," which can be renewed
Payment (Medicare)[a]	Prospective payment by Medicare, single payment per discharge (mean, $18,258)	Prospective payment by Medicare, per diem, not by entire stay (mean, $11,357)	Prospective payment per 60-day episode (mean, $2720)
	Patients pay no additional costs unless coming from community ($1260 up front, $315/day for days 61-90)	Patients have no copayment days 1-20 after hospital discharge, then pay ~$160 per day during days 21-100, then pay full cost. Benefit resets after 60 consecutive days without using Medicare benefit	Patients pay no additional costs
Mean Length of Stay[a]	12.9 days	27.6 days	1.9 episodes (~120 days)
Services Provided	Usually supervised by physical medicine and rehabilitation physician	Usually supervised by geriatrician, nurse practitioner, or physician assistant; providers may work in several facilities	Supervised by primary care physician
	Physical, occupational, and speech therapy, ≥3 hours combined daily	Nursing, physical, occupational, and speech therapy, generally ~1 hour of therapy per day	Nursing, physical, or occupational therapy, average of 33 individual visits by different providers over 60 days

[a]Mean costs and lengths of stay are from 2013 data.[18]

NOTE: Abbreviations: IRF, inpatient rehabilitation facility; SNF, skilled nursing facility.

ternatives to nursing home–based care, such as home-based primary care, medical foster homes, and Medicare/Medicaid's Program of All-Inclusive Care of the Elderly (PACE).[22-25]

Choosing PAC Providers Wisely

Medicare's *Nursing Home Compare* tool (https://www.medicare.gov/nursinghomecompare/search.html) provides a "5-star" system for rating SNFs on several quality metrics; these metrics, however, are not correlated with readmission or mortality rates.[26,27] Improving quality measurement in PAC and tying payment to quality and outcomes are major emphases of the IMPACT Act and PAMA, respectively. PAC providers must publicly report an expanded list of quality measures and outcomes by 2018. In 2017, SNFs will begin reporting rates of "potentially preventable" readmissions, and starting in 2019 they will face penalties for having high risk-adjusted rates.

These reforms coincide with an increased emphasis on hospitals and PAC providers sharing responsibility for costs and outcomes. One model of the Bundled Payments for Care Improvement (BPCI) initiative includes a single payment for an acute hospitalization and PAC up to 90 days after hospital discharge for select conditions. The Medicare Spending Per Beneficiary (MSPB) measure compares hospitals on their spending for Medicare beneficiaries from 3 days before hospital admission to 30 days after hospital discharge, and penalizes outliers with high costs.[28] PAC spending is the main driver of costs in both BPCI and MSPB.[29] One way that hospitals have responded to the BPCI is by drastically reducing their referrals to SNFs and increasing their referrals to HHC providers; unfortunately, this response has resulted in increases in post-discharge emergency department visits.[29,30] Taking a novel step in November 2015, the Centers for Medicare & Medicaid Services (CMS) ruled that hospitals in more than 67 metropolitan service areas will be involuntarily enrolled in the BPCI initiative, using elective lower extremity joint replacement as the sample condition.[31] This ruling signaled that these reforms are not meant solely for "high-performing" hospital and PAC systems able to volunteer for novel models of payment.

These changes have direct implications for hospitalists. Bundled payments incentivize hospitalists to reduce hospital length of stay and choose PAC alternatives with lower costs. SNFs may start accepting fewer "high-risk" patients in order to avoid readmission penalties. Hospitals will need to identify and partner with high-performing PAC providers in their community to maximize outcomes for their patients. On their websites, the Society of Post-Acute and Long-Term Care Medicine (AMDA) lists its state chapters,[32] and the National Association for Home Care & Hospice lists national HHC agencies.[33] Reviewing early lessons learned in the evaluation of PAC providers as potential hospital partners in Pioneer accountable care organizations may be helpful,[34] though the PAC cost savings in these organizations largely resulted from redirecting patients from SNFs to HHC providers.[35,36] In many markets, the relationships between hospitals and PAC providers may become more formalized, leading to vertical integration.[37] Hospitalists may increasingly be asked to work with, or even in, SNFs.[38] For hospitalists who begin working in PAC, the AMDA is developing an educational curriculum to maximize efficacy in a new practice setting.[39] In other markets, hospitals may turn to for-profit entities that provide "integrated post-acute care services,"[40] taking over PAC decision making from inpatient teams and sharing any resulting profits from bundled payments.

TABLE 2. High-Value Areas For Hospitalists to Address Before Discharge to Post–Acute Care

Ideal Transition of Care Domain[a]	Goals	Challenges	References
Discharge Planning	Assess cognitive, functional, and medical impairments as well as social support to match PAC resources to needs	Accurate assessment challenging No clear guidelines for matching needs to resources Hospitalists may have less understanding of PAC capabilities/constraints	16,73-77
Complete Communication of Information	Provide appropriate content in information transfer to PAC	Transfer information may not include elements desired by PAC clinicians (eg medication indications, anticipated completion of time-limited medications) Infrequent documentation of care goals, mental status, and physical function	78-83
Availability, Timeliness, Clarity, and Organization of Information	Transfer information in a timely and efficient manner	Discharge summary arrives after patient PAC and hospital seldom infrequently share electronic medical record PAC clinicians may struggle to reach inpatient clinician to ask questions	84,85
Medication Safety	Effective in-hospital medication reconciliation, accurate list of medications provided to PAC	Medication list often inaccurate Medication list may include medications known to cause adverse events in elderly	8,9,86-90
Educate Patients, Promote Self-Management	Engage patients in their own medical care and functional recovery	Cognitive impairment common Patients and caregivers may struggle to transition after long hospital/post–acute care stay in which care was provided by others	82,91-95
Enlist Help of Social and Community Supports	Identify high-performing PAC providers for collaboration	Medicare "5-star" ratings may not correlate with readmissions and consumer perceptions and may exacerbate disparities Unclear how to identify high-performing sites	8,26,34,96,97
Advance Care Planning	Identify decision maker and care goals; palliative referral when appropriate	Hospitalization often chaotic, patient and caregiver participation difficult Varying levels of comfort among providers who are having these conversations	45,98-102
Coordinating Care Among Team Members	Coordinated evaluation before discharge and with PAC provider	Time-consuming bidirectional barriers to reaching responsible clinician at other care site	78,79
Monitoring and Managing Symptoms After Discharge	Identify and treat acute medical issues before PAC discharge to prevent readmission	External influences to discharge patients to PAC "quicker and sicker" Unclear expectations of level of monitoring PAC can and should provide Limited medical training and increased turnover of frontline PAC staff	2,4,8-10,103,104

[a]Not included is the tenth Ideal Transition of Care domain, Follow-Up With Outpatient Providers, which is more relevant to home discharges.
NOTE: Abbreviation: PAC, post–acute care.

OPPORTUNITIES FOR HOSPITALISTS

Improve Hospital and Transitional Care to Ensure Successful Early Outcomes in PAC

Payment reform ensures hospitalists will increasingly have a stake in these matters, as joint responsibility for costs and outcomes increases for patients discharged to PAC. Hospitalists play a major role in these outcomes by deciding when and where to discharge patients and ensuring that optimal transition-of-care processes are used.[8-10,41-45] Although no single intervention has been prospectively found to improve hospital-to-PAC transitional care outcomes, areas in need of improvement are known. Table 2 lists these within 9 of the Ideal Transition of Care Framework domains.[43,46]

Advocate Patient-Centered PAC Placement That Maximizes Long-Term Outcomes

Payment reforms could reinforce the cynical view that the optimal PAC setting is the least costly one that avoids hospital readmission. This view does not incorporate evidence that, in some cases, placement in a more costly PAC setting results in better long-term outcomes (eg, community discharge rates).[47,48] It is also incongruent with a holistic view of the patient's needs, particularly for patients who may otherwise be suitable for home-based PAC but have limited social support.[49] Finally, it does not acknowledge the reality that patients who are inadequately rehabilitated often transition to long-term nursing home care,[50] which could result in significant cost-shifting from Medicare to Medicaid, the predominant payer for long-term care.[51] Given the extraordinary cost of long-term nursing home care, attending only to short-term costs and outcomes could increase national healthcare expenditures.

With most PAC-related decisions being made in the hospital, hospitalists find themselves at the center of a care team that must advocate the PAC that is best for the patient over the long term. This endeavor requires that hospitalists and others work for improvements in at least 3 aspects of in-hospital care. First, systems for accurately and reliably identifying patient factors that could substantially affect ability to rehabilitate (eg delirium) must be developed or enhanced.[52-54] Second, more formal evaluation of the ability of patients and their caregivers to succeed at home is needed.[55-60] Patients and caregivers may not understand their home needs without first "testing" the experience prior to discharge.[61] Third, hospitalists must understand PAC in order to provide safe transitions.[16] It is logistically challenging to expose practicing hospitalists to PAC, and it is unclear which exposures are most effective in improving decision making.[62] An alternative approach that provides hospitalists with feedback about the short- and long-term outcomes of patients they have discharged to PAC may iteratively improve decision making. However, despite the high rate of

discharges to PAC, there are anecdotal reports that few hospitalists receive feedback on patient outcomes.

As these reforms are tested and implemented, advocacy at regional and national levels is needed. The American Geriatrics Society (AGS), the AMDA, and the American Academy of Home Care Medicine all have well-developed advocacy platforms hospitalists can access.[63-65]

Share Expertise to Improve Quality in a Constrained Environment

There are opportunities for synergy between robust quality improvement (QI) efforts in PAC (often as part of Quality Assurance and Performance Improvement programs) and similarly robust hospital QI efforts led by hospitalists.[66-70] These efforts have largely occurred in parallel, but now some important bridging QI interventions (eg, collaborative root cause analyses for patients readmitted after PAC) are starting at some sites, and these may drive improvement across the care spectrum.[45] The Society of Hospital Medicine, the AGS, and the AMDA have written White Papers on care transitions that may serve as starting points for discussion.[41,71,72]

CONCLUSION

PAC is rapidly changing in response to reform legislation that is intended to address poor outcomes and high costs. Hospitalists will increasingly feel the effects of these reforms in their day-to-day practices. To continue to deliver high-value care, hospitalists should review their in-hospital and transitional care practices and start building relationships with high-quality PAC providers in their community.

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