

2011

**Delivery of Post-Acute Care Services
Among Leading Health Systems**

A case study of current best practices

EXECUTIVE SUMMARY

National Rehabilitation Hospital
and
MedStar Health



MedStar Health

Delivery of Post-acute Care Services among Leading Health Systems

Executive Summary

A mix of apprehension *and* opportunity hovers over health care today as reform takes shape. Of the many provisions in the reform legislation, bundling of acute and post-acute payment is among the most significant: it represents one of the most far-reaching modifications in Medicare payment policy in nearly 30 years, and is likely to reshape much of the way in which health systems manage episodes of care in the future.

Post-acute care has been one of the fastest growing segments of American health care. Exempted from the DRG-based prospective payment system (PPS) that was established for acute care in 1983, post-acute care settings proliferated and spending grew. Today post-acute care accounts for more than \$50 billion in annual Medicare spending under the fee-for-service portion of the program alone. Reducing costs has become a major priority and bundling is seen as an effective vehicle for accomplishing this goal.

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In a “bundling world,” vertically integrated health systems will have enormous advantages. MedStar Health has the potential to be an important player in this scenario. It has a well-established network of providers, with eight acute care hospitals across the Washington-Baltimore and Southern Maryland region, the National Rehabilitation Hospital with its 34 NRH

Regional Rehab outpatient centers, home care services through the Visiting Nurse Association, and a transitional care unit and hospital-based skilled nursing facility at Good Samaritan Hospital in Baltimore. Nearly a third of all patients discharged from MedStar acute care hospitals require some type of continued care related to the condition for which they were admitted.

Significant gaps exist in MedStar’s post-acute offerings. However, MedStar is well positioned to seize the opportunity that bundled payment offers by broadening its network of services and developing innovative approaches to patient management across the care continuum.

Policy and Payment Environment

When Congress did establish a PPS for post-acute care in 1997, it authorized separate payment formulas for each post-acute setting, which were phased in over several years. As a result, each post-acute setting has its own patient assessment instrument, case-mix adjusters, documentation system, and payment rules, making it difficult to serve patients seamlessly across settings as their needs change. This has led to an unintended consequence of the 1997 legislation—increased use of multiple post-acute venues for the same episode of care.

Providers adapted and learned to live with their payment formulas. In a May 2010 article in *Physical Therapy*, Gerben DeJong, PhD, Director of NRH's Center for Post-Acute Innovation & Research, wrote, "Providers have developed their clinical and business models accordingly...and by adaptation, have become invested in the system." Meanwhile, the federal government instituted many utilization review and compliance protocols in an effort to mitigate the unintended problems of the post-acute PPS regime. But, DeJong wrote, the consequence is a "*culture of compliance* where the focus has been on *compliance management* rather than *care management*."

Bundling—paying by episode of care—would create a single payment for both acute and post-acute services provided to Medicare fee-for-service beneficiaries. An episode would start three days prior to acute hospitalization, include the acute hospital stay, and cover the first 30 days following discharge from acute care. In the proposed bundling system, the Centers for Medicare and Medicaid would be authorized to modify care episodes in keeping with the natural history of specific health conditions.

In a "bundling world," vertically integrated health systems will have enormous advantages.

Policy makers see bundling acute and post-acute payment as a way to align financial incentives across care settings and to promote the delivery of more efficient and cost-effective episodes of care. Proposals to bundle acute care and post-acute care payment for Medicare beneficiaries are part of the Patient Protection and Affordable Care Act (HR 3590; Pub L No. 111-148) signed into law March 23, 2010.

The law calls for a period of pilot testing starting in 2013 followed by full implementation in FY 2018. This period offers an opportunity for stakeholders to try different approaches to the bundling concept. If designed well, bundling could enhance the management of patient care while reducing costs. But, if designed poorly, bundling could undermine quality of care and defeat any potential cost savings. Congress saw pilot testing as a way to tweak the bundling concept in order to minimize unintended—and negative—effects.

Selection of a "bundler or an accountable entity" in a bundling regime remains a major unresolved issue. This entity would administer all payment functions and be accountable for both payment and outcome.

For successful administration, the accountable entity will need to be able to tolerate financial risk; have the ability to contract for the entire bundle of services; develop clinical pathways, including discharge planning; manage care transitions and hand-offs from setting to setting; establish quality standards and track quality indicators and patient outcomes across settings; provide information technology and decision-support systems; and coordinate with non-health related community services.

In order to flourish, health care systems will need fully-developed post-acute care networks—through ownership or contractual relationships—and seamless delivery throughout the continuum of care.

Study Methods

To better meet the challenges ahead, MedStar Health initiated a study to search for best practices in post-acute care delivery among peer health systems around the nation. [The study did not attempt to examine practices among large post-acute companies that provide services across the country such as RehabCare, Kindred Healthcare, HealthSouth, SelectMedical, Mariner Post-acute Care, Golden Living, and others, although many have relationships with the large health systems interviewed for this study.]

The research is essentially a series of case studies developed through examination of source documents and by conducting informational interviews with health system leaders who were knowledgeable about their organization's post-acute offerings. A study guide was developed to address the following topics:

- Market context
- Organizational capabilities and degree of organizational integration
- Service integration
- Payment methods
- Clinical pathways, discharge planning, information systems and case management
- Clinical staffing, training and practice
- Quality metrics and outcomes
- Role of patients, family and choice
- Lessons learned

Nine health care systems from across the country were identified for the study and interviewed between January and June 2010—six were regional health care systems and three were rehabilitation systems. They represent diversity in degree of post-acute system maturity; geographic region; key market features, such as payer mix (HMO and fee-for-service mix); demographic profile; and socioeconomic characteristics.

Site visits were made to eight systems. Interviews were conducted in person or by telephone with a range of staff involved in the post-acute process of the systems: planners, case managers, admission coordinators, information systems personnel, care coordinators and executive staff. [See Acknowledgements for a more complete listing of informants.]

Additional fact gathering interviews were conducted with representatives from other health systems, trade associations, and with other health and rehabilitation experts. Information was compiled and a narrative was developed that summarized key findings and recommendations for appropriate next steps.

Overview of Findings

1. Corporate Oversight—Critical but Variable

Generally, acute care CEOs and executives have yet to acquire a good understanding of the post-acute care continuum and how it fits with the needs of patients discharged from their acute care hospitals. They tend to focus on the needs of acute patients in acute care settings, and on the need to limit lengths of stay to maximize reimbursement, free up beds for elective surgical procedures, and eliminate admission back-ups in busy emergency rooms. They tend to see post-acute care as a vehicle for bed and

volume management, not as an essential part of the care continuum needed to effectively manage an episode of care.

Many have yet to consider the implications of a bundled payment system and their responsibility for quality and outcomes beyond acute care. Those who have considered the issue think that they will likely control distribution of the payment bundle and don't need to be particularly anxious about the future. They don't yet fully appreciate their accountability for post-acute quality and outcome—or their role in the development of value-based purchasing, in which dollars will be linked to outcomes, not just inputs and volume. With few exceptions this problem was evident in nearly every system surveyed and remains a key cultural and attitudinal barrier to be addressed.

Most individuals interviewed agree that some overall corporate strategic planning, oversight, and coordination is essential.

Partners Health Care System in Boston demonstrates a case in point. When first organized, Partners Continuing Care (PCC) post-acute care system served as a holding company. As PCC evolved, member organizations continued to grow and to be guided by their own leadership. However, six years after it was developed, PCC was reorganized to become an operating company

in order to improve efficiencies and streamline coordination of care. Many management functions were consolidated, as was its governance: a single PCC board was created. PCC is now a corporate entity with management control and responsibility for the entire range of post-acute services—IRF, LTCH, SNF, home health, and outpatient therapy.

The development of a continuity-of-care model requires significant effort and commitment on the part of executive corporate leadership.

Another major system, Memorial Hermann Healthcare System in Houston, embarked on a similar corporate post-acute restructuring, but then abandoned it with the advent of a new executive leadership team and new organizational objectives. The system sold off many post-acute assets. Several market features and reimbursement issues drove Memorial Hermann to develop a different approach to its mission.

Assessing the local market's payer mix, reimbursement anomalies, competition, regulatory environment, and socioeconomic and demographic characteristics is critical in the development of a coherent plan for post-acute integration. Partners' experience demonstrates that a fluid evolution of corporate leadership is also an important component for success. Health care remains a local business, fundamentally driven by local issues, as well as national reimbursement policy.

2) System Global Budgeting—Essential to Success

A global budget—and corporate acceptance that there will be financial winners and losers—is essential. Those organizations that have identified “loss leader” facilities have been successful in creating a true system across the care continuum. They develop a global budget that accepts negative financial performance of some entities for the greater good of all.

These loss leader facilities might be free standing or units within other facilities. Each is able to accept clinically appropriate patients without undue financial constraints, which makes them a key resource to the entire health system. While many people acknowledge that this approach makes sense, it is politically difficult, particularly among acute care hospitals.

Today, competition between care providers within a health system remains a significant concern—and an impediment to the development of seamless system. Acute and post-acute providers alike have separate budgets driven by volume and revenue. The current payment environment offers few incentives for financial collaboration across multiple settings in a more service-

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line, patient-centered system of care.

Instead, there is an overwhelming mandate for subsidiaries to meet budget targets.

At PCC, a global budget is prepared by rolling up budgets of “families” of related operational entities. The global budget accounts for expected volumes, and pays attention to the goals and program needs of the system *and* of individual facilities. Partners Health Care budgets financial losses for some parts of the system, knowing that overall gains will offset those losses. Shared overarching goals have been critical to the success of PCC. And the desire to increase financial efficiencies across the system has driven the integration of finances.

3) Organizational Integration—Silos Still Rule

Most acute care provider entities remain in their own “silos of care.” This is common even within multi-institutional health systems. As a result, it is often very difficult to move patients from one appropriate setting to another. While study informants report a high interest in making the process seamless for the patient, cost-effective for payers, and convenient and clinically appropriate for physicians and caregivers, lack of data sharing and the complexity of the national payment systems have made this very difficult to achieve.

In some systems, there has been little financial incentive for movement of patients to the appropriate level of care. Instead, providers have sought to maximize reimbursement for each patient at the most lucrative level of care. Hardened budgets, narrowly focused outcome objectives and care patterns, and reluctance to think beyond acute discharge prevail. Traditional physician practice patterns and referral arrangements, and distinct organizational and professional cultures exacerbate the problem.

Systems have had varying success in breaking down these barriers. Solaris Health System in New Jersey is small, but has a reasonably integrated post-acute care system within the constraints of current payment policies. Still, it struggles with “silos of care.” Solaris is testing remedies including incentives to drive discharges to its sub-acute and long-term care beds when clinically appropriate.

Those systems that have created information system (IS) interfaces between acute and post-acute care have been more successful—and efficient. Integrated IS helps ensure expeditious transfer of patients to an appropriate level of care within the system. Partners’ 4NEXT system, for example, is “a web-based application...used to support the transition of patient care from the acute hospital to the post-acute

setting.” Acute hospital staff can gather patient information, and securely communicate with several post-acute providers simultaneously—in real time.

Still, 4NEXT is an “IS patch” between acute and post-acute care to help bridge communication across care settings. Patient data remain in the 4NEXT system for only 48 hours. 4NEXT is not intended to be a continuous IS platform for ongoing post-acute care management, but only a window through which a limited set of patient data can be made available to providers in the transition process.

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4) Case Management—Remains a Significant Challenge

These “organizational silos” impede the development of care coordination that includes discharge planning across multiple organizations, and monitoring and coordination of medical management as patients move across settings. In most systems, creating this kind of comprehensive case management remains a challenge. And many of the same stumbling blocks that have kept organizations isolated in “silos” also impede the development of seamless care coordination, including:

- Continued desire to maximize reimbursement at each provider entity
- Unresolved issues related to physician continuity and payment
- Lack of information flow to allow appropriate choice
- Historical referral patterns
- Lack of shared patient assessment tools and clinical information systems

Some of the more progressive post-acute care systems have developed care coordination—but they too continue to refine the model. *Clinical floaters* at PCC use the 4NEXT information system tool to coordinate patient flow from acute to post-acute care. But, as already noted, 4NEXT remains an embryonic version of what needs to be developed to effectively coordinate an entire episode of care as envisioned under bundled payment.

Barnes Jewish HealthCare System (BJC HealthCare) in St. Louis is developing “integrated practice units” organized by medical condition. The clinical team is led by a physician who serves as team captain and includes a patient logistics coordinator who facilitates the details of patient placement.

SSM Health Care in St. Louis is in the process of building a post-acute care network and developing a *nurse navigator* program. The nurse navigator would prepare and execute a 90-day care plan for each patient needing services following discharge.

Some systems have developed pilot programs to test “packages of care,” which consider both clinical *and* financial requirements. Intermountain Health Care in Utah has tested packages for orthopedics and obstetrics. They successfully implemented a bundled obstetrics package, which is acceptable to payers, physicians and patients. But Intermountain Health Care noted it was a massive undertaking, which included a complete review of best practices, coordination of multiple resources, and obtaining payer and physician buy-in.

Developing packages of care for the exiting list of diagnostic categories would be time-intensive and expensive and could overwhelm a single health system, especially a smaller system. A collaborative national effort to share information about evidence-based best practices would help remedy this problem.

5) Growth of Post-acute Care Continuum—Gaps in Services

There are service gaps in most of the systems that participated in this study. Few have the full range of post-acute care resources, which include freestanding rehab facilities (IRFs), long term acute care (LTAC), skilled nursing facilities (SNFs), home health agency (HHA) services, and ambulatory care.

Many systems have recognized these deficiencies and are moving to expand their post-acute services through owned or contracted facilities.

More extensive systems, such as Partners and BJC HealthCare, have well-established freestanding rehabilitation hospitals. SSM Health Care, which currently has outpatient centers, day programs, an extensive home health network, as well as two in-house IRF units, has joined with Select Medical in a joint venture to build a freestanding rehab hospital.

Despite the growth of post-acute services, none of the systems studied had developed a proven risk-sharing model—although several trials are underway.

SSM is also interested in the Continuing Care Hospital (CCH) concept that combines all hospital-level post-acute care—such as IRF care, LTCH care, and hospital-based SNF care—into a virtual continuum of care that would facilitate patient transition and treatment within one post-acute venue. The CCH could also contract with free-standing SNFs and HHAs. The health care reform law calls for CCH demonstrations as part of the new CMS Center for Medicare and Medicaid Innovation (CMI).

But most individuals surveyed believe patient volumes for freestanding rehabilitation hospitals will decline over time. While they report a need to expand their SNF, LTCH, HHA, and outpatient offerings, they recognize that there is excess capacity in some parts of the nation, especially in the number of LTCHs. They also understand that integrated ambulatory care networks are the most cost-effective levels of care in the continuum.

In addition to its IRF, BJC HealthCare has skilled nursing, extended care, assisted living, and an extensive home care network. Now it is developing an ambulatory care network.

Solaris has a large full-service IRF, as well as three LTCHs that include a sub-acute capacity. It is expanding this post-acute capacity by building a new 180-bed facility on the hospital campus that will include 90 additional sub-acute beds.

Despite the growth of post-acute services, none of the systems studied had developed a proven risk-sharing model—although several trials are underway. In a bundled payment system, development of a model system of shared financial and outcome risk is critical.

Any joint venture arrangement between a system, an acute care provider or an unrelated or independent post-acute care provider must guarantee access to beds, and include mutually agreed upon outcome and length-of-stay targets. It must ensure that patients are returned to the system if they need further care—and guarantee that the post-acute care provider receives fair payment.

6) Physician Role is Key

There is consensus that physician participation in the development of a post-acute care system is essential to its success. Physicians remain key decision makers in moving patients to appropriate levels of care. However, they frequently don't understand the rationale for moving their patients to post-acute levels of care, which they often consider to be inferior. Additionally, poor communication and inadequate care coordination can frustrate a physician's daily work schedule.

Physicians want assurance that every level of post-acute care meets high quality standards, that they can easily access these services, and that the process won't jeopardize their patient relationships. The right financial incentives are also essential. One physician interviewed stated this clearly: "Tell me how you're going to pay me," he said, "and I'll tell you how I'm going to practice."

Successful relationships between systems and the medical community recognize the value of

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inclusiveness and rewards. BJC HealthCare has the advantage of a loyal and supportive contingent of Washington University trained physicians. This relationship has helped ensure active physician participation in the system. Nonetheless, BJC Healthcare engaged physicians in the beginning of the development process by widely disseminating the system's vision and plan, and involving the medical community in the development of care algorithms.

Solaris has demonstrated its commitment to physicians by participating in a Medicare demonstration project. The project enables hospital systems to share gains that are generated by physician efficiency and their adherence to best practices. Intermountain Health Care is also developing models of "gain sharing" for physicians. This type of "pay-for-performance" incentive program could prove to be an important component of a post-acute care system's financial structure.

Conclusion

The study found that most health systems reviewed are still in the early stages of acute and post-acute integration. Most have undertaken modest steps to enhance care coordination and information sharing, and to make the organizational changes that are needed to deliver relatively seamless services across the continuum for a given episode of care.

Many of the actions taken to date are simply "patches" in care delivery, which don't yet amount to true "systemness." Of the health systems interviewed for this study, HealthPartners of the Boston area

appears to be the most advanced, primarily because it has organized all its post-acute assets under one management and governance system, known as Partners Continuing Care (PCC). Still, PCC remains very much a work in process.

This study reinforced what many in health care have long understood: the essential ingredients of effective acute and post-acute integration are corporate leadership, physician buy-in, integrated information and case-management systems, sound quality and outcome metrics, and, above all, financial systems that align incentives across all entities. Most critical for success is the development of systems that pay for value, not volume, by rewarding both near-term and longer-term outcomes. Health care reform embraces many of these elements by offering new tools and incentives for innovation and best practice across the acute and post-acute continuum of care.

Acknowledgements

Site visits were made to a number of organizations and interviews were conducted in person or by phone with the following organizations and individuals:

Partners HealthCare, Boston, MA

David Storto

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Charles Pu, MD

Geriatrics

Terry O'Malley, MD

Medical Director for Non-acute Services

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Harvard Medical School

James Mongan, MD

Past President and CEO, Partners and the Massachusetts General Hospital

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