RE-INVENTING THE AMERICAN HOSPITAL

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Payment reform and the impact on the continuum of care

Dan Mendelson *is CEO of Avalere Health, a strategic advisory company providing product and data solutions that help healthcare organizations improve their operational effectiveness. Prior to founding Avalere in 2000, he directed the healthcare portfolio at the White House Office of Management and Budget (OMB). He is on the Board of Coventry Healthcare, is Adjunct Professor at Duke University's Fuqua School of Business, speaks frequently on provider strategy, and can be followed @dnmendelson.*

Mary Coppage *is a manager with Avalere Health, where she provides strategic support to Avalere clients, including hospitals and health systems, on payment and delivery reform, care transitions, and health information technology policy. Before joining Avalere, she held operations, compliance, and member advocacy roles at Presbyterian Health Plan in New Mexico.*

Erik Johnson *is a senior vice president with Avalere Health. Using rigorous analytics and practical experience, he provides strategic guidance to hospital and health system clients on healthcare technology, operations, and financial issues. Before coming to Avalere, he was a managing director with Manatt Health Solutions and the Advisory Board Company.*

While leaders in Washington fret over deficit reduction, Medicare reform, and the future of Obamacare, a quiet re-invention of the American hospital is proceeding. Payment reform aims to reward value over volume by holding providers explicitly accountable for outcomes while creating clear incentives for cost containment. Emerging payment models are taking the initial steps by focusing on specific, high-profile metrics to which payment will be tied, including the rate of unnecessary readmissions. Hospitals that don't figure out how to care for patients across the continuum of care will be rendered obsolete.

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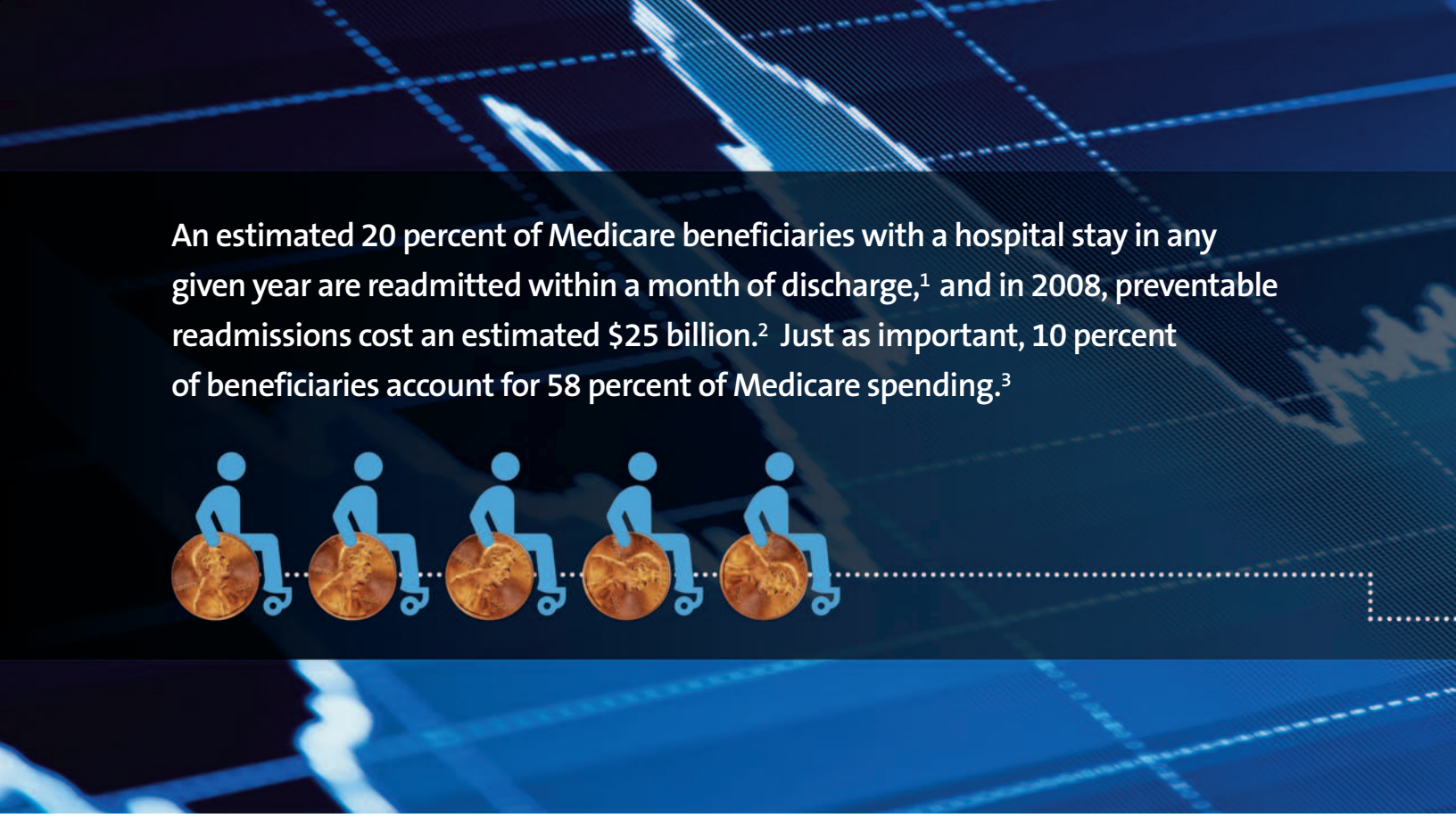

An estimated 20 percent of Medicare beneficiaries with a hospital stay in any given year are readmitted within a month of discharge,[1] and in 2008, preventable readmissions cost an estimated $25 billion.[2] Just as important, 10 percent of beneficiaries account for 58 percent of Medicare spending.[3]

Our current fee-for-service payment system often works against true improvements in cost reduction and quality improvement. It implicitly encourages excess volume while discouraging coordination of care across sequential sites. The Centers for Medicare & Medicaid Services (CMS) has been incrementally modifying payment systems for years to encourage provider accountability through various programs and demonstrations. More recently, private payors have also followed suit and started to move their own quality incentives to the provider level. The Affordable Care Act accelerated this process by enhancing CMS' authority and experimental reach.

New payment systems are forcing a focus on care coordination

Payment penalties for hospitals demonstrating above-average rates of readmissions were introduced into the Medicare program last October in an attempt to address major gaps in quality. An estimated 20 percent of Medicare beneficiaries with a hospital stay in any given year are readmitted within a month of discharge,[1] and in 2008, preventable readmissions cost an estimated $25 billion.[2] Just as important, 10 percent of beneficiaries account for 58 percent of Medicare spending.[3]

The penalties are small in terms of their dollar impact, but they represent a fundamental shift in a hospital's scope of accountability by factoring in post-discharge activities that hospitals can't necessarily control or have traditionally not paid for. The goal is to foster coordination among hospitals and post-acute and long-term care providers to prevent such readmissions.

Present payment systems do not always create incentives for healthcare systems to think this way. Quality-related challenges – such as the lack of standardized discharge planning processes, poor follow-up, failure to reconcile medications, insufficient or missing data transfer post-discharge, and problems with patient/family engagement – can also complicate effective care transitions.

CMS is tackling the care coordination problem from a number of angles. Its most comprehensive attempt to date is through two accountable care organization (ACO) programs, the Medicare Shared Savings Program and the more sophisticated Pioneer ACO model run by the Center for Medicare & Medicaid Innovation. Both programs are based on the concept of shared savings, with Pioneer offering the option of partial capitation in later years of the program. CMS is also developing the Bundled Payments for Care Improvement Initiative, which includes care episodes that span acute and post-acute care settings. ACOs and bundling represent the future of care delivery, yet much remains to be learned, and, as

a result, the models continue to be voluntary under Medicare. CMS' implementation of the Hospital Inpatient Valued-Based Purchasing Program (VBP) reinforces the longitudinal nature of the new focus hospitals must develop. The VBP program will include a new spending-per-beneficiary measure that is another example of how hospitals are being held responsible for a patient's full episode of care. This measure compares expenditures for a Medicare beneficiary based on Part A and Part B spending from three days before to 30 days after the inpatient stay.

ACOs, bundling, readmission penalties, and the spending-per-beneficiary measure all have something in common. All extend provider responsibility for patient care beyond a single inpatient stay and well beyond a facility's four walls.

Hospitals need to prepare to take on health-system risk

To meet standards associated with these and other programs, providers will be forced to leave their silos and collaborate with a range of other providers across the care continuum. Success depends on identifying the right providers with which to collaborate. Payment reform will inevitably drive providers to seek greater visibility into both upstream and downstream patient flow in order to identify preferred partners in the care continuum. Under current public and private programs, hospitals bear most of the burden for reducing readmissions and addressing inefficient care, and there are no signs that payors will let up. In fact, the metrics against which payments are assessed will only become more stringent over time. As a result, hospitals must take the lead in identifying opportunities that support alignment of their new business imperatives for improving quality of care, risk management, and financial performance.

Hospitals have a number of options to identify and better manage their patients across the care continuum. Perhaps two of the most important approaches are identifying at-risk populations and the collaborations that can best mitigate risks.

In addition to finding appropriate collaborators along the care continuum, hospitals must understand the local populations they serve and their health needs. Specifically, hospitals should analyze patients with select diseases and benchmark utilization relative to other facilities in their local market area and region, as well as to the national average. Including socioeconomic indicators, such as homelessness, financial status, family/caregiver support, drug dependence, or other community variables, would elevate such techniques to more precisely stratify patient readmission risk.

Hospitals, as well, should utilize risk-assessment tools at admission and discharge to identify specific patients most likely to be readmitted within 30 days.

Knowing where discharges go is key to improving care coordination

Discharges to home

For the 64 percent of patients who go home after a hospitalization,[4] partnerships among those in the community referral network—consisting of primary care physicians and specialists, pharmacies, retail or outpatient clinics, and other community-based organizations—contribute to keeping patients "safe and sound." Yet, these partnerships are not always fully leveraged. In fact, only 44 percent of Medicare beneficiaries discharged to home have a primary care visit within two weeks of discharge,[5] and 60 percent of frail elderly patients fail to follow their full prescribed medication therapy after leaving the hospital.[6]

The Center for Medicare & Medicaid Innovation is supporting new post-discharge collaborations through the Community-Based Care Transitions Program. Such programs can provide important lessons about which home discharge services and collaborations are most effective in reducing readmissions.

Discharges to post-acute care (PAC) or long-term care (LTC)

Knowing PAC provider-level readmission rates is critical to a hospital's discharge strategy. Over 20 percent of patients are discharged from the hospital to a PAC/LTC facility, yet that patient population returns to the hospital at higher rates than those discharged to home, most likely due to the more-complex nature of the patient population. Understanding the PAC/LTC facilities in a hospital's service area by examining discharges and readmissions will allow hospitals to identify the most clinically appropriate and cost-effective PAC settings.

For example, an analysis using Avalere's Vantage Care Positioning System™, found that one hospital in Indiana discharged patients to 112 different skilled nursing facilities (SNFs) for post-acute care in 2010. Not surprisingly, SNF readmission rates were 22 percent. For this hospital, less concern with finding any empty PAC bed and more focus on a strategic discharge approach and care-transition partnerships holds the potential to improve patient readmission rates and lower spending.

Operators of PAC facilities are beginning to recognize their new role in helping hospitals better manage patient care. In the past, the two had little incentive to work together. Now payment reform is spurring a mutually beneficial collaboration. Some hospitals engage with PAC partners by sending practitioners to the PAC facility to facilitate communication and collaboration among PAC staff and hospitalists, case managers, and physicians. Further, many SNFs and home health agencies run care transitions programs to ease the burden on hospital case management resources.

These new collaborations, along with a better understanding of data and a more robust approach to patient risk stratification, can help shift an otherwise catch-all discharge process to one that is strategic, targeted, and efficient.

Discharges to assisted living facilities (ALFs)

ALFs have emerged as additional potential downstream collaborators for hospitals. Not traditionally considered care providers, many ALFs have steadily built their own care-giving capabilities over the last few years. In particular, given the vulnerabilities that their residents exhibit, ALFs represent significant potential for reducing unnecessary readmissions and emergency room visits. With focus areas surrounding fall prevention and memory care, ALFs have targeted the health needs of their own residents and made significant clinical investments to address them. Hospitals, in turn, have begun to address these populations and residencies creatively, with investments of their own expertise and personnel to augment ALF efforts.

Managing care transitions creates hospital value

The re-invention of American hospitals underway today is, in part, about how to effectively manage care transitions across the care continuum. In meeting this challenge, hospitals have the opportunity to thrive in any payment reform environment – whether value-based purchasing, shared savings, bundled payment, or global payment. Understanding patient populations and the capabilities of providers beyond a hospital's four walls will ultimately be a key factor in defining the value of American hospitals in the context of integrated care.

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