CURRENT AND FUTURE TRENDS IN POST ACUTE CARE
The Value and Role of Acute Inpatient Rehab

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Medical Director
Banner Good Samaritan Rehabilitation Institute
Stewardship
Profitability
Perspective
Patient Advocacy
Patient C.D.

- Age 45
- Was in good health and completely independent
- Admitted to BGSMC 11/30/2012- 12/18/12
- At Banner Good Samaritan Rehab Institute 12/18/12-1/23/2013
<table>
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<th>Where we’re at</th>
<th>Where we’re going</th>
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<td><strong>Current</strong></td>
<td><strong>Future</strong></td>
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<td>Variable quality, expensive, wasteful</td>
<td>Consistently better quality, lower cost, more efficient</td>
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<td>Pay for volume</td>
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<td>Quality assessment based on provider and setting (process)</td>
<td>Quality assessment based on patient experience (outcomes)</td>
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ACO
BUNDLED PAYMENTS
Growth of Post Acute Services

Each year more than 10 million Medicare beneficiaries are discharged from acute care hospitals into post acute settings.

Grabowski, et.al
2012 – 35% FFS Medicare patients hospitalized received post acute care
40% of geographic variation in Medicare expenditures 2007-2009 can be attributed to variations in post acute care expenditures – mainly to variation in home health expenditures.
2011 Post Acute Care Spending (in billions)

IRF
Home
Health
SNF
Medicare spending on post acute care has doubled in the past decade increasing from $26.6 billion in 2001 to $58 billion in 2010.
Many patients utilize more than one level of post-acute care.
Examining Post Acute Care

• 20% of all Medicare beneficiaries hospitalized at least once a year
  - Admitted for a wide range of reasons including medical, surgical, functional diagnoses

• About 35% will be discharged to PAC:
  - 41.1% → SNF
  - 37.4% → Home Health
  - 10.3% → IRF
  - 09.1% → Outpatient/ambulatory therapy
  - 02.0% → LTCH

Source: Gage et al, (2009). Examining post-acute care relationships in an integrated hospital system, ASPE
The Changing of Incentives

1988-96 Medicare ALOS 8.9 → 6.5 days
SNF days/beneficiary up 3 times
HH visits up 7 times
Current Medicare ALOS 4.8
The growth in post-acute care utilization continues.

Source: CMS Office of the Actuary.

[Graph showing the increase in total Medicare spending on post-acute care and per beneficiary PAC spending from 2000 to 2012.]
Patient functional ability affect care costs

Distribution of episodes & average Medicare episode payment by functional ability score for 30-day fixed-length episodes (2007-2009)

Source: Dobson/DaVanzo analysis of research-identifiable 5 percent SAF for all sites of service, 2007-2009.
Hospital Readmissions vary among post-acute settings

Percent of 30-day fixed-length episodes with readmissions by first setting of post-discharge care

Sources: RTI International and Cain Brothers’ Analysis.
Post-acute care contributes to controlling hospital readmissions

The highest percentage of readmissions comes from patients who did NOT receive post-acute care.

Percent of readmissions by source, 30-day fixed length episodes, 2007-2009

Post Acute Silos

Site specific payment systems
Site specific documentation
Artificial Boundaries

LTACH – 25 day LOS
IRF – 60% rule/3 hour rule
SNF – 3 day prior hospitalization
Post Acute Care Goals and Values

• Minimize medical complications
• Minimize readmissions
• Optimize function/mobilization
• Promote independent/community living
• Patient/caregiver education and support
• Safe, effective transitions of care
• Sick role → learning/health role
Global Goals

- Need for full continuum of post acute services with clear usage criteria
- Effective transition of care management
- Aligned payment incentives
Medicare Criteria for Inpatient Rehabilitation

- Medically stable – able to participate in intensive rehab
- Requires intervention of at least two therapies (PT, OT, Speech)
- Requires, can participate from at least three hours of therapy, five days per week
- Requires medical management of an experienced rehabilitation physician, and receives at least three face to face visits per week
- Requires an intensive, coordinated interdisciplinary team approach
Allowable IRF Medical Conditions

- Stroke
- Spinal Cord Injury
- Congenital Deformity
- Amputation
- Major Multiple Trauma
- Femur Fracture
- Brain Injury
- Neurological Disorders
- Burns
- Active polyarticular rheumatoid arthritis, psoriatic arthritis, and seronegative arthropathies
- Systemic vasculidities with joint inflammation
- Severe or advanced osteoarthritis (osteoarthritis or degenerative joint disease) involving two or more major weight bears joints (elbow, shoulders, hips or knees, but not counting a joint with prosthesis) with joint deformity and substantial loss of range of motion, atrophy of muscles surrounding the joint
- Knee or hip joint replacement or both, during an active hospitalization immediately preceding the inpatient rehabilitation stay
Questionable Diagnoses

- Single extremity fractures
- Joint replacements without complications
- Debility/Deconditioning
Goals of Medical Rehabilitation

- Optimizing patient health
- Preventing medical complications
- Improving functional skills
- Restoring independence
- Promoting participation in society
- Education
- Optimize experience
- Achieve durability
- Promote efficiency
Critical Transition Needs

- Manage transitions
- Focus on palliative care goals
- Supported discharges
- Improved linkages with medical homes

ASA International Stroke Conference
San Diego
February, 2014
Key Program Linkages

- Neurosciences
  - Stroke
  - Neuro-medical programs
  - Neurosurgery
- Trauma
  - TBI
  - Concussion
  - SCI
- Neuro-oncology
- Others
  - Transplant
  - Cardiac
• About 4% of U.S. adults will have a stroke by 2030 (potential 20% increase)
• Costs to treat stroke may increase from $71.55 billion (2010) to $183.13 billion
• Americans currently 45-64 years old will have highest increase in stroke at 5.1%
• Stroke prevalence to increase most among Hispanic men by 2030 and the cost of treating stroke among Hispanic women is expected to triple

AHA/ASA
Does Post Acute Care Site Matter?

222 patients

Home Health vs SNF vs IRF

IRF gains > SNF in
- Basic mobility
- Cognitive
- Daily activities

Chan, et.al
Archives PM&R
2013; 94: 622-9
Potential Added Value of Acute Inpatient Rehab Facilities:

- More intensive physician direction and intervention
- Physician specialty follow up
- More intensive and specialized RN care
- More intensive and specialized therapy
- Team/care coordination
- Psychosocial management
- Patient/family education
- Discharge/transitional planning
- Quality/Outcome focus
Generally stroke patients treated in IRF’s have greater improvement and shorter stays than stroke patients treated at a SNF.

Medicare Payment Advisory Commission
Report to Congress
March, 2011
There is strong evidence that organized, interdisciplinary stroke care will not only reduce mortality rates and the likelihood of institutional care and long term disability, but also may enhance recovery and increase activity of daily living independence.

ASA
Assessment of Patient Outcomes of Rehabilitative Care Provided in Inpatient Rehabilitation Facilities and After Discharge

DaVanzo, et.al.
IRF vs SNF

Returned home two weeks earlier.
Remained home two months longer.
8% lower mortality over 2-year period.
5% fewer ED visits.
5/13 conditions had fewer hospital readmissions.
Anybody who can be cared for at home should be cared for at home.

Michael Reding, MD
Burke Rehabilitation Hospital
Episode Based Care with disease specific focus
• Value, focus and goals of different care continuum environments

• Determine appropriate mix of medical supervision and therapy intensity

• Understand and minimize risks of transitions

• Episode based case/care management and navigation
Accreditation
Quality
Outcomes
Efficiency
Patient T.N. (Age 36)