Post-acute and Hospital Perspectives on Compliance Challenges

HCCA Orange County
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Agenda

• Define the Continuum of Care and what this means to health care systems and post-acute
• Challenges related to Continuum of Care
• Type of alliances and the compliance challenges – how can we be proactive?
Definition of Continuum of Care

• Continuum of care guides and directs patients over time through a comprehensive array of health services spanning all levels and intensity of care (per Healthcare Information and Management Systems Society)

What does that look like?
Facts related to Continuum of Care

• 2016 study profiled in *The Journal of Post-Acute (PAC) and Long-Term Care Medicine (JAMDA)* found
  • 3,246 acute hospitalizations followed by PAC facility stays,
  • 739 (roughly 23 percent) included at least one hospital readmission.
  • The largest reason for readmission included impaired function, due to non-compliance with PAC discharge recommendations.

• CMS initiative to avoid readmissions targets preventable readmissions with the penalty program introduced by the Affordable Care Act.
  • Acute care providers have been penalized for "excess" readmissions in the first 2 years of the CMS Readmissions Reduction Program.

Definition of Continuum of Care

Despite Network Development, Minimal Shifts Seen in Utilization

**Very Few Hospitals Shifting Volumes to Major Referral Destinations**

*Hospitals' top SNFs by volume, 2013 - 2016*

n=3421 – All hospitals with 100+ discharges to SNF

- 1.6% of hospitals increased the share of patients sent to their top 5 SNFs by 10%

**Few Networks See Even Minimal Narrowing**

- 16% of hospitals have eliminated referrals to one or more SNFs
- 1.74% of hospitals have eliminated referrals to five or more SNFs
Continuum of Care-Initiatives

**Hospitals**
- Care pathways
- Patient education materials
- Education for post-acute staff

**Post-Acute Providers**
- Care pathways
- Joint staff training
- Telehealth
Challenges

• Hospitals fail to shift patient discharges to preferred providers
• Significant quality differences between low- and high- performing SNFs
• Patient does not want to go back to the facility or where directed
• Lack of access to discuss issues with patients
• Lack of care coordination between the PAC transitions including follow-up visits
• A lack of information sharing and communication between patient and the physician and care providers

Challenges

• Early warning signs of a patient's worsening condition, medication adherence and reconciliation on a timely basis.
• A poorly planned or lack of understanding by the patient and/or caregiver of the discharge plan
• Insufficient quality of care or lack thereof at home, where the care provider may not be skilled or educated in the discharge plan.
• Medication related incidents due to patients or family being non-compliant with discharge plan.
• Discharged patients often go home alone without support.
Challenges

• IT infrastructure is lacking to allow ease in completing true continuum of care
• Steering of patients to one facility (Anti-kickback statute (AKS))
• Sometimes require incentive—both traditional acute and post-acute provider
• Even in narrow networks – not the same managed care contracts
• The secondary payer carriers make a much bigger play on where patient goes
• Compliance with MediCal Bed Hold Contracts

Ideas: Approaches to grow post-acute outcomes

Help Patients choose high-quality, in-network providers
• Understand the parameters of patient choice laws
• Educate discharge planners
• Develop resources for patients and families
• Referrals based on outcomes of PAC provider

Grow better outcomes by raising overall post-acute quality
• Offer training to clinical staff in downstream settings
• Invest in telehealth capabilities
• Facilitate hospital/post-acute consortiums with partners
• Assist in evaluating the at-risk patients for intervention before emergency room or hospital admission

Other
• Transitional care management nurses / Care Coordinators
• Collaboration to create a patient centered care plan
What are some compliance situations? Case examples or Specific risks

Compliance Examples - Readmission

• Two sites of services for discharge were considered - SNF and LTAC. A decision was made for the patient to go to SNF level of care due to cost. Patient had respiratory complex issues. Patient re-hospitalized with an exacerbation of condition.

• Second discharge, the patient is sent to an LTAC.
  • How could this have been prevented?
  • What Compliance issues come out of this?
Compliance Examples – Transfer of Care

Meetings occurred between the hospital and the post-acute provider but the information shared at the time of transfer about the patient had gaps related to medication and changes in therapy

• How can this be prevented?
• What are the compliance risks?

Compliance Examples – Triage

• Triage the primary diagnosis for admission and/or placement with limited regard to complexities and comorbidities. Patient arrives at PAC without proper planning.
  • What are the compliance concerns?
Data Mining

• PEPPER data
• Quality data mining
• Current data from local ACO and/or insurance providers
• Data from hospital to post acute is better than from post acute to hospital

Assessing Specific Partners

• Assess Current Admission and Discharge Patterns
  • Identify the care providers your organization utilize
  • Look back in data over one year
• Analyze Quality and Performance data
  • Analyze care providers performance data such as quality, staffing models, etc.
  • Look at disease specific certifications, accreditations, and special skills training
  • Equipment
• Conduct tour of remaining sites
  • Tour care facilities to determine if a partner
What can we add to our audit or monitoring work plan?

• Ensure medical necessity is reviewed for all audits
  • Federal guidance
  • Look at medical necessity from all care providers: Nursing, Rehabilitation, Respiratory, etc.

• Involuntary transfer and discharge in Nursing Homes
  • With PDPM
    • Concerns under provide services or shorten the length of stay based on rate changes and not medical necessity
    • Review ICD-10 coding accuracy

Summary Points

• Continuum of Care Initiatives
• Improving Acute / Post Acute Outcomes
• Compliance Risks
• Data Mining
• Audit or Monitoring Work Plan

Questions
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