Post-acute and Hospital Perspectives on Compliance Challenges

HCCA Orange County

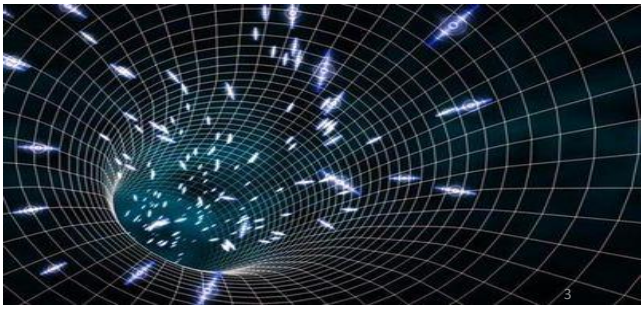
June 12, 2020

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)



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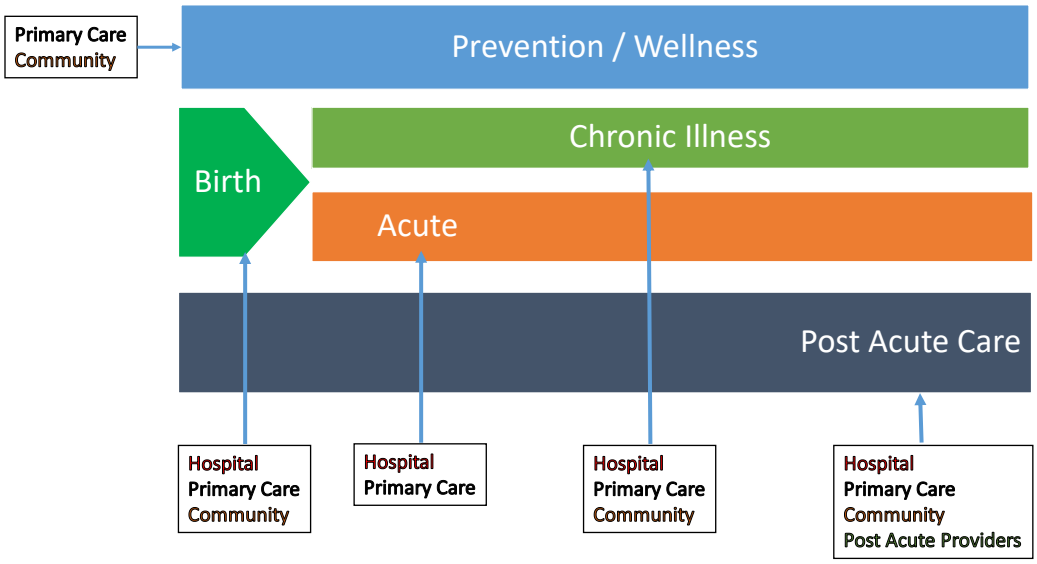
What does that look like?



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Tami to update

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.

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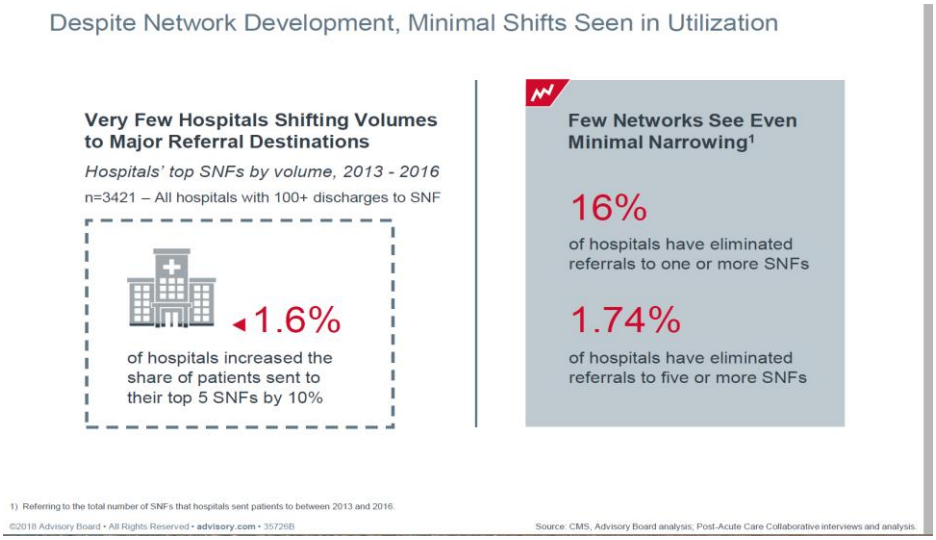
Definition of Continuum of Care



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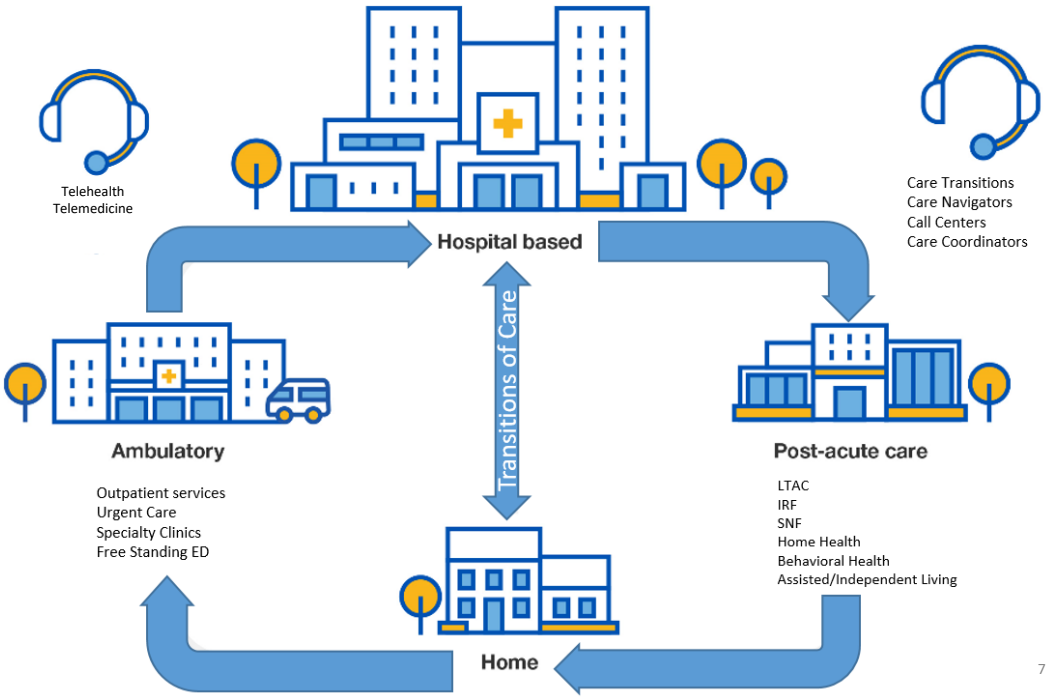

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Continuum of Care-Initiatives

Hospitals

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

Post-Acute Providers

- Care pathways
- Joint staff training
- Telehealth

1 Care pathways and educational sessions are the most common joint acute/post-acute initiatives

Top 5 partnership activities	Percent
1. Care pathways	64.2%
2. Educational sessions for post-acute staff	45.3%
3. SNFist program	36.8%
4. Telehealth	35.8%
5. Joint training for hospital and post-acute staff	34.7%

DATA SPOTLIGHT

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Median number of initiatives that providers are working on with their partners

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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

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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.

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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

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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

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What are some compliance situations? Case examples or Specific risks

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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?

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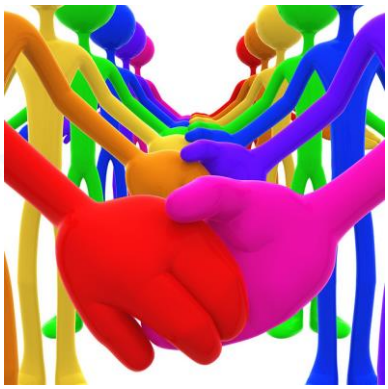
Compliance Examples –Transfer of Care

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?



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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?

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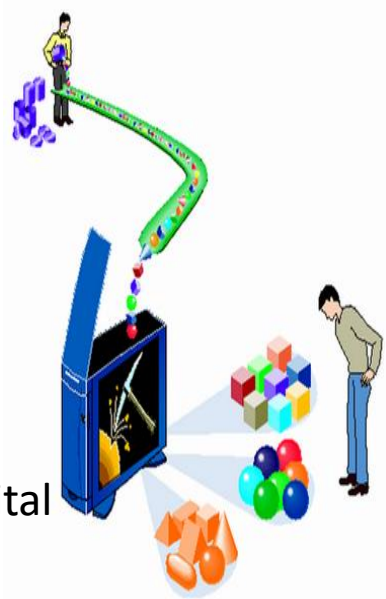
Data Mining

- 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



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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

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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

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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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