Objectives:

- Understand the driving forces and mandate to build an innovative and sustainable post-acute care network (PAC)
- Discuss the design, challenges, and successes of the Bed Reservation Program & Home Health Enhanced Program
- Discuss the issues and complexities of developing a robust post-acute care network
- Identify the Post PAC Future

A Fragmented System…2008

“Providers need to increase care coordination and be jointly accountable for quality and resource use. There is a focus on procedures and services rather than on the beneficiary’s total needs. This becomes a particular problem for beneficiaries with several chronic conditions and for those transitions between care providers. Poorly coordinated care may result in patient confusion, overtreatment, duplicative service use, higher spending and lower quality of care.”

Patients Who Did Not Receive Appropriate Post-Acute Care Referral (12 wks post discharge)

- Readmission rate-77%
- ED visit-86%

Source: Bowles, Kathryn et al. "Post Acute Care Referral Decisions Made by Multidisciplinary Experts Compared to Hospital Clinicians and the Patients 12-week Outcomes," Medical Care, 2008 February 46 (2).

PAC Game Changer

2010 Accountable Care Act
Is a Mandate with Penalties!
HR 3590 (ACA) Targeted Readmissions

- Section 3025-Readmission Reduction Program, 2012
- Section 399KK-Quality Improvement Program, 2012
- Section 3026-Community-Based Care Transitions Program, $500M over 5 years-high risk patients, 2011

Current State vs. Future State

- Current: Outpatient care, Readmission-Hospital, SNF, Readmission-Hospital, Assisted Living, Readmission-Hospital
- Future: Home, Physician Office, OP/Ancillary Services, Assisted Living, SNF, Hospital

CMS’ Continuum of Care

- Emerging Scope of Hospital Accountability
  (30 day readmission rates, 30 day mortality rates)
- Reimbursement is increasingly spanning the Continuum
  - Inpatient bundling (ACE demonstration): Acute
  - Episode-based (National Pilot Program on Payment Bundling): Pre, Inpt, Post
  - Shared Savings (Medicare SS Program): Pre, Inpt, Post
  - Readmission penalties: Post
Six Reasons to Coordinate Care:

- ACO’s (MSSP incentive)
- Bundled Payment Initiatives
- Value based Initiatives
- Readmission Penalties
- RAC Audits
- MSPB (The new readmission penalty-October 1, 2014)

Seventh Reason:

- Improving Medicare Post-Acute Transformation Act of 2014
- Crucial step toward modernization of Medicare payments to post-acute care providers-mostly documentation to prove medical necessity

Chronic Illness & Aging Requires Post-Acute Care Services

For every 1% change in the incidence of chronic illness there is a corresponding increase in health care utilization of 6%

Source: CA Health Care Foundation
Post Acute Services Continue to Grow

- In 20 years chronic illness is expected to increase by 37%
- 45% of Americans have 1 or more chronic illnesses
- 91% of adults 65 years > have at least 1 chronic illness
- 20% of people with chronic illness have ADL limitations
- 67% with 5 > chronic illnesses have limitations

UCLA Health

- Hospitals located in Los Angeles and Santa Monica, CA
- Comprised of Ronald Reagan UCLA Health: Ronald Reagan- 520 Beds, Santa Monica-266 beds, Resnick Neuropsychiatric Hospital (74 beds), Mattel Children's Hospital-100, and the UCLA Medical Group with its wide-reaching system of primary-care and specialty-care offices throughout the region.
- Ronald Reagan-Level 1 Trauma Center
- 25,000 admissions and over 45,000 ED visits

Post-Acute Network under Development
UCLA’s Mandate to Build a PAC

- Too few beds
- Occupancy rates exceed 95%
- LOS increasing
- Queueing in ED
- High patient acuity and complex discharges
- Most discharges occur after 4:00pm
- Significant homeless population
- Discharge barriers

Occupancy by Month
(Excluding Nursery, Psychiatry)

SNF & HH Placements
RR & SM-CY 2012 to 2014
Bed Reservation Program (Est. 2011)

- 2011 Site visits: Selected 2 SNFS-6 leased beds
- 2015-25 leased beds in two facilities

Bed Reservation Program (BRP): 2011

- Established daily bed lease rate to hold bed based on acuity to facilitate discharges for unfunded/underfunded patients
- Funded care includes board/care, medications, PT/OT
- Established concept of "Backfill" to reduce daily bed lease costs
- SNFs can deny patient due not meeting criteria
- Started funding post SNF transitions of care (2012)

Crown Jewel of the BRP

Two Nurse Practitioners
**Financial Overview BRP Program**

January 2014 to December 2014

<table>
<thead>
<tr>
<th>Program</th>
<th>Number of Patients</th>
<th>Estimated Avoidable Hospital Days</th>
<th>Back Fill Savings*</th>
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</thead>
<tbody>
<tr>
<td>BRP Homeless Patients</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>New Vista (Jan to Dec 2014)</td>
<td>143</td>
<td>10.6</td>
<td>122</td>
</tr>
<tr>
<td>Female (July to Dec 2014)</td>
<td>15</td>
<td>11.6</td>
<td>177</td>
</tr>
<tr>
<td>Male (Jan to Dec 2014)</td>
<td>3</td>
<td>13.4</td>
<td>50</td>
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<tr>
<td>Country Villa (Jan to June 2014)</td>
<td>18</td>
<td>20.1</td>
<td>362</td>
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<tr>
<td>BRP Patients</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>New Vista</td>
<td>151</td>
<td>7</td>
<td>1,057</td>
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<tr>
<td>Female</td>
<td>12</td>
<td>7</td>
<td>84</td>
</tr>
<tr>
<td>Male</td>
<td>9</td>
<td>7</td>
<td>64</td>
</tr>
<tr>
<td>Country Villa</td>
<td>24</td>
<td>7</td>
<td>168</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>261</td>
<td>2,491</td>
<td></td>
</tr>
</tbody>
</table>

Approximate Backfill Contribution Margin/Day* $1,798

Backfill Contribution Margin $4,478,818

BRP Program Cost (Jan 2014 - Dec 2014) $1,997,136

*FY12 CM/Day Medicine Patients

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**Total Cost of Leased Beds Program**

January 2014 to December 2014

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**Bed Reservation Program**

2012 = 91 patients

2013 = 163 patients

2014 = 261 patients

2013 vs 2012 = 82% increase in # of patients placed
New Vista Occupancy Rates
January 2014 to December 2014

Goldstar Rehabilitation Occupancy Rates
October 2014 – December 2014

BRP Readmissions Compared to Health Services Advisory Group (HSAG)
All cause 30 day Readmissions
Q2 2013 to Q1 2014

HSAG Report  vs BRP
All Causes
California 2000%

Post SNF Funded Services  
January 2014 to December 2014

<table>
<thead>
<tr>
<th>Services</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recuperative Care</td>
<td>$56,514.00</td>
</tr>
<tr>
<td>Assisted Living Facility/Guest house</td>
<td>$3,600.00</td>
</tr>
<tr>
<td>Home Health</td>
<td>$2,035.00</td>
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<tr>
<td>Medications</td>
<td>$1,425.59</td>
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<tr>
<td>DME</td>
<td>$641.66</td>
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<tr>
<td>Transport</td>
<td>$100.00</td>
</tr>
<tr>
<td><strong>Total Amount</strong></td>
<td><strong>$64,516.47</strong></td>
</tr>
<tr>
<td>Avg Cost Per Patient (23 patients)</td>
<td>$2,805.06</td>
</tr>
</tbody>
</table>
Opportunities

- Communication: external/internal providers
  - To/from PMD
  - Inpatient teams
- Lack of accountability infrastructure
- High number of patient refusals at time of service
- Differences in referral processes from inpatient and outpatient setting
- Absence of electronic home health orders

Enhanced Home Health Program
A minimum of seven touch points to occur within the first two weeks of discharge.

Improving Quality Outcomes

- Enhanced Home Health Quality Council-3 contracted home care vendors
- Components
  - 7 touchpoints in first 2 weeks post hospital discharge
  - 1st touchpoint in the inpatient setting (in-person or phone)
- Measurement
  - 30-day all-cause readmission
  - % of patients who refuse home health services
  - % of patients who were unable to be located post-discharge
  - % of patients who had a delayed start of care
Percent of UCLA Hospital Discharges with any Home Health Assignment Found with All-cause Readmission within 30 days

Percent of UCLA Hospital Discharges with any Home Health Assignment Found with ED Visit within 30 days

No Significant Effect Found between HH Enhanced and Standard HH Services

- The touchpoints have tremendous benefits for the patients as have the relationships with the HH agencies:
  - sharing of data
  - establishment of Home Health Council
  - standardization of practice

- Next step: tailor interventions to specific populations for next data analysis
Lessons Learned in HH Enhanced Program

- Invest in the relationships over the long term
- Establish expectations for quality
- Develop a process to review metrics, address issues (denials, refusals, etc) and readmissions
- Establish a process to review real-time failures
- Establish a claim reconciliation system for funded patients
- Constantly improve referral processes/handoffs, especially for referrals that occur during non-business hours

Post Pac Future

Care Coordination must focus on:
Transition Planning vs. Discharge Planning

- Admission: Prevention
  - (Comprehensive assessment)
- Transition
  - (Identify PAC settings)
  - Risk assess patients early and often
  - Requires tailored interventions
Develop a “Transition” Mentality

• Cross-continuum care coordination
• Admission triggered discharge planning
• Frontloaded PAC referral pathways & resources
• Risk stratified transition plans

Admission triggered discharge planning

• Within 24 hours of admission, patient is comprehensively assessed to determine clinical and psychosocial needs
• Risk Stratification of patients (ie, LACE)
• Family/partner/caregiver is also assessed
• Address emotional/readiness components of patient/family related to PAC needs

Frontloaded PAC referral pathways

• Electronic predictive software required to make referrals and generate responses within preset timeframes
• Care coordination team must have access to appropriate PAC resources and match resource to patient’s clinical needs, insurance, quality scores, patient/family preference
• Multiple and simultaneous referrals made to different levels of care
Value-Added Innovations

- Risk stratification in acute and post-acute connectivity
- Expansion of home health services: Home Based Transition program (ie, CCTP)
- Predictive Software in SNFs: (ie., Interactive) trains nurses when red flags arise and how to react to warning signs
- Extensive training in SNFs to increase capacity to accept higher acuity

Post Acute Expectations

- POLST
- SBAR
- Stop and Watch
- Return to Acute Log (ED)
- ED Root Cause Analysis
- Predictive software/electronic quality data

Post ACA Era will include:

- Hospitals: Last Resort

- SNF: Second to last resort; increase capability to manage med/surg patients, shorter LOS

- Home health expansion: Networks will be narrowed, expansion of in-home services-alignment of financing

- Patients will be directed to lower levels of care (home care, assisted living, private duty nursing, remote monitoring, etc)
The Reality Is Now!

- Incentives will be aligned to avoid hospital care
- Direct to SNF transfers from ED
- Tele monitoring monitoring at home, SNFs, assisted living etc.
- Frequent Home visits
- Expansion of home health to ambulatory via case managers

UCLA’s New PAC

UCLA’s Universe

Post Acute Strategies
References


Thank You!

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