Briefing on Long-Term and Post-Acute Care

Health IT Standards Committee
June 20, 2012

John Derr, RPh, Golden Living, Member Standards Committee in collaboration with
Larry Wolf, Kindred Healthcare, Alternate Member Policy Committee
LTPAC Silo Spectrum of Care

- Acute Care
- LTAC
- IRF
- SNF
- PACE
- ALF
- Adult Care
- Independent
- Home Care
- Hospice

Relative Cost

High

Low

Low

Acuity Level

High
Briefing on Long-Term and Post-Acute Care (LTPAC)

• Essential to patient-centered coordinated care
  – Post-Acute Care: healing and rehabilitation after an acute event
  – Long-Term Care: people with disabilities or chronic care needs
  – **Interdisciplinary** care teams

• Increasingly able to participate

• Aligned with National Priorities for Quality Health Care
  1. Making Care Safer
  2. Ensuring Person- and Family-Centered Care
  3. Promoting Effective Communication and Coordination of Care
  4. Promoting the Most Effective Prevention and Treatment of the Leading Causes of Mortality, Starting With Cardiovascular Disease
  5. Working With Communities to Promote Wide Use of Best Practices to Enable Healthy Living
  6. Making Quality Care More Affordable
Federal Health IT Strategic Plan

Objective C

Support health IT adoption and information exchange for public health and populations with unique needs

Strategy I.C.3: Support health IT adoption and information exchange in long-term/post-acute, behavioral health, and emergency care settings. Providers working in long-term and post-acute care (LTPAC) and behavioral health settings are essential partners in patient care coordination. ONC, CMS, and the Assistant Secretary for Planning and Evaluation (ASPE) will collaborate to address quality measures and evolving clinical decision support opportunities that will promote appropriate exchange of health information in LTPAC and behavioral health care settings for optimal coordination of care.

HHS will build on meaningful use to adopt electronic standards for the exchange of clinical data among facilities and community-based LTPAC settings, including, where available, standards for messaging and nomenclature. ONC will leverage the State HIE and Beacon Community grant programs in demonstrating methods for which the electronic exchange of information with LTPAC entities can improve care coordination. In addition, HHS will identify opportunities in the Affordable Care Act to support the use of health information exchange technologies by LTPAC and behavioral health providers to improve quality of care and care coordination.
• Began 2005
• 8th Annual Summit
  June 18-19, 2012
  Baltimore, MD
• Roadmaps
  – 2005
  – 2008
  – 2010-2012
  – 2012-2014

Government Representatives from
ASPE, ONC, CMS, HRSA

www.ltpachealthit.org
Individual Health
Life Cycle / Care Cycle

- Diagnosis
- Intervention

Acute

Person

- Wellness
- Prevention
- Long-term Management

Post-Acute

- Healing
- Rehabilitation
- Recovery
Care Cycle / Example Care Settings
Transformation of Healthcare

STATIC, REACTIVE, EPISODIC HEALTHCARE SYSTEM  TO  DYNAMIC, PROACTIVE, WELLNESS HEALTHCARE SYSTEM

HOW

An Integrated, dynamic, longitudinal Person Centric Electronic Health Record Empowering Personal Health Accountability, Wellness, and Proactive Care through transitions of care interoperability based on standards.

June 2012, Baltimore, MD
High Cost of Chronic Care

Annual Health Care Costs Per Person by Number of Chronic Conditions (Boomer and non-Boomer)

- $12,000
- $10,000
- $8,000
- $6,000
- $4,000
- $2,000
- $0

Spending on medications
Hospital spending
Other spending

Number of chronic conditions
0
1
2
3
4
5+

$12,699
$8,518
$6,178
$4,256
$2,241
$850

Source: Johns Hopkins and Partnership for Solutions, Chronic Conditions: Making the Case for Ongoing Care, September 2004

Note: Other spending refers to costs associated with physician office visits, home care visits and tests.

June 2012, Baltimore, MD
OBJECTIVE TO KEEP A PATIENT WITHIN HIS/HER NORMAL QUALITY OF LIFE RANGE

Episodic Care
Out of Normal Range
*Highest Cost Care*

John F. Derr, R.Ph. 1998
June 2012, Baltimore, MD
Patients Discharged to Post-Acute Care

35% of Medicare beneficiaries discharged from short-term acute hospitals receive post-acute care

Source: RTI, 2009: Examining Post Acute Care Relationships in an Integrated Hospital System
Chart 1: Short Term Acute-care Hospital (STACH) and PAC Severity of Illness (SOI), in Prior STACH Stay

Percentage of Patients

- 9.0% for Acute-care Hospital
- 31.8% for LTACH
- 42.4% for IRF
- 2.4% for SNF
- 46.7% for HHA

Legend:
- Level 1 (least severe)
- Level 2
- Level 3
- Level 4 (most severe)

Source: Analysis of the 2008 100% Medicare Standard Analytical Files by The Moran Company.
Note: SOI is measured by the 3M APR-DRG Grouper.

TrendWatch: Maximizing the Value of Post-acute Care
American Hospital Association, November 2010
http://www.aha.org/research/reports/tw/10nov-tw-postacute.pdf
Medication Related Problem Costs

- $76.6 billion - ambulatory care\(^1\)
- $20.0 billion - acute care\(^2\)
- $4.0 billion - nursing home care\(^3\)

$100.6 billion direct medical costs of MRPs


June 2012, Baltimore, MD
### Chart 2: Medicare Patient Volume and Spending for Fee-for-Service Beneficiaries, by PAC Provider Type

<table>
<thead>
<tr>
<th>Facility Type</th>
<th>Number of Facilities (2009)</th>
<th>Number of Beneficiaries Treated (2008)*</th>
<th>Estimated Medicare Spending (2009)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Long-term Acute Care Hospital</td>
<td>432</td>
<td>115,000</td>
<td>$4.9 billion</td>
</tr>
<tr>
<td>Inpatient Rehabilitation Facility</td>
<td>1,196</td>
<td>332,000</td>
<td>$5.7 billion</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>15,053</td>
<td>1.6 million</td>
<td>$25.5 billion</td>
</tr>
<tr>
<td>Home Health Agency</td>
<td>10,422</td>
<td>3.2 million</td>
<td>$18.3 billion</td>
</tr>
</tbody>
</table>

Post-acute care accounted for approximately 12% of all Medicare spending in 2008.


*Data from Medicare Payment Advisory Commission. (March 2010). *Report to the Congress: Chapter 3.* Washington, DC.

Includes fee-for-service beneficiaries only.

---

**TrendWatch: Maximizing the Value of Post-acute Care**
American Hospital Association, November 2010
[http://www.aha.org/research/reports/tw/10nov-tw-postacute.pdf](http://www.aha.org/research/reports/tw/10nov-tw-postacute.pdf)
Required Electronic Assessments

- **Nursing Facility**: Minimum Data Set (MDS 3.0)
- **Home Health**: Outcome and Assessment Information Set (OASIS-C)
- **Rehab Hospitals**: Inpatient Rehab Facility-Patient Assessment Instrument (IRF-PAI) / Functional Improvement Measure (FIM)
- **Prototype Multi-Setting**: Continuity Assessment Record and Evaluation (C.A.R.E.)
NQF – MAP (Measure Applications Partnership)
Harmonize Measures

Vision
- National Quality Strategy
- Coordinated and accountable care delivery models
- Measurement Tactics
  - Cascading measure sets focused on value
  - Harmonized measures across settings and populations

Clinician
Core = Available Measures + Gap Concepts

Hospital
Core = Available Measures + Gap Concepts

PAC/LTC
Core = Available Measures + Gap Concepts

MAP Input on HHS Proposed Program Measure Sets

- PQRS
- EHR Incentive Program
- Outpatient Quality Reporting Program
- Hospital VBP
- ESRD Quality Incentive Program
- Long-Term Care Hospitals
- Hospice Care

Programs Listed for Illustrative Purposes
- Inpatient Quality Reporting Program
- Cancer Hospitals
- Psychiatric Hospitals
- Inpatient Rehab Facilities
- Home Health Care
- Skilled Nursing Facilities

Coordinated Delivery Programs (ACOs)
Certified EHR Technology

1. Includes patient demographic and clinical health information, such as medical history and problem lists; and

2. Has the capacity:
   i. To provide clinical decision support;
   ii. To support physician order entry;
   iii. To capture and query information relevant to health care quality;
   iv. To exchange electronic health information with, and integrate such information from other sources; and
   v. To protect the confidentiality, integrity, and availability of health information stored and exchanged

What is the minimum necessary for all settings to
• Provide a base for process and quality improvement?
• Ensure a legal medical record?
• Improve care coordination? Standards and Interoperability?
• Enable a Learning Healthcare System?
Software, Certification

• ONC-ATCB – Modular Certification
  – Potential for a common core
• CCHIT – LTPAC Certification
  – Specialized needs of these settings
History of LTPAC HIT

- **Shift from Paper**
- **Increased Documentation Requirements**
- **Shift to off the shelf Software**
- **EHR/EMR/PHR**
- **Standards & Certification**

- **Financial Pre 1999**
  - Nursing Homes using local or regional accounting firms for financial software

- **MDS/Raven 1999 - PPS**

- **Clinical 1999-2004**

- **Enterprise 2005-2014**
  - President Bush’s 2004 Executive Order
  - President Obama 2009 ARRA HIT Program

- **Integration 2015**

June 2012, Baltimore, MD
Hospitals Ineligible For Federal Meaningful-Use Incentives Have Dismally Low Rates Of Adoption Of Electronic Health Records
Larry Wolf, Jennie Harvell, Ashish K. Jha
Health Affairs, Vol 31, No 3 (2012)

Use of Electronic Information Systems in Nursing Homes, United States, 2004
Helaine E. Resnick, Barbara B. Manard, Robyn I. Stone, Majd Alwan
Journal of the American Medical Informatics Association, Vol 16, No 2, March/April 2009
EMR Adoption and Use in Home Health and Hospice
CDC National Center for Health Statistics, September 2010.
Care in Multiple Settings

Note: Often physician, pharmacy, laboratory and other services are fragmented among the settings and care may bounce back to an earlier setting.
Care Coordination Is Multi-Step

- At Referral / Discharge Planning
  - Admission Decision
- At Discharge
  - Current Status
- At Admission
  - Physician: Admission Orders, Admission History and Physical
  - Nursing/Therapy: Initial Assessments
  - Reconciliation processes

Note: Each setting has its own perspective, payor and regulatory requirements. The needs of sender and receiver are different.
HIE Challenge Grants: Improving Long-Term and Post-Acute Care Transitions

• Colorado
  – Community-based care management with focus on reducing hospital readmissions
  – Address developmentally disabled populations
  – 160 organizations in four communities to use results delivery, community record, CCD

• Massachusetts
  – Learning Collaborative to improve care transitions
  – Universal Transfer Form
  – Hybrid tools to bridge different technology levels

• Maryland
  – Building on work of three early adopter LTPAC providers
  – Portal access for those with limited technology
  – Registry of Advance Directive documents

• Oklahoma
  – Two-way communication between nursing facilities and hospitals
  – Include information from INTERACT (Interventions to Reduce Acute Care Transfers)
    http://www.interact2.net/
  – Also Advance Directives, ADLs, MDS

• National Governors’ Association workshops on HIE and LTPAC:
  Alaska, Arkansas, Indiana, Michigan, North Dakota, Pennsylvania, Rhode Island and
  Washington + HIE Challenge Grantees for LTPAC

• Delaware HIN
  – 100% of acute hospitals, 100% of SNFs and other LTC providers
  – 88% of medical providers
Reusing Existing Assessments

- Transform MDS and OASIS to CCD/C-CDA
  - Select components for inclusion
S&I Framework: Community-Led Initiative

Longitudinal Coordination of Care WG

Meeting Schedule
To add these meetings to your calendar, subscribe to the Longitudinal Coordination of Care Calendar.

LCC WG Monthly All Hands Meeting
Date of Next Meeting: Thursday, Apr. 5, 2012
Recurring Meeting: First Thursday of Every Month from 9:00-10:00am ET
Webinar: siframework1.webex.com
Dial-in: 1-408-600-3600 | Passcode: TBA

LCC Use Case Extension Working Session (Link to Wiki Page)
Next Meeting: Thursday, Mar. 22, 2012
Recurring Meeting: 3rd, 4th & 5th Thursday of each month from 9:00-10:00am ET
URL: siframework1.webex.com
Dial-in: 1-408-600-3600 | Passcode: 669 990 773

Note: Meetings will have streaming web audio for those unable to access the meeting using the phone dial-in information. Please plan to
Building on the S&I ToC Framework

Discharge Summary & Instructions
- Reconciled core data
- Overview of patient care information from hospital stay
- Follow-up/plan of care

Primary Care Physician
- Consultation Request
  - Reconciled core data
  - Data relevant to consultation context
- Consultation Summary
  - Reconciled core data
  - Consultation findings & recommendations

Specialist

LTPAC Settings (SNF, Home Health, etc.)

Examples of exchanges addressed through S&I LTPAC WG

Addressed through S&I ToC Initiative
Baseline Transaction and Build

Future: Full LCP Support
Building Incrementally
Now: Foundation

Master Longitudinal Care Use Case

Version …: Other trading partners
Round out full longitudinal picture

Version 4: (IRF, Behavioral Health, CBO, ???)

Version 3: (IRF, Behavioral Health, CBO, ???)
White Paper Roadmap lays out priority order to incrementally add requirements of other trading partners

Version 2: (IRF, Behavioral Health, CBO, ???)

Version 1: Baseline Developed with HHA/ SNF
Creates base LCC Use Case Structure and focuses on HHA/ SNF as the starting point that gives the best overall coverage of data elements.

June 2012, Baltimore, MD
8th LTPAC HIT Summit Summary

- New Approaches to Care Coordination
- Patient Engagement
- Quality Outcomes
- Getting Ready for Meaningful Use
- Interoperability & Interconnectivity Showcase
- Re-Hospitalization & Telemedicine
- Clinical Decision Support
- S&I Framework LCC
- Project Direct
- HITECH and HIPAA
- Medication Management
- Workforce Challenges
Helping people live their lives