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INSIDE THE NUMBERS:

EVIDENCE-BASED QUALITY DATA IS INCREASINGLY ESSENTIAL FOR POST-ACUTE CARE

As value-based services take root, operators are finding they must adapt. Affiliations with aligned partners are becoming more prevalent. So too, is the ability to provide more granular data in areas such as discharges, readmissions, mortality rates, patient management and process standardization.

Long-term care organizations will be well positioned to compete for a place in the post-acute care continuum, experts from COMS Interactive and Medline say. But they must focus on adopting the technology, risk-sharing and data analytics necessary to operate in the lower-cost, high-quality marketplace that's emerging.

If the future of healthcare isn't here yet, it will be arriving shortly. The up-and-coming business model that eschews conventional fee-for-service in favor of new-phase concepts like value-based delivery, service bundling and provider risk-sharing has been rapidly moving forward. Post-acute providers need to take action if they are to be in the right position to compete in the emerging landscape.

Long-term care professionals learned about these quickly evolving developments during the recent Medline-sponsored *McKnight's* webcast "How Evidence-Based Quality Data Conveys Value to Hospitals and Managed Care Organizations." Two leaders dug into the topic: Terry Sullivan, M.D., chief medical officer for COMS Interactive, LLC, and Martie Moore, RN, chief nursing officer at Medline.

Moore, who has worked in both the acute and post-acute care settings, says the shift from inpatient to outpatient care is "rapidly accelerating" and "happening much faster" than in previous years.

"The world is changing, causing mergers and acquisitions. New partnerships and alliances are being developed among former competitors. In order to be sustainable, we have to change," she says.

The migration from acute care to settings outside hospital walls has been gradual but constant, Sullivan says. As the shift has unfolded, the value of data and technology has hit a premium, and long-term care providers need to boost their capabilities if they are to be considered part of the continuum, he says.

"It's too bad post-acute didn't get included in the Meaningful Use initiative, but we need to

A SUPPLEMENT TO McKnight's LONG-TERM CARE NEWS

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> *Have your data available in a way that can say what you're able to do.*

move ahead anyway," he says. "We have to analyze data, coordinate transition and follow patients over the last few years of their lives. Our challenge is to build a system that will accommodate the people who have to follow it over time."

To be sure, Moore says the healthcare industry is "moving to where data and analytics are critical…that data is used to tell your story about how you will improve care, decrease costs and elevate quality and outcomes. Technology will help us standardize practice and stabilize a plan of care."

Impetus for change

At the heart of the healthcare reconfiguration is cost reduction, Sullivan says, and post-acute care providers are "fundamental to these new models" because they serve as critical partners in measuring the quality of patient care.

Calling Medicare "the largest welfare and jobs program in the history of the country," Sullivan said the traditional fee-for-service format instituted with the program since it began in 1965 is rapidly vanishing. It is being replaced by risk-based, value-oriented models. More than half of all Medicare fee-for-service programs are currently tied to quality or value, and over the next few years, he predicts that 90% of fee-for-service programs will be similarly linked.

"The issue isn't money. The issue is value," he says. "The cost of the product delivered is too much and we are overcharging for it. We generate too much care. What we have to do is manage the patient and the process better. We have to manage care, specifically the patient transition. We have to figure out how to get at the 30 percent of services that are of no value to the patient."

The crux of the cost issue is hospital inpatient care, which "eats up 60 percent to 65 percent of all the money," Sullivan says, "so keeping patients out of the hospital is key. The population that utilizes most of the resources are patients in their last three years of life, so we need to keep them out of the hospital. If there are services being done in the hospital that can be done in long-term care, that is where they will be done."

Medicaid is changing as well, Sullivan says, forecasting that the program also will undergo radical changes within the next 18 months. "It actually became managed overnight — one-third is already managed and the other two-thirds will be soon."

Starting a conversation

The new healthcare continuum is beginning to be composed of accountable care organizations and other risk-sharing alliances designed to provide discharge-to-home continuity of care across the post-acute environment. This includes outpatient medical services, long-term care, home care, rehabilitation, palliative care and hospice. Long-term care facility operators need to ascertain how they fit into this equation and engage in a dialogue with their provider peers to handle the patient flow.

Although Moore, a former acute-care executive, acknowledges some hospitals have been reticent to engage in a conversation with potential partners, she believes that it's just a matter of time before that attitude changes.

"Knock on their door," she says. "Start with the care manager or director of care transitions. Their lives have changed and they are accountable. Approach them and have your data available in a way that you can say what you are able to do, which patients you can take care of and your plan of care. You will catch their attention."

The conversation doesn't necessarily have to start at the acute care level, either, Sullivan adds. Going "downstream" to home care, hospice and palliative care partners is a logical place to begin because "the hospital has them for three days, and you have them for three years," he notes.

In preparing data for hospitals, long-term care providers should focus on 30-day readmission rates, mortality rates, outcomes for infections and how standardization is being used, the presenters say Moore emphasizes providers should "claim your space — you have a legitimate role in the healthcare delivery system and it is vital … it is important to claim it."

Data drivers

As Meaningful Use — an integral contingency of the Ameri-

> *What we have to do is manage the patient and the process better.*

For more information

The original webcast is available at www.mcknights.com

can Recovery and Restoration Act's billions in health information technology funds — has driven acute care organizations to develop an integrated platform for data to travel across the provider landscape, health systems are focused on producing meaningful data within patient electronic health records.

Major software developers like Epic have devised interoperability frameworks, such as the physician-guided Care Everywhere that enables data to follow patients between healthcare systems no matter where they are.

As a result, hospitals and integrated delivery networks are striving to realign and standardize their service lines, making procedures uniform across their enterprise and the continuum.

"Care delivery must be aligned through the IDNs, physicians and the continuum," Moore says. "The rules are changing to require standardization across the entire system."

This standardized approach has ramifications for post-acute care providers through a discharge system that is morphing from "patient unloading" into a care transition plan that ensures patients are moved to the post-acute setting in a seamless manner, Moore says.

"Health systems are realizing that their revenue streams are changing and emerging more around wellness and home care. So where do you fit in the continuum?"

Readmission rates studied

As Moore and Sullivan identified, readmission data is what hospitals are looking for when considering adding partners to their post-acute network — and with good reason. Medicare is levying heavy penalties on acute care providers for patient readmissions within 30 days of release. Therefore, hospitals are examining long-term care facilities' data to protect themselves against unnecessary readmissions.

Moore listed the major reasons for 30-day or quicker returns:

- *Clostridium difficile*, which accounts for 30% of readmissions
- Skin injuries such as pressure ulcers, which comprise 22% of readmissions
- Falls with injuries, which are responsible for 6% of readmissions

With *C. diff*, patients are twice as likely to be readmitted; pressure ulcers are another major contributor. With enhanced collaboration between hospitals and post-acute care providers, both conditions can be dramatically improved, Moore says. Better diligence is needed by both sides to boost fall prevention as well, she adds.

As part of the analytics movement, outcomes metrics provide insight into why things happen, Moore says.

CATCHING THEIR ATTENTION

Providers need to approach potential hospital partners with a "Here's what we can do for you" attitude, long-term care experts say.

"It is a tool to understand ourselves and our partners. By using those analytics, we can develop action steps and action plans in a collaborative effort to drive down readmission rates."

> *"The issue isn't money. The issue is value."*

A competitive marketplace

Providers today are really thought of as payers, Sullivan says, "not because they are becoming insurance companies, but because they are assuming more risk."

For the healthcare economy, globalization is re-setting of the cost of goods and the United States is in a position where costs are consuming financial growth. While Asian countries such as China and India have seen their economies grow at rates between 4% and 8%, the U.S. is growing at just 1% to 2% and any more growth "is unlikely," Sullivan says.

"We borrow 43 cents for every dollar for Medicare and we can't grow our way out of this deficit — we have to figure out another way to deal with it."

Competition is the best way to take costs out of the system and even though the prospect may be daunting to some providers, in the long run it will be healthy for the industry and overall economy, he says.

"For the first time, the American healthcare system has become a competitive marketplace," he says. "We should welcome it and not be afraid." ■

Editor's note

This McKnight's *Webinar Plus supplement is based on a similarly named webinar* McKnight's *presented on May 20. The event was sponsored by Medline. The full presentation is available at* www.mcknights.com/webcasts/section/297.