Care Transitions: Finding the Appropriate Venue...
“Where do we go from here?”

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Objectives:

At the end of the lecture, the attendee will be able to:

- Compare and contrast the different options for placement from the short term acute care hospital into the post acute continuum
- List typical diseases and complications that are best managed within each level of the post-acute care continuum and describe how LTACH, IRF, SNF, Geri-psych, Palliative Care, Hospice, Home Health, Memory Care, Transitional Care, and Assisted Living can work together to reduce re-admissions and improve patient outcomes
- Design a process that maximizes the value throughout the continuum as defined by maximizing quality outcome measures and efficiency in processes by appropriate utilization of the different levels of care
Objectives (continued):

At the end of the lecture, the attendee will be able to:

- Discuss the quality problems associated with a “he who gets there first wins” discharge process
- Diagram the process for moving from a “first curve” discharge process to a “second curve” post-acute performance and outcome based system
- Describe how discharge choice across the continuum effects the quality and clinical connections, and positively impacts patients and enables change with an organization
- Discuss ways to improve post-ICU outcomes and LOS by reducing unnecessary transfers
- How can your organization respond effectively?
“Efficiency without quality is unthinkable, but quality without efficiency is unsustainable”

- Robert Wiebe, MD
VALUE AS THE DETERMINANT OF HEALTH CARE PURCHASING DECISIONS

Value = \text{Quality} \times \text{Patient Satisfaction} / \text{Cost}
First Tier Thinking:
The Solution Is A Moving Target...

Traditionally volume driven:

Fixed vs. Variable Costs → $ “on the margin”
➢ “Butts in beds” and “a can of peas”

Fixed payment
➢ “He who gets there first wins”
First Tier Thinking: The Conventional Pathway (Reactionary)

**Acute Incident**

**ER**

**ICU**
Medically complex diagnosis. Patient remains inactive and receives little physical rehabilitation.

**Rehabilitation Unit**
Patient must be well enough to tolerate 3 hours of therapy.

**Med/Surg Unit**
Patient stable but remains physically debilitated with acute medical needs preventing placement to lesser level of care.

**Skilled Nursing Unit**

**Assisted Living**

**Home**
<table>
<thead>
<tr>
<th>Focus</th>
<th>Short Stay Acute Care Hospital (STACH)</th>
<th>Long Term Acute Care Hospital (LTACH)</th>
<th>Inpatient Rehab Facility (IRF)</th>
<th>Skilled Nursing (SNF)</th>
<th>Nursing Home (ECF) Custodial Care</th>
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<tbody>
<tr>
<td></td>
<td>Diagnosis, surgery, and short-term acute interventions</td>
<td>High acuity, medically-complex, catastrophically injured</td>
<td>Restoration of functional independence</td>
<td>Step-down medical/rehab care</td>
<td>Long-term supportive care</td>
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<td>Average Length of Stay</td>
<td>4-7 days</td>
<td>25+ days</td>
<td>12-15 days</td>
<td>12-15 days</td>
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<td>Diagnostic / Imaging Studies</td>
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<td>Program for Medically Complex Patients</td>
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<td>Yes</td>
<td>No</td>
<td>Some</td>
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<td>Program for Ventilator-Dependent Patients</td>
<td>Yes</td>
<td>Yes</td>
<td>Rare</td>
<td>No</td>
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<td>Yes</td>
<td>Yes</td>
<td>Seldom</td>
<td>No</td>
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<td>High Success Rate in Weaning Vent-Dependent Patients</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
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<td>Reimbursement</td>
<td>PPS / MS DRG</td>
<td>PPS / LTACH MS DRG</td>
<td>PPS / IRF DRG</td>
<td>PPS Lifetime Days</td>
<td>Medicaid/Private Pay</td>
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<td>Broad Range of Physicians / Specialists</td>
<td>Yes</td>
<td>Yes</td>
<td>Variable</td>
<td>No</td>
<td>No</td>
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<tr>
<td>Nursing Hours/PPD</td>
<td>4-6 hours</td>
<td>9-10 hours</td>
<td>4-6 hours</td>
<td>3-5 hours</td>
<td>2-4 hours</td>
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</table>
Current Critical Clinical Issues: A Review of Outcome “Drivers”

- RN and RT ratios drive Clinical Outcome Measures
- CNA ratios drive Patient Satisfaction scores
- Best Practices: Vent, Infection Control, Wound Care
  - Standardized Order Sets: It’s time to move “downstream”...
- Pharmacy Protocols and Formulary Development – “guidelines” – should not be inflexible
- Some Things Never Change - “All Medicine is Local”
Current Critical Clinical Issues:  
“The ICU Transfer Dump”

- Medical errors increase with the number of transfers
  - “Required” ICU stays associated with worse outcomes and longer LOS
  - Transfers associated with increased medical errors and adverse events
- ICU transfer to medical ward <24 hours prior to discharge associated with worse outcomes*
- ICU direct to home discharge associated with shorter overall hospital LOS (with same ICU LOS)**

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“...all the care that will help, and none that won’t.”

Don Berwick (2002)
So Why Does It Matter?
Why Do We Need This?

Readmissions
and The Post Acute Continuum...
Readmissions: The Scope of The Problem…

- 19.6% of all Medicare STAC discharges were readmitted within 30 days*

- Physicians said, “WE knew this all along…”

- BUT suddenly Congress cared…

- SO, just as suddenly, CMS cared…

# American HealthTech Data and Medicare (MedPAC) Initial Proposed “Benchmarks” for Readmissions

<table>
<thead>
<tr>
<th></th>
<th>30-day Readmission Rate</th>
<th>Average Payment</th>
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<tbody>
<tr>
<td>Long-Term Acute Care (LTAC)</td>
<td>10%</td>
<td>$38.6K</td>
</tr>
<tr>
<td>Inpatient Rehab Facility (IRF)</td>
<td>7.2%</td>
<td>$17K</td>
</tr>
<tr>
<td>Skilled Nursing (SNF)</td>
<td>21%</td>
<td>$10.2K</td>
</tr>
<tr>
<td>Home Health</td>
<td>29%*</td>
<td>$2.6-3.1K</td>
</tr>
<tr>
<td>MedPAC Readmission Proposed Targets</td>
<td>8% to 18%**</td>
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*Includes ANY “unplanned” patient contact (yes, the data really was that bad)
** This may be also be interpreted as “they have no idea”
SNF Readmits:
National Rates Highly Variable... but generally high...

• 25% for cardiac SNF patients nationally*

• 21-28% market ranges for all SNFs**

• Rates as high as 35-50% for SNF vents***

*Skilled Nursing Facility Referrals and Readmission Rates After Heart Failure or Myocardial Infarction, Chen J., et.al; American Journal Of Medicine, 125 (1), January 2012

** The Advisory Board, Market Specific SNF readmit rates to STAC, 2012

***Market Specific Analysis of The Advisory Board Post-Acute Collaborative SNF readmit data from MSAs in Pennsylvania, Texas, and Nevada
So Where Do You We Go From Here?

The Care Transitions Balancing Act
Second Tier Thinking: What is “The Solution” Among So Many Choices?

LTAC?
Rehab?
SNF/ECF/Custodial Care?
Geriatric Psychiatry?
Hospice?
Home Health?
Assisted Living?
Memory Care?
Moving to the Second Tier: Outcomes, Quality and Why It Matters…
Mutual Goals: They haven’t changed...

- Returning to keeping the patient at home (or the highest functional level of care possible)
- Decrease total cost of care
- Efficient treatment processes
- Reduce multiple transfers (improves outcomes!)
- Re-admission prevention – still “#1”!!
- Maximize quality of interventions
A Second Tier Proposition: Proving “Value” in the Continuum:

- Acuity – patient level criteria
- Acuity – facility level criteria
- Acuity – practitioner level criteria
A Second Tier Proposition: Proving “Value” in the Continuum:

- **Acute level of care: STAC and LTAC**
  - Level of care differences within the facility: patient, staff, technical

- **Sub-acute level of care: SNF, Rehab, GeriPsych, Home Health, Hospice, “Custodial Care”, and now “Transitional Care”**

- **The “blur” of SNF/ECF and “single” post acute care:**
  - the move to the middle of “mediocrity”
  - “Transitional Care Unit” – attempt to “erase the blur”

- **Common “composite” measures? Impossible?**
Within the Continuum of Choices...the “solution” is:

Getting It Right The First Time!
It’s not “what’s next”...
It’s “what’s the end point”...
We need to think about “the end at the beginning”
Second Tier Thinking:
“Think of the End at the Beginning”

Acute Incident

ER

ICU

Acute Rehab, SNF/ECF, Geri-psych, Psych

Med/Surg

LTAC

Home, Home Health Assisted Living, Hospice, Memory Care
LTAC Care Concepts: “Extended Acute Care”

- New Treatment Methodologies – “System Change”
- Catastrophic Illness and Injury – Medically Complex
- Early Identification, Early Intervention – Better Outcomes with Shorter Overall Lengths of Stay with Improved Dispositions
- Simultaneous Critical Care and Therapy Concepts with Trans-disciplinary Team Approach
- BARRIER TO ENTRY: The new LTACH criteria law – >50% of patients must have 3 day cumulative ICU stay immediately prior to admission or >96 hours on the vent
**Typical “LTAC” Patient**

- Requires acute care services for an extended period of time... so MUST meet acute criteria!
- Readmit rates in single digits...<10%
- Medically stable for transfer – ICU capable
- Medically complex – needs daily MD rounds
- Better access to sub-specialty care
- Average Medicare LOS of ~25+ days
  - MS-DRG LOS varies from ~15 days to ~45 days

- The “Train Wreck” – complex problems have all “Piled Up”.................
Rehab Unit Concepts

- Emphasis on functional improvement

- Medical Issues: Re-admit rates highly variable — acuity, trachs, and dialysis examples

- Rehab physician and staff comfort levels

- Needs reasonable post-rehab DC disposition
Typical Rehab Patient

- Requires less than “aggressive” acute care
- Can handle 3 hours of therapy per day
- Is medically stable
- Defined discharge setting pre-established
- Is not medically complex
- “Anticipated” average LOS of ~7-14 days
- Does NOT need daily hospitalist rounds
SNF/ECF Concepts

- Medically complex vs custodial care
- Short-term SNF vs “moving in” – what’s realistic?
  - The “money reason” why everyone starts out as “SNF”
- Bi or tri weekly rounds by provider typical (Medicare says once every thirty days)
- Mid-levels versus physician care
- Chance for turn-around?!!
Typical SNF/ECF Patient

- Requires less than acute care
  - NOT daily rounds

- May overwhelm mid-levels if complex
  - Frequency of rounding is highly variable
  - Complexity of diagnostic/therapeutic needs

- Readmit rates >20%

- Vent and “complex” readmit rates >30%

- Variable benefit from “rehab”/therapies
  - The “biggest lie in medicine”...

- Is “relatively” medically stable
Typical Home Health Patient

- Requires less than acute care
- Too high functioning for inpatient rehab
- Can’t easily go to “the office” or a care center
- CHF and COPD readmit rates high - 20-30%
- Standardized orders reduce readmits – COPD, CHF
- Nursing and Therapy issues
- Family support?
- Safe discharge? Can they make it at home?
  - Matching function to environment
Geriatric Psychiatry

- Pure Psych unit can’t handle medical issues
- Pure Med unit can’t handle behavioral issues
- “Co-management” with IM and Psych is best
  - Senior Bridges model
- Family support versus “drop ‘em off and run”
- Need to have a DC disposition before transfer
- Safe discharge? Will they make it at home?
  - Memory care units
  - ECF with memory care ward for medically complex
Palliative Care and Hospice

What’s the real difference?

- Symptom focus >>> disease focus
- Dropping rx for the disease process

► Palliative care often a “lead in”...
► Need early involvement

► “Hospice” versus “Comfort Care”
  ► Terminal illness versus actively dying
  ► Physician-Assisted Suicide (“Medical Aid in Dying”)
Where People Die...  
...changing fast...and moving too much!

<table>
<thead>
<tr>
<th>Location</th>
<th>2000</th>
<th>2013</th>
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<tbody>
<tr>
<td>Hospitals</td>
<td>62%</td>
<td>25%</td>
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<tr>
<td>Nursing Home</td>
<td>16%</td>
<td>18%</td>
</tr>
<tr>
<td>Home and Hospice</td>
<td>22%</td>
<td>57%</td>
</tr>
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</table>

BUT ICU care in the last 30 days of life (40%) and the number of care transitions in the last 30 days of life (median 3.1) have increased

Typical Hospice Patient

- **Terminal** – 6 months or less
  - NOT necessarily ACTIVELY dying
- **OK to be wrong on estimated life-span**
- **~30-40% readmit rates in terminal phase**
  - The nurse isn’t moving in!
  - Communication with family...what’s it going to look like at the very end?!?
- **Home vs. SNF – can they stay out of here?**
- **NOT just for cancer anymore**
  - COPD
  - Stage III/IV of CHF
Advanced Directives and “POLST”

- Advanced Directives: a good idea with bad planning
- The provider’s problem: “can never say always and can never say never”
- The “hard talk” and why it sometimes doesn’t happen...
- Full Code, DNR, and the infamous “middle box”...
- “POLST” – Physician Orders for Life Sustaining Treatment...
  - Does NOT replace Advance Directives – it clarifies them
  - The solution for the “middle box”
  - NPs and PAs now ok to sign
Linking Quality and Efficiency Throughout the Continuum...
“It’s all about the data...”
A Culture of Quality AND Efficiency
SHOWING THE DATA

- Documentation education and acuity:
  - why it matters…
  - they are only as sick as the DRG says they are…

- Resource profiling: lab, radiology, pharmacy…
  - Overutilization – efficiency issue
  - Underutilization – quality issue

- Initially “blinded” provider data – not any more…
  - Individual physician, group practice, medical directors
  - Yes, you will (and are) being judged…by everyone!
How Do I Know When One of My Patients is Appropriately Placed?

- Is the patient “too much” for staff at a Rehab. SNF/ECF, or Geri-psych unit?
- Does the patient need daily physician (hospitalist) assessment and rounds?
- Is the home environment safe? Is the family capable?
- How likely is the patient to “bounce back” to the ER from the discharge destination that you are considering?
How do **YOU** know where to go?

- Develop guidelines for admission and discharge to different levels of care
- Look at final destination in the beginning
- Look at all resources – community wide
- Continuum of care model – not silos
- Establish “experts” for each level of care
- Improve “hand off” communication
Benefits of “Getting It Right the First Time”

- Places complex patients in most appropriate care setting = better quality measures, satisfaction, and cost reductions
- Reduces readmit rates and multiple transfers
- Better resource management
- Helps referral hospital manage length of stay
  - Move patients that exceed DRG payment
  - Move patients before becoming outliers
  - Free ICU and other beds sooner
  - Improve surgery scheduling
  - Allow for additional admissions
Education Upstream
AND Downstream

- The need for increased quality control over downstream partners:
  - The critical piece will be improving SNF and Home Health quality and outcomes for higher acuity patients
  - Managing quality downstream from the STAC or LTAC –
  - Establishing “control” - “own” or “partner” ??

- Rehab implications

- Earlier introductions to Palliative Care and Hospice
Moving Forward...

- Outcomes and Criteria ...then what?
- Measure, Validate, Educate then repeat...

- Bundling and the post–acute continuum:
  - The “blur” of “single payment” care...
  - the move to the “middle of mediocrity” ???
  - The upstream “gorilla” usually controls the $ \rightarrow risk for cutting corners downstream
Summary

- LTAC, Acute Rehab, SNF/ECF, Hospice, Memory Care, and Home Health are all appropriate for patients who meet specific criteria in each particular category in the continuum – expertise is improving in understanding the benefits and challenges with each level of care.

- Interventions in improving the patient experience will positively impact both patient and staff satisfaction and will improve overall quality and efficiency throughout the continuum of care.

- Appropriate post-acute placement reduces the need for transfers improves quality, safety, and efficiency while reducing expenses.
Summary

- Moving from the “first tier” to the “second tier”
  - Moving away from volume based and expense focused drivers
  - Outcome and “endpoint” based care with efficiency = value

- Early intervention with high acuity patients positively impacts outcomes while reducing overall cost and re-admissions

- Reducing medical ward transfers from ICU right before discharge improves outcomes and LOS

- Managed care and a competitive marketplace will continue to challenge our assumptions about how to care for these types of patients
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