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INVITED COMMENTARY

Are We Asking the Right Question About Postacute Settings of Care?

Gerben DeJong, PhD, FACRM

From the MedStar National Rehabilitation Hospital, Washington, DC; Georgetown University School of Medicine, Washington, DC; and MedStar Health Research Institute, Washington, DC.

Abstract

This issue of *Archives* includes an article by Mallinson et al that compares the outcomes of patients with hip fracture who received rehabilitation services in 3 different postacute settings: skilled nursing facilities, inpatient rehabilitation facilities, or home health. Except in 1 instance, Mallinson found no setting-specific effects and noted that the issue of defining an optimum postacute rehabilitation program is complex and requires more investigation. Mallinson's findings are interesting in their own right but raise a more fundamental issue. This commentary observes that rehabilitation patients typically use multiple postacute settings, not just 1 setting of care, for the same episode of care. This commentary asks whether we should be examining episode outcomes and not just setting-specific outcomes, especially in the face of bundled payment and value-based payment reforms in the Affordable Care Act.

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This issue of *Archives* includes an article by Mallison et al[1] on how hip fracture rehabilitation outcomes, controlling for patient differences, vary across 3 postacute settings: skilled nursing facilities (SNFs), hospital-based rehabilitation facilities, and home health in the United States. This study joins a growing array of studies[2-8] that essentially ask the following question: Does the postacute site matter? The question has become more pertinent in the face of rising postacute expenditures, overlaps in types of patients, differences in payment methods and payment levels, and proposals for reform of postacute payment (eg, bundled payment).

Studies examining the relative effectiveness of postacute rehabilitation have faced significant methodologic challenges; the most important of which has been the absence of a uniform patient assessment instrument that can be used across settings to compare risk-adjusted patient outcomes for patient differences. If there was a uniform patient assessment instrument, it would have been possible for studies to use large-scale administrative data. Instead each study has had to develop its own workaround, mainly by using a new site-neutral instrument[9] or by using an existing site-specific instrument that may be unfamiliar to other study sites.[1,8] This requires de novo data collection and training that are expensive and limit sample sizes.

An audio podcast accompanies this article. Listen at www.archives-pmr.org.

Are We Asking the Right Question?

In asking whether the postacute site matters, we may be asking the wrong question. What these and other studies have uncovered is that each setting under examination for its relative effectiveness is often one of several postacute sites used by a patient during an episode of care.[10-12] Some patients have a planned trajectory of care, but what most receive often depends on the availability of postacute beds at any given moment, degree of family support, geographic access, preexisting provider relations, and the vagaries of their health plan payment policies.[13]

This raises the more fundamental questions: What is the appropriate unit of analysis? Are the specific settings under review? Or is the entire episode of care stemming from a given health event, such as an infarct, injury, illness, or surgical intervention, under review? Yes, it may be appropriate to ask which site is more

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effective as an initial postacute placement or when it is the only postacute site of care used; both are instances where we can learn about the value that a particular setting adds to the recovery process. Asking which site is more effective is, however, much more difficult to answer when a particular site is used midway along a trajectory of postacute sites. If we limit our analyses to first-site or only-site effectiveness, we overlook the relative effectiveness of that site when used by others later in their postacute journey. Comparing multiple trajectories of care is methodologically far more challenging than comparing single sites of care.

Role of Payment Policy

The success of a patient's postacute journey depends in part on how the upstream acute care provider launches the patient into the postacute system. The nexus between acute and postacute care is creaky and not well oiled. Postacute placements are often made moment by moment, sometimes driven more by the "bed imperative," namely, by the need to empty acute hospital beds and the availability of postacute placements at any given time.

Payment drives practice. Much of postacute care owes its existence to acute care's fixed-price-per-stay diagnosis-related group (DRG) payment system, which was launched 3 decades ago. The DRG fixed-price-per-stay payment system incentivized acute care hospitals to shorten their lengths of stay; however, in doing so, hospitals needed postacute alternatives for the patient that would still allow for ongoing medical supervision and rehabilitation, some of which had previously been rendered in an acute stay.

American postacute care has grown enormously during the last 30 years albeit unevenly as postacute providers experienced different growth spurts and contractions in response to increasing demand, local market conditions, and the vagaries of federal budget policy and state certificate of need laws. Today, 35% of Medicare fee-for-service beneficiaries who are hospitalized for an acute episode migrate to postacute care and accounted for $62.1 billion in annual expenditures in 2012[14]; this excludes postacute outpatient services paid by Medicare Part B. These numbers do not include the 27% of Medicare beneficiaries who participate in private health plans under the Medicare Advantage program[15]; it also does not include children or working-age individuals who participate in the veterans' health system, Medicaid, Workers' Compensation programs, or private health plans. If all these additional sources of payment were included, postacute care expenditures in the U.S. would easily exceed $100 billion per year.

In a report prepared for the Institute of Medicine, MaCurdy et al[10] identified postacute care as the main driver in the geographic variation of Medicare expenditures. They estimated that 40% of the geographic variation in overall risk-adjusted Medicare expenditures from 2007 to 2009 can be attributed to variation in postacute care expenditures, mainly to variation in home health expenditures.

List of abbreviations:

BPCI	**Bundled Payment for Care Improvement Initiative**
CARE	**Continuity Assessment Record and Evaluation**
CMS	**Centers for Medicare and Medicaid Services**
DRG	**diagnosis-related group**
IRF	**inpatient rehabilitation facility**
LTCH	**long-term care hospital**
MDS	**Minimum Data Set**
SNF	**skilled nursing facility**

Although acute care hospitals migrated to the DRG-based prospective payment system in 1983, postacute facilities meanwhile remained under a modified cost-based system until the Balanced Budget Act of 1997 authorized prospective payment systems for postacute care facilities, which were gradually implemented over the next 10 years. Instead of a single payment method for all postacute care, which would probably have been unworkable at the time, we ended up with 4 separate prospective payment systems, 1 for each postacute venue (SNFs, home health, inpatient rehabilitation facilities [IRFs], and long-term care hospitals [LTCHs]) using 4 different payment models with different mixes of incentives and disincentives. The 4 new postacute prospective payment systems had 2 unintended consequences. First, although it sought to constrain per-patient costs in any one setting, it created new pressures to discharge patients to other postacute settings for the same episode of care, which made the use of multiple settings more common.

Second, setting-specific payment systems helped to harden the postacute silos as each sought to defend its turf and valued traditions. Each silo has rightfully invested heavily in its own patient assessment and payment systems through staff training, quality and outcome metrics, electronic information systems, and industry-wide databases. As the axiom goes, we defend what we sweat for. Each postacute setting is bolstered by its respective trade association that advocates tirelessly on behalf of its members. Interests become increasingly vested. Industry leaders across all postacute sectors believe strongly that their institutions provide meaningful and medically necessary care and present patient satisfaction scores, quality metrics, and patient testimonials to bolster their case.

Bridging the Silos

Today's postacute silos come with artificial boundaries that are not clinically meaningful: the 25-day length of stay requirement for LTCHs, the 60% and 3-hour therapy rules for IRFs, and the 3-day prior hospitalization rule for SNFs, to name only a few. They are usually blunt policy instruments designed to avert inappropriate placement and constrain setting costs. They are not attuned to the needs of patients who may need titrated levels of medical supervision and therapy as they recover from the acute phase of their care. The continuing care hospital concept, promoted by the IRF industry, is an example of an attempt to break down boundaries and allow more flexible titration of patient care under one roof without having to move patients from one setting to another.[11,16] Today, we have the bizarre situation where we have 3 distinct hospital-level postacute settings (IRFs, LTCHs, and SNF units) within acute care hospitals. Each has its own conditions of participation, patient assessment instrument, and payment system. Upstream providers, patients, families, policy makers, and foreign observers are rightfully befuddled by our postacute system.

Grand unified theories of postacute care sometimes seemed doomed but they continue to inspire, starting with the desire for a uniform patient assessment instrument across all postacute sectors. In 1998, the Centers for Medicare and Medicaid Services (CMS), then known as the Health Care Financing Administration, proposed the Minimum Data Set (MDS) for postacute care, which was modeled after the MDS for SNFs.[17] The one-size-fits-all instrument proved unwieldy as it sought to encompass a diverse range of patient conditions across all postacute platforms only to provoke resistance among postacute providers who saw parts of the instrument as irrelevant in their area of practice. They also saw

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