Out of The Penalty Box:

Avoiding unnecessary rehospitalizations in the post-acute setting

Roughly 40% of Medicare beneficiaries leaving the hospital are discharged to a post-acute setting, where the risk for rehospitalization begins, and the role of the skilled and assisted living facility and home health agency becomes critical in prevention. Effective October 2012, The Affordable Care Act instituted the Hospital Readmission Program, requiring the Centers for Medicare and Medicaid to reduce payments to hospitals with excessive 30-day readmissions. Read *Out of the Penalty Box* to learn about what you can do to implement evidence-based care processes and effective training, while partnering across the healthcare continuum to deliver better patient care and reduce unnecessary costs to your organization as well as CMS. Explore CMS's new payment and service delivery models of care that leverage both penalties and incentives for all healthcare providers.

Hospital Outcome of Care Measures – National Averages

All-cause Readmission Rate (2010)	19.2%
Heart Attack Readmission Rates	19.7%
Heart Failure Readmission Rates	24.7%
Pneumonia (PN) 30-Day Readmission Rates	18.5%

Source: Medicare https://data.medicare.gov

Nearly one in five Medicare patients return to the hospital within a month of discharge, costing the government an extra $26 billion annually, including $17.5 billion in inpatient spending[1]. Today, the Centers for Medicare and Medicaid Services (CMS) believe that as many as 25 to 42% of these readmissions are avoidable[2], highlighting a tremendous gap in U.S. care transitions.

From poor communication and a breakdown in accountability to deficient medication reconciliation, transitioning from the hospital to the post-acute care setting, be it to a skilled nursing facility (SNF), assisted living facility (ALF) or home health care, can be the single greatest health risk for today's aging population.

In an effort to refocus U.S. healthcare efforts from quantity of service to quality of care, the Affordable Care Act of 2010 requires every nursing home to institute a facility-wide compliance program by the end of 2013 (see The Case for Compliance, Care2Learn, 2011) and a comprehensive quality assurance and performance improvement (QAPI) program soon after (see Developing an Effective Quality Assurance Program, Care2Learn, 2012).

Furthermore, as dictated by Section 3025 of the Affordable Care Act (ACA), the Hospital Readmissions Program requires the Centers for Medicare and Medicaid (CMS) to reduce payments to hospitals with excessive 30-day readmissions, effective October 2012, currently targeting episodes of acute myocardial infarction, heart failure and pneumonia diagnosis related groups (DRGs). Additionally, Section 3025 directed CMS to calculate and make publicly available information on hospital readmission rates for these conditions (www.hospitalcompare.hhs.gov/) and expand the policy to additional conditions beginning in 2015.

For the fiscal year 2013, Hospital Readmission Program penalties will be benchmarked off the hospital's readmission rates for the three-year period between July 2008 and June 2011.

A total of 2,217 hospitals are expected to be penalized in the first year of the program. Altogether, these readmission penalties are expected to recoup as much as $280 million in their first calendar year[3].

DID YOU KNOW?

- Hospitalizations account for nearly one-third of the total $2 trillion spent annually on healthcare in the U.S.
- Hospital inpatient costs make up a quarter of the $556 billion Medicare spent in 2012, which is expected to grow more than 4% annually in the coming years, according to the Congressional Budget Office.
- In 2009, 3.3 million Medicare beneficiaries received Medicare home health services, resulting in $18.9 billion in total Medicare payments.

What's Inside?

Sidebars

Care2Learn
The Complete Online Training Solution for Healthcare

1 Jordan Rau. Medicare Revises Hospitals' Readmissions Penalties, Kaiser Health News. Oct. 2, 2012.
2 Long-Term Quality Alliance. Improving Care Transitions: how quality improvement organizations and innovative communities can work together to reduce hospitalizations among at-risk populations. June 2012.
3 See #1.

But, hospitals don't exist in a bubble. Roughly 40% of Medicare beneficiaries leaving the hospital are discharged to a post-acute setting, with as many as half of them entering skilled care or rehab facilities where the risk for rehospitalization begins. With penalties aimed at keeping patients out of the hospital, both formal and informal incentives to keep acute patients in SNF, ALF and home health care will naturally develop. This means caring for sicker patients during the 30-days post-acute period, a task many facilities have already begun.

"As we've seen over the last several years, facilities are being asked to care for an increased level of acuity among beneficiaries," said Emma Sandoe, CMS spokesperson. "There is no indication that this trend will end so facilities will need to increase their ability to care for beneficiaries with higher levels of acuity. Therefore, their role will become even more critical in preventing readmissions."

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Emma Sandoe
Spokesperson
Centers for Medicare and Medicaid Services (CMS)

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Amy Boutwell, MD, MPP,
President,
Collaborative Healthcare Strategies

By embracing an enhanced role in palliative or hospice care and training staff accordingly, the SNF, ALF and home health agency may stand to increase its business, benefitting financially, both in volume of residents and in the high-end reimbursements of these acute beneficiaries.

"The smarter nursing homes are saying: 'How am I going to take care of sicker patients than I take care of now?,'" said Charlene Frizzera, senior advisor at healthcare intelligence consultant Leavitt Partners (www.leavittpartners.com) and former acting administrator with 30 years of experience at CMS. "Because there's a push to move patients out of the institution and into the community, the SNF facility is going to lose a lot of the low-acuity patients, giving them an opportunity to take more of the high-acuity patients. They are in a perfect position to partner with hospitals and this is a real dynamic change in the way hospitals and homes do business."

But, with opportunity comes increased risk as well. Sicker patients requiring more skilled care means an increased chance for rehospitalization, a risk the post-acute provider will need to be armed and ready for.

"It's only natural that hospitals will begin to look at readmission rates from the post-acute and LTC setting," said Amy Boutwell, MD, MPP, president, Collaborative Healthcare Strategies (www.collaborativehealthcarestrategies.com), a healthcare research and advisory firm. "Hospitals are going to expect LTC facilities to implement best practices such as INTERACT in order to reduce readmissions from their facility, thus helping the hospital meet its goal of getting out of the penalty box. A hospital readmission penalty is now a post-acute provider's problem."

New Models of Care

Using the ACA as a vehicle, CMS hopes to achieve true healthcare reform through a combination of both penalties and incentives for collaborating healthcare entities, moving from a fee-for-service model of healthcare to pay-for-performance (P4P) or bundled payments models. As a result, CMS has developed a number of new payment and service delivery models in the form of demonstration projects and collaborative partnerships. Working together with the participants in these initiatives, CMS will assess whether each model resulted in an improvement in patient care and lower costs to Medicare to determine its viability.

While these initiatives are just a sampling of those being tested and fine-tuned by CMS, they represent a new wave of healthcare delivery that first begins, not ends, at the crossroads between the hospital and the post-acute setting, promising to significantly alter the way U.S. healthcare is practiced forever, regardless of which models succeed.

The following models of care will be explored in this whitepaper: Accountable Care Organizations (page 4), the Community-based Care Transitions Program (page 5), the Nursing Home Value-Based Purchasing Demonstration P4P Program (page 6) and the Bundled Payments for Care Improvement Initiative (page 7).

Visit the CMS Innovation Center for information on all new models of care at: http://innovation.cms.gov/initiatives/index.html

INTERACT

In order to prevent rehospitalization and make acute to post-acute transitions easier and safer, a number of evidence-based care transition interventions have surfaced over the last decade, namely INTERACT, or Interventions to Reduce Acute Care Transfers (www.interact2.net). Initially designed in a project supported by CMS, INTERACT promotes early identification, assessment, documentation and communication about changes in the status of residents in SNF facilities, providing both clinical and educational tools and strategies for use in everyday practice.

"Whenever changes are made, there are potential unintended consequences, though one of the concerns is that if you incentivize providers to keep sicker people in their facilities financially and don't provide quality improvement programs and education and clinical practice tools, care quality could deteriorate and that's where the INTERACT tool comes in," said Joseph Ouslander, MD, professor and senior associate dean for geriatric programs, Charles E. Schmidt College of Medicine, Florida Atlantic University and founder of INTERACT.

INTERACT works by creating an internal team dedicated to quality improvement, led by an INTERACT "champion," to track, trend and benchmark all quality assurance measures, which includes a root cause analysis of acute care transfers and tracking outcomes (for more information on quality assurance measures and root cause analysis, see Developing an Effective Quality Assurance Program, Care2Learn, 2012). Providing a format for communication within the home, including documenting changes in the

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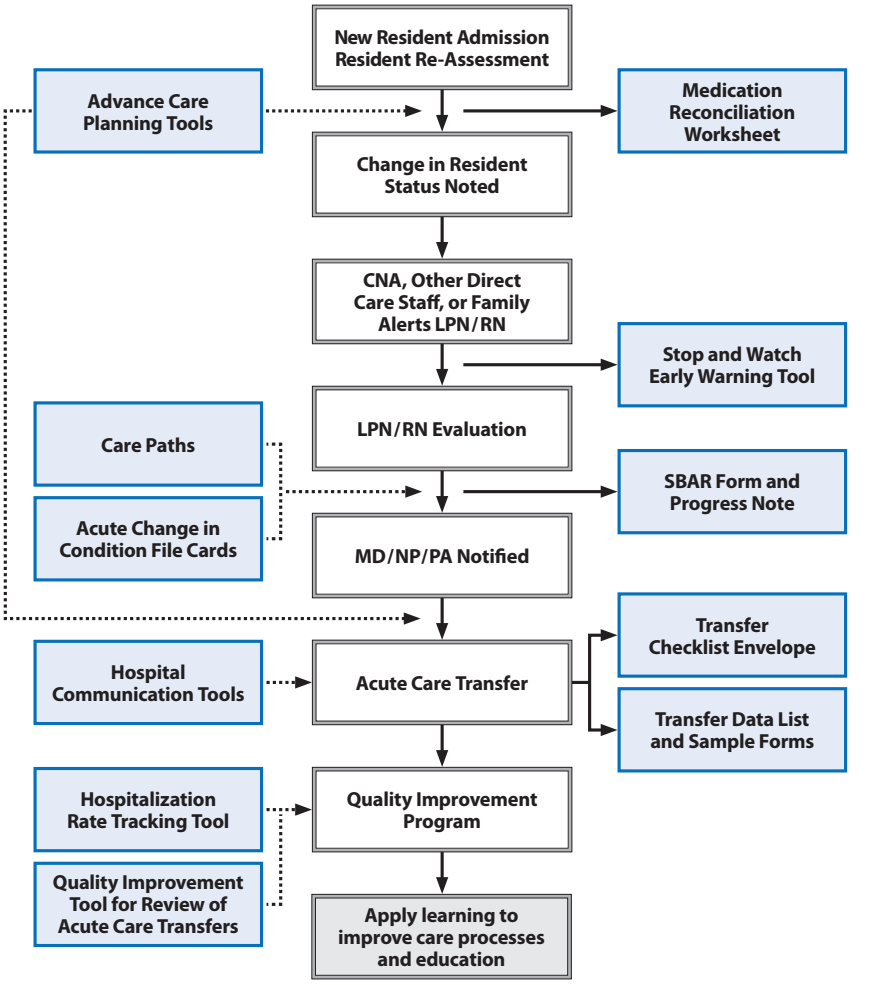
Using the INTERACT Tools
In Every Day Care

INTERACT® Version 3.0 Tool



resident's condition and medication reconciliation as well as a format and checklists for optimal hospital/nursing home communication and the imperative data transfers between the two, INTERACT also emphasizes advanced care planning tools that highlight criteria for residents requiring hospice or palliative care and how to communicate this to family members.

"While we have tools and suggestions for data that should be transferred back and forth, get to the hospital before the forms, as the forms are only a tool. It's about relationships, communication and mutual respect," said Ouslander. "Invite them to your facility; form a cross-continuum team as a way to improve quality, not to blame each other. At the transfer level, there's no substitute for a warm handoff."

"If I see a patient has escalated to acute because of a specific symptomatology, I deliver an action plan to educate the nursing staff on those related programs offered in Care2Learn; whether it's respiratory exacerbation, dehydration, etc."

Dianne Sullivan, RN, BSN,
VP of Clinical Operations,
StoneGate Senior Living

The transfer period from the acute to post-acute care setting is arguably the most crucial in preventing rehospitalization. While common, it is often during these transfers that significant complications arise in older nursing home residents, including delirium, falls, medication errors and more.

Other Evidence-based Care Transition Interventions:

BOOST (Better Outcomes for Older Adults Through Safe Transitions) www.hospitalmedicine.org/boost

Project RED (Project Re-Engineered Discharge) http://www.bu.edu/fammed/projectred/index.html

Care Transition Program www.caretransitions.org

POLST (Physician Orders for Life Sustaining Treatment) www.ohsu.edu/polst

Bridge Model www.transitionalcare.org/the-bridge-model/

Transitional Care Model www.transitionalcare.info/

Accountable Care Organizations

To date, more than 428 public and private Accountable Care Organizations (ACOs) have been established, caring for over 4 million Medicare and numerous private insurance patients, since the passage of the ACA. Made up of a group of physicians, hospitals, insurers and community-based organizations under contract, an ACO oversees the clinical provision of patient care for the group's beneficiaries and bears the financial risk of this care, therefore providing incentive to improve how care is practiced.

This market share approach to achieving integrated, cross-continuum healthcare attracted StoneGate Senior Living who joined Pioneer ACO, a Medicare ACO in the Dallas/Ft. Worth area. With four SNFs invested for almost a year, StoneGate doesn't anticipate immediate performance improvement, but understands that being part of this new model of healthcare will leverage their organization as a leader in the marketplace.

"It's kind of a pioneer field out there; no one has really done an ACO so far," said Dianne Sullivan, RN, BSN, VP of Clinical Operations, StoneGate Senior Living (www.stonegateseniorcare.com). "We've been looking at the options and formulating our strategy going forward. At the end of the day, though, we want to get our feet wet and see what it's like."

Since joining the ACO, StoneGate has initiated a transition team that assigns a care navigator to each patient for 30 days post-acute. Using BOOST criteria (www.hospitalmedicine.org/boost), StoneGate identifies patients that are at a higher risk for potential rehospitalization, focusing further efforts on educating their staff on related topics including medication reconciliation, INTERACT 3.0 tool and beefing up the SNF's palliative care and advance care planning.

"Utilizing the Reducing Rehospitalization course series that Care2Learn provides with the identified five diagnoses for our frontline staff and CNAs, they are better able to understand why we keep measuring this," said Sullivan. "If I see a patient has escalated to acute because of a specific symptomatology, I deliver an action plan to educate the nursing staff on those related programs offered in Care2Learn; whether it's respiratory exacerbation, dehydration, etc."

Medication Reconciliation

Medication errors, which can lead to reconciliation failure, often occur at transitions of care, such as the 30-day post-acute period. In fact, one study found that as many as 49% of previously hospitalized patients who were receiving continuing care from their primary care physician experienced at least one medication error within two months of discharge from the hospital[4].

"We brought the home health agencies we work with more closely into the conversation with the goal of improving the transitions of care, including patient safety and health outcomes as older adults transition from the hospital to the community,"

Madeleine Rooney,
Manager for Transitional Care,
Department of Health and Aging, Rush
University Medical Center

And because individuals 65 years and older are more likely than any other population group to require emergency room treatment for an adverse drug event (ADE), medication reconciliation during transitions with the elderly population is essential to the delivery of safe medical care.

"There is a great deal of evidence that patient's medication regimens change when going in and out of the hospital and that change is often confusing and not infrequently results in medications being overlooked or duplicated," said Gordon Schiff, MD, associate director Brigham Center for Patient Safety Research and Practice (www.patientsafetyreserach.org) and associate professor, Harvard Medical School. "Patients are very confused and vulnerable in this transition period, which can include intermediate locations such as SNF or rehab to further compound confusion and complexity."

Communication failures are the most common causes of medication errors that result in ADEs. Very often medication errors occur because a patient misunderstands the physician's directions or label instructions during the transition between the acute and post-acute care setting.

"Medication reconciliation is one of the key items to a successful care transition and a mistake during this process can result in not only a rehospitalization, but also may cause a negative outcome to the resident," Cheryl Swann RN-BC, BSN, WCC, LNHA, VP of Clinical Services, Care2Learn. "Facilities need to provide

Community-based Care Transitions Program (CCTP)

Created by Section 3026 of the ACA, the Community-based Care Transitions Program (CCTP) is part of the public-private funded Partnership for Patients (www.partnership-forpatients.cms.gov/) that aims to reduce preventative hospital errors by 40% and all-cause hospital readmissions by 20%, compared to 2010 data.

Beginning in 2011 with $500 million in total funding available through 2015, CCTP agreements are being awarded to community-based organizations (CBOs) to test models for improving care transitions from the hospital to a variety of post-acute settings by building partnerships made up of a cross continuum of local healthcare providers. Currently 102 CBOs are participating in CCTP agreements, awarded initially for a two-year period, with the potential for annual extensions.

The Illinois Transitional Care Consortium (ITCC, http://www.transitionalcare.org/the-bridge-model/), made up of 10 local Chicago hospitals, CBOs in the aging network and research-based healthcare policy-advocacy organizations, was awarded CCTP status working under the CBO Age Option (www.ageoptions.org), in March 2012.

"We brought the home health agencies we work with more closely into the conversation with the goal of improving the transitions of care, including patient safety and health outcomes as older adults transition from the hospital to the community," said Madeleine Rooney, manager for transitional care, Department of Health and Aging, Rush University Medical Center, Chicago (www.rush.edu). "At Rush, we conduct weekly phone meetings where I am together with the home health liaison from the agencies connecting with the clinical nurse, therapy staff and managers to talk about readmission risks and what we have to do to help those from happening throughout the 30-day post-acute period for each 3026 patient," said Rooney.

Rush created a list of standards describing what the agency should do if they identify a problem during the immediate post-acute period. Completed within 72 hours of discharge, the form is returned back to the Rush team and reviewed by the social worker assigned to each patient, who then helps to resolve any areas of discrepancy.

"As hospitals look to reduce 30-day readmissions, they will have to bring their relevant, local providers into the conversation," said Rooney. "It's all about mutually agreed upon expectations of care and the ability to build in accountability and ownership for those expectations. It's all geared toward changing practice behavior."

4 American Medical Association. The Physician's Role in Medication Reconciliation: Issues, Strategies and Safety Principals. 2007.

nurses with the tools and resources needed to assist them, including adequate staffing and training on how to conduct a thorough med reconciliation."

"Education is going to be key to helping those nurses reconnect with the skill set that they need and maybe haven't used in a while."

Sherry Johnson, Director of Clinical Development, United Clinical Services, UHS-Pruitt Corp

The Care2Learn module Transitions of Care provides crucial information for nurses on medication reconciliation, while outlining the following 5 steps to successful acute to post-acute transition:

1. Obtain the most current list of medications
2. Obtain a list of all medications that have been prescribed
3. Reconcile medications by comparing each list to identify any discrepancies
4. Formulate a decision, i.e. make a medical judgment with respect to the patient's condition and necessary medications
5. Communicate the new list to appropriate caregivers and to the individual

Training as a Tool to Prevent Rehospitalizaton

Staff training is one of the fundamental components of evidence-based care transition models like INTERACT, as well as a proven way to enhance resident care, including medication reconciliation, in everyday practice.

Following the diagnoses for each care path outlined in INTERACT II, Care2Learn online training provider (www.care2learnenterprise.com) offers a series of 14 courses aimed at reducing rehospitalization and more than 20 courses in the Rapid Review Series set to complement them.

"With patients being released from the hospital earlier, they're coming with more medically complex situations to our healthcare centers, and therefore, we really need to look at ways to improve the care and reduce the chance to go back to the hospital," said Sherry Johnson, Director of Clinical Development, United Clinical Services, UHS-Pruitt Corp (www.uhs-pruitt.com). "Because the Care2Learn modules include the INTERACT tool, with its early identification of problems, we can put interventions in place earlier to prevent unnecessary rehospitalization."

The Nursing Home Value-Based Purchasing Demonstration

Another CMS P4P initiative, the Nursing Home Value-Based Purchasing (NHVBP) Demonstration program, assessed 182 paticipating nursing homes annually between 2009 and 2012 for improvements in quality performance.

Participants who ranked in the top 20% in overall performance on an annual basis are eligible for financial compensation, based on their facility size and the percentage of improvement made in targeted areas. Conducted only in Arizona, New York and Wisconsin, NHVBP awards are funded by a Medicare savings pool from each state that accumulated as a result of the avoidable hospitalizations from the program's improvements in quality of care.

The rural, central Wisconsin Eastview Transitional Care and Rehabilitation campus of Kindred Healthcare (www.kindredhealthcare.com) submitted payroll, labor and turnover data and rehospitalization numbers to CMS on a quarterly basis. Choosing wound care as their target area for improvement, Eastview sent two RNs to become certified wound specialists, hired both a certified infection control nurse and a nurse practitioner two days a week and changed facility protocols to mirror hospital protocols for some targeted readmission diagnosis including COPD, congestive heart failure, sepsis and pneumonia.

Originally ranked 36 out of the 62 NHVBP facilities in Wisconsin in 2009, Eastview rose to 18 in just the first year of the program. The site received 10 survey citations in 2009 and no citations in 2012, the final year of the program. Similarly, Eastview went from 28% potentially avoidable rehospitalizations in 2009 to only 11% in 2012, when they were awarded financial compensation for improving quality measures throughout the NHVBP Demonstration.

"We saw a significant improvement in our participating facilities over the three-year program, both in general and in our targeted areas," said Wanda Hose, RN, LNHA, area executive director of Kindred Healthcare. "I would tell any post-acute care provider to get involved with their local hospital. If the hospital is confident that you can meet the patient's needs and keep them, you not only give better patient care, but you're also developing a better working relationship with the hospitals, which benefits both sides financially."

The Reducing Rehospitalization Series targets congestive heart failure, myocardial infarction and urinary tract infections to chronic obstructive pulmonary disease (COPD), sepsis, delirium and more, each half-hour module including a pre- and post-test using interactive exercises and real-life scenarios to demonstrate evidence-based strategies for reducing rehospitalization and maintaining best care practices.

"For our specialty programs including wound care, respiratory care with trachs and vents, and IV management, we have the nurses take prerequisites with Care2Learn online modules and then come to an all-day workshop which includes a review of the content of the online courses and a return demonstration of skills competency testing," said Johnson.

Caring for both long-term and post-acute residents simultaneously, Johnson says, is one of the greatest challenges for providers today, but it's one that can be met with the help of the Rapid Review Series, which features five- to 15-minute mini-modules developed to ensure that clinicians can perform techniques that address diagnoses in the INTERACT II Care Paths for reducing rehospitalization.

"The nurses in our healthcare centers are taking care of long-term care patients and post-acute care patients coming in for a short-term rehab, each requiring a different kind of skill set," said Johnson. "Education is going to be key to helping those nurses reconnect with the skill set that they need and maybe haven't used in a while."

Get Started Now: Top 3 Ways to Prevent 30-day Rehospitalizations

Working to reduce rehospitalizations through her work with healthcare providers and stakeholders at the state and national level, Amy Boutwell, MD, MPP, started Collaborative Healthcare Strategies (www.collaborativehealthcarestrategies.com), a healthcare research and advisory firm, after founding the STARR Initiative in 2009 with the Institute for Healthcare Improvement, the first cross-continuum collaboration.

"It would not surprise me if in the next several years the payment policy around avoidable readmissions extends into the post-acute setting."

Amy Boutwell, MD, MPP,
President,
Collaborative Healthcare Strategies

"LTC providers, specifically SNF and nursing homes, are mandated to report when patients are sent to the hospital," said Boutwell. "Medicare has this data and when they start down this path, you can expect payment policy to potentially follow. It would not surprise me if in the next several years

Bundled Payments for Care Improvement Initiative

Another three-year bundled payment initiative, Bundled Payments for Care Improvement (BPCI) presents four models of care in which providers enter into a fixed payment arrangement with Medicare.

During the 3-year BPCI initiative, program awardees will care for and follow post-acute Medicare patients with pre-determined DRGs for a set amount of time, all for a set target price that includes a 3% discount over the average local claim for the DRGs.

In order to prepare for their involvement in BPCI, The Evangelical Lutheran Good Samaritan Society (the Society) in Sioux Falls, South Dakota, is currently working to strengthen five of their skilled inpatient and three home health care agencies before the July 1, 2013 risk-sharing program begins. Care redesign models are being implemented including a client advocate model, the LivingWell@Home Program (technology and nurse monitoring) and Care2Learn online training modules are used to educate staff.

"Through this bundled payment initiative, the Society has the opportunity to further advance our mission and help frame the healthcare delivery and payment system for Medicare beneficiaries. The Society is committed to further enhancing well-being and patient engagement while achieving better health and lower costs," said Joanne Powell, director of reimbursement strategies for the Good Samaritan Society (www.good-sam.com).

During the 3-year BPCI initiative, the Society will care for and follow post-acute Medicare patients with major lower joint replacement and/or heart failure for a 90-day period to achieve positive outcomes in the person's desired health goals.

As one of the largest non-for-profit providers of senior care and services with 240 locations nationwide, the Good Samaritan Society's national average rehospitalization rate was 16% for Medicare patients in 2012.

"The Society has invested resources to review current care coordination and care transition processes and to identify potential gaps within all levels of care, including the transition to self-care," said Powell. "We know the quality of life for the people we touch will be improved. Collaboration with all healthcare providers is essential for better health outcomes."

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To get started in preventing 30-day rehospitalizations now, follow Boutwell's lessons learned for any post-acute care environment:

1. **Post-Acute Providers Need to Know Their Data**. What are your 30-day overall readmission rates? Look another layer deeper: What types of patients go back to the hospital within 30 days? What reason are they going back? Here lies the opportunity to reevaluate your own care.
2. **Form or Join a Cross Continuum Team.** This does not need to be a major new strategic business alliance, but a practical meeting of your referral partners. From this team, you can identify what each organization can do to improve care transitions and reduce readmissions. When this is achieved, the efforts of your organization are multiplied and enhanced by the collective efforts of partners across the continuum.
3. **Get the Story Behind the Story.** Interview the frontline staff person (could be the nursing assistant, nurse or aide.) We tend to think about chart reviews being a medical doctor, but the changes that end up sending someone back to the hospital are often numerous and very small. To get that rich and very actionable information, go to the patient, family member or frontline caregiver to see how that change in clinical status unfolded that ultimately led to the decision to hospitalize.

The Unintended Consequences of the Hospital Readmissions Program

On the other side of the rehospitalization debate lays incentives that SNFs currently have to send residents to the hospital and the fear that the new Hospital Readmissions Program will actually limit a patient's access to necessary care.

For example, after a 3-day hospital inpatient stay, the SNF resident typically qualifies for Medicare Part A post-acute care nursing home payment, which is three to four times the daily rate paid by Medicaid[5], while Medicaid's current bed-hold policies which pay nursing homes to reserve beds of Medicaid residents during an acute hospitalization have also been shown to influence rehospitalization rates[6].

On the hospital side, some ACA critics have cited the potential for selection of only the most lucrative patients, "upcoding," or coding a patient's condition to trigger higher reimbursements and even withholding of patient care, all as potential outcomes of the new 30-day readmission penalty.

"The program has the potential to introduce a range of unintended effects including the incentives to select healthier patients, assign extra resources to these 'penalty' conditions at the expense of other non-penalty conditions, divert necessary readmissions and re-code admissions away from the penalty conditions," said David Grabowski, PhD, professor in the Department of Health Care Policy at Harvard Medical School in Boston. "Ultimately, if the program ends up only penalizing those resource-poor programs, then it may widen the gulf between resource-rich and resource-poor hospitals, thereby magnifying potential health care disparities."

> **". . . In order to change the system, we must both properly align the payments to hospitals and post-acute providers and assist hospitals and post-acute providers with implementing best practices known to decrease readmissions."**
>
> David Grabowski, PhD,
> Professor,
> Department of Health Care Policy at
> Harvard Medical School

Ideally, though, the goal of CMS's new models of care will be to eliminate these unintended consequences by creating accountability across the entire spectrum of providers.

"The key issue is whether these global payment policies will properly align the incentives for post-acute providers to invest in effective interventions to safely reduce readmissions. Historically post-acute providers have had little incentive to make these investments because the savings go elsewhere in the system," said Grabowski. "Thus, in order to change the system, we must both properly align the payments to hospitals and post-acute providers and assist hospitals and post-acute providers with implementing best practices known to decrease readmissions."

5 Grabowski, David. Medicare and Medicaid: Conflicting Incentives for Long-Term Care.
6 Vincent Mor, Orna Intrator, Zhanlian Feng and David C. Grabowski The Revolving Door of Rehospitalization From Skilled Nursing Facilities, Health Affairs, 29, no. 1 (2010): 57-64

CONCLUSION

Implementing evidence-based care processes and effective training, while partnering with and communicating across the healthcare continuum, will together ideally result in the delivery of better patient care while reducing unnecessary costs. Whether currently a participant in CMS's new demonstrations or not, all organizations must look deep into their current practices of care and begin to make real, qualitative improvements.

"We're identifying gaps and that's the thing I recommend to any post-acute provider: If you're not participating, you should start today and develop a positive team that is willing to say, 'Let's dive into everything we do on transition to a different level of care,'" said Powell. "What can we do better? Where are our gaps? Just that process alone can save many dollars to the government and your home. It's just a whole different world out there now. It's all about quality, and Medicare and insurance companies are going away from being a passive payer and instead moving toward being a purchaser demanding quality."

Moving from a volume-based to value-based healthcare system means that it's less about how many patients are cared for in a given time period and more about how well they are taken care of.

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"People are saying they really feel there's a paradigm shift in the way we've been thinking and doing things," said Rooney. "There are real opportunities to make changes and improvements that are going to really improve the patient and caregiver experience. There's cautious optimism."