

MINNESOTA HEALTH CARE ROUNDTABLE



MR. STARNES: Today, we are discussing the topic of post-acute care. Like so many other topics in health care, this one will be defined 10 different ways by 10 different people, all of whom may work in the field. This is a good starting point for problems to arise, and there are many problems. There is also significant motivation to address them. How significant? If we look only at CMS spending in this area, some estimates put it at more than \$62 billion in 2012. This is a figure that commands attention and one that is projected to grow. Let's get started with the definition of some terms. What is meant by the term "post-acute care?"

DR. KORANNE: I would define it as including community-based services which not only have to do with medical care, but are essential to keeping our neighbors in the community: hospice, palliative care services, faith community nursing, home health services, custodial services, county services, adult day care programs, and other social services in the community can all be under this broad umbrella.

MS. THURLLOW: It's not just facility-based, and includes community-based service providers. And it's not necessarily post-hospitalization, but can also be prehospitalization. It's not about fixing cracks in the system, it really is about building a system, and that starts with the definition. I would use the more expansive definition, looking more broadly to facilities but also community providers, as well as informal caregivers and family members.

MS. KLEFSAAS: We want to allow customers choice for the setting that they prefer. We've talked about the setting but not about the time frame of post-acute care. Is it a 30-day time frame? Ninety days? What are we including in the post-acute definition, and who should be involved in those conversations? How do we balance the voices of preferred networks and customer choice?

MS. SIMONSON: From my perspective working with the Area Agency on Aging in the community, the older adult—primarily someone who needs post-acute care—is at home at some point in their post-acute stay. We need to think about post-acute care in all its settings. Home is often where post-acute care takes place.

About the Roundtable

Minnesota Physician Publishing's forty-first Minnesota Health Care Roundtable examined the topic of post-acute care. Six panelists and our moderator met on April 17, 2014, to discuss this topic. The next roundtable, on Oct. 30, 2014, will address treating chronic illness.



Post-acute care Fixing cracks in the system

DR. FREDERICK: I would rather call it transitions of care across the continuum of care, because whether you're a senior or not, you're going to be dealing with different levels of disease and different needs of care. If it involves a hospital stay, there will be transitions in/transitions out.

MS. BOSTON: When you look at it from a policy perspective, we're really looking at it as admission to a nursing home. I like the fact that at the national and state levels, you're seeing a change in terms. They're using "care transitions." People understand that better than "post-acute care."

MR. STARNES: Now that we have a sense of the waterfront covered by this term, let's look at what it has to offer, or the value proposition that post-acute care brings to the health-care delivery system. That might help us define it. Sharon, from Presbyterian Homes' point of view, what is the value proposition for post-acute care?

MS. KLEFSAAS: We bring value to reducing costs and providing efficient care, but having great outcomes too. We have regulatory components that have added value in terms of assessment, protocols for treating different diagnoses in our care centers, etc. Our cost model is less than the hospital system. When we look at bundled payments, total cost of care, the cost of the episode, we are a vital player in that and a great partner to acute-care systems and other providers because we are one piece of that total episode of care.

DR. KORANNE: The framework that a lot of health care systems are starting to use is the Triple Aim. It should be the paradigm that we should embrace for quality, cost, and the member's experience of care. At HealthEast, we've added a fourth dimension, employee engagement. Those of you working in institutional post-acute care facilities realize that's the challenge we face now and in the future. I don't just mean LPNs and RNs. I also mean physical therapists, social workers, chaplains, nurse practitioners, PAs, physicians, and many others.

MR. STARNES: If we look at post-acute care as the way we treat patients when they come out of an acute facility, where is the value that post-acute care brings to the organization?

MS. BOSTON: Preadmission screening is a federal requirement before someone goes into a nursing home. They have to meet a level of care and the federal government requires the state of Minnesota to screen to determine whether that person is mentally ill or might need special services in the nursing home. In working with nursing homes over the years on an initiative called Return To Community, we have learned that the critical point at which that person is going to avoid hospital readmission is at about the three-day mark. Are meals being delivered? Did home care arrive? Did they see the physician? Did their medications get filled? Were they compliant with medication? When I think of post-acute care I think about it from hospital care transitions to nursing home, to home, and the array of services that must be delivered at that critical point. Because if they're not delivered, that person will return to the nursing home or hospital. That's a systemic expense. When I think of the value

proposition for post-acute care, I think of the great potential for partnerships. We're trying to incentivize that in all the payment structures. It's not there yet, but it's getting there.

MR. STARNES: If we can create an equation that demonstrates this value, what evidence do we need in that equation to make it meaningful?

MS. THURLOW: Aging Services of Minnesota has partnered with our national organization, LeadingAge, to help primarily nursing home providers benchmark with other providers in the state on CMS quality measures. The most robust data we have is rehospitalization data. We have that for nursing homes and across all long-term care providers, assisted living, and home care. Rehospitalization is important, but it is not the only quality metric. We're working on benchmarking costs of certain episodes of care and communicating that to our other partners.

MS. SIMONSON: We have to consider extending the definition of value to include non-medical home and community-based services. They are part of the continuum of post-acute care. That's where we have an opportunity to assign value to home-delivered meals, home modifications, and consultations about care options or how to pay for care.

MS. KLEFSAAS: Infrastructure to support obtaining that data is lacking, especially in many post-acute settings. Care centers for example: We're not given funding, as hospitals were, for computer technology and system upgrades. But it's intuitive that we know the value of a meal delivered to someone's home might make the difference in their care. To quantify that, we're at the tip of the iceberg of what we need to do.

MR. STARNES: Let's assume we have that equation. What will different stakeholder groups gain from hearing this message? Why do we need the public to hear this message?

MS. SIMONSON: Often, political will stems from the public. To have a policy framework that supports a comprehensive post-acute model in our country, the public must understand the importance of care and the breadth of that care. Not only for older people or someone labeled post-acute, but also for their family. We haven't talked much about what post-acute means for families. What are the roles of family caregivers in helping to make certain

that someone's recovery proceeds well? We have a political and public process here, driving policymakers to think about a comprehensive long-term care benefit and financing mechanisms.

DR. KORANNE: Part of the discussion needs to be burden versus benefit of the continuum before and after the hospital, and how we can reduce overall societal burden. The public needs to hear it. The payer? The revolution has begun: There is experimentation happening in CMS, several SNFs in the Twin Cities are experimenting. DHS is striking its own path. In this day of high-deductible plans, Medicare Advantage, dual eligible plans, it's important to have very simple messaging to the end customer so that decision-making can become easier.

MS. KLEFSAAS: There's a lag behind the sustainable financial payment model to support programs through the federal government and our state fund pilot initiatives. When we talk about the value of our payers knowing that, they need to know early on the value of these programs through evidence-based information and outcomes, so that they can more quickly support the efforts. Some pilots had wonderful models of care with evidence-based outcomes that were fantastic at maintaining people in the community, but when funding ended the program died because there wasn't an insurance payer, governmental provider, or state funding behind that program to sustain it. The more we can publicize the work that we're doing and the outcomes, maybe the more quickly we'll get that support.

MS. THURLOW: We see hospital systems leading the charge and experimenting. Much of the experimentation has been metro-based. We haven't seen much robust experimentation in rural Minnesota. What works in the Twin Cities might not work as well in Warroad, where you have a different array of services, a different work force.

MR. STARNES: What do legislators need to hear, and how they could help?

MS. KLEFSAAS: There's work being done to eliminate requirements for the three-day hospital stay for Medicare payment for patients going from acute care to a skilled nursing facility. State and federal governments could support creative waivers for certain programs or exclusions from regulatory require-

ABOUT THE PANELISTS



Krista Boston, JD, directs consumer assistance programs for the Minnesota Board on Aging and for Minnesota Department of Human Services' Aging and Adult Services Division. Her 18-plus years of policy and legislative work includes advocating for and building access systems, including the award-winning website www.minnesotahelp.info, which contains the Long-term Care Choices Navigator. Boston manages Senior Link-Age Line and directs the Minnesota Help Network, the statewide Aging and Disability Resource Center initiative that supports the Disability Linkage Line.



John P. Frederick, MD, is executive vice president and chief medical officer of PreferredOne, a health insurance provider based in Golden Valley. He has served in this capacity since October 2000, in addition to serving on numerous committees, task forces, and boards of physician/clinic groups and health plans in the Twin Cities. Board-certified in family medicine, he earned a medical degree from, and completed a residency in family medicine at, the University of Minnesota. His experience includes active medical practice, medical teaching, practice management, medical care management, and quality management.



Sharon Klefsaas is vice president, operations, for Presbyterian Homes and Services (PHS). In this capacity, she oversees operations for 45 senior communities in Minnesota, Wisconsin, and Iowa, which provide a total of more than 12,000 units devoted to senior care. PHS senior communities include stand-alone independent living, assisted living, enhanced assisted living, memory care, long-term care, and short-term rehabilitation models. Klefsaas is currently directing a new franchise model for short-term rehabilitation services with Allina Health Systems on Allina's West Health Campus in Plymouth.



Rahul Koranne, MD, MBA, FACP, is vice president and executive medical director, HealthEast Care System community and post-acute services. Board-certified in internal medicine and geriatrics, he oversees and provides strategic direction to all inpatient and outpatient programs at Bethesda Hospital, St. Paul. Koranne's work as physician lead on the transformation of HealthEast's care navigation strategy resulted in that system being the first in the nation to have certified Level II transition coaches and the first in the Twin Cities to use care coaches, shown to reduce post-discharge hospital readmission.



Dawn Simonson, MPA, is the executive director of the Metropolitan Area Agency on Aging, Inc., a nonprofit organization that helps older adults maintain their independence. The Agency provides resources for long-term services and supports; offers information and assistance to help older adults make decisions about services and housing options; and works with community partners to improve quality of life for older adults and family caregivers. Simonson's 20-plus years' experience in the field of aging includes work in many different sectors.



Kari Thurlow, JD, is senior vice president, advocacy, at the nonprofit organization Aging Services of Minnesota, the state's largest trade association of elder care providers. This organization works with more than 50,000 caregivers statewide that serve more than 125,000 elders each year in settings across the care spectrum, including private homes, congregate housing, assisted living, and care centers. Thurlow collaborates with a wide range of advocacy groups, external partners, and policymakers to accomplish common public policy objectives.



ABOUT THE MODERATOR

Mike Starnes has been the publisher at Minnesota Physician Publishing since 1986. His duties include the production of MedFax, Minnesota Physician, Employee Benefits Planner, and Minnesota Health Care News; directing the Minnesota Health Care Consumer Association; and hosting the Minnesota Health Care Roundtable.

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ments that might be a barrier. Looking at the payment structure, for example, how much more we pay for two physicians for a hospital visit versus a visit in a care center. Where should incentives be aligned to support post-acute care settings? Get to our legislators with those messages, and make them aware of the barriers we face. We have a responsibility in the provider network to offer solutions, not just to complain to our legislators.

MS. THURLOW: Public-policy makers have to be aware that the older adults services continuum is grossly underfunded. It seems counterintuitive that if you invest a little bit of money on that side of the equation, you save money in the long run. I don't know that policymakers get that.

MS. BOSTON: Post-acute care providers understand. A lot of innovations are part of a long-term care reform agenda that is trying to redesign the system for the impending baby boom. Many people have their first episode of long-term care need in their 60s. We need to prepare for it; it could essentially bankrupt our state budget if we don't.

MS. KLEFSAAS: I'd be interested in what Dr. Frederick would say about this in terms of insurance products that are available, barriers that need to be removed so that you can be more creative in what you cover, and how plans are constructed. Could we develop plans that incent customers to make those choices, just like we have with health insurance policies: If you use the nurse triage line, there's no cost. If you go to the emergency room, it's \$150. Could we apply those same concepts to this post-acute care arena when we have data to support what pathways are most cost-effective, and have the best outcomes and experience for our

customers? Could we also align our insurance products to give our customers choice, and say, hey, if you want to stay in the hospital for 10 days and pay for it yourself, that's an option, but here's a less expensive one. Is it possible to align insurance products with choices and changes we're seeing in the model of the community?

DR. FREDERICK: Yes. The biggest concern is that at this point, we haven't got a well-defined product. This discussion is about how can we do it better. At some point, the whole system's got to be accountable. The way health care is paid for these days is incentive-based, so we have to have some way of defining the most effective system for an individual.

MR. STARNES: What are obstacles to delivering post-acute care?

MS. KLEFSAAS: One barrier is the sharing of electronic medical record information. We're making progress slowly on finding ways, if not to fully integrate our electronic medical records, to sharing information and having it available when transitioning from acute care to the next post-acute care setting. We talk about having person-to-person contact between the acute care provider and the post-acute care provider, and what value that brings to the patient in understanding the handoff, understanding their responsibility, what their outcomes are likely to be, what their choices are. It's the elephant in the room that if you are a large provider, a large health care system, you have more leverage, more dollars to invest in collaborative arrangements with post-acute providers. How will that develop in the future? How narrow will our networks be in the future? If you're a small provider, how will you be able to compete against

larger organizations that have more resources? Those are challenges statewide.

DR. KORANNE: Another obstacle involves transitions. About 10 years ago, I was a primary care doc and geriatrician in Starbuck, Minn., and I saw Mrs. Johnson in the primary care clinic. Then she fell and

broke her hip, so I followed her in the critical access hospital, and then transitioned her into the TCU. Then, I made a house call to see her. Life was easy; I was the care coordinator and the primary care physician.

Now, systems are going toward health care home or medical home, where the primary care physician and system know the patient. We need to connect with the patient's primary care physician. ACOs nationwide have talked about primary care as the basement where the ACO will be built. Population health concepts could get lost if physicians only see patients in nursing homes or assisted living or make house calls, but don't connect with the health care home. Let's not duplicate and look at payment models as spurring us to create something new.

MR. STARNES: Does the quality of hospital discharge information create a problem?

MS. SIMONSON: It does. The process of helping to educate the patient, identifying the family caregiver, preparing that caregiver to implement the discharge plan once someone is home: All are critical to the discharge planning process and the success of the person once they're home. And to the critical 48 hours once the person is home, when it is important to see the discharge plan in action. Whether it's getting medications in place, figuring out wound care, the reality that might hit when the discharge plan places a fairly large burden on the family caregiver and realizing that the caregiver has mild cognitive impairment. Discharge planning is critical but it's not just what happens in the hospital, it's what happens with that consumer, their family caregiver, and those critical hours at home short term, and then long term.

DR. FREDERICK: Dollars are limited and all of these things cost money. My experience has been that the best way to define success is to say who's doing the best job of getting the best outcomes. I'm not sure if there are good methods in place to be able to define measurable outcomes, but I feel very strongly that we need to have those metrics before we can start saying somebody's successful.

MS. BOSTON: For figuring long-term care costs, there's a great financial calculator online that Dr. Robert Kane at the University of Minnesota put together. Minnesota



On average, boomers have about \$50,000 in savings.

Krista Boston, JD

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is the No. 1 state in terms of long-term care insurance policies per capita. Nationally, on average, boomers have about \$50,000 in savings. The daily rate for a nursing home, assisted living, or 24-hour care means you'll go through that money in six or seven months. You need a lot of assets to successfully live at home and avoid going onto Medicaid, which isn't necessarily fun. We all have an obligation to talk to our friends and family and plan ourselves for our future, and soon.

MS. KLEFSAAS: When we're talking about access to health care and having finances to pay for it, how can we make this easier for older adults to understand, and reduce the number of people we send into that independent housing setting? After services have ended, how many individuals are going to have to call that person to see how the care was? No wonder our seniors are confused. What can we do, as a system of providers, to help streamline that and make it more understandable?

MS. THURLOW: We talk about access problems like it's going to happen in the future. In nursing homes, we are seeing it already throughout the state, not because we have a shortage of beds, but because of a shortage of workers. There are open beds out there, but if you can't staff them, you can't admit residents to use them. It's not just nursing homes that need to think about access. Think about community-based services. If you want to hone in on where access issues lie, especially in post-acute care, look at the Gaps Analysis, a study DHS does every few years. Do you know what the No. 1 gap is for long-term care in the state? Transportation. Particularly in rural Minnesota, if your patient can't get the transportation to go to the follow-up doctor visit, we have a broken system. We have gaps in mental health, gaps in adult day services. Those types of services are going to be critical to post-acute care. So going back to the very first question, I would say that transportation, adult day, mental health, all of those things should be part of the definition of post-acute care.

MR. STARNES: Let's say that someone leaves one facility for another facility before they're able to go home. This could lead to several layers of care being provided. Improving coordination of care along that continuum becomes a different challenge because the

person at step four may be so far removed from hospital discharge that they may not know it occurred. Are there tools that are available or could be created to improve this care coordination?

DR. KORANNE: Care coordination; case management; the new CMS regulations emerging around paying for telephonic or non-in-person services that nurse practitioners, PAs, and physicians provide—that model of connectivity to primary care as part of the neighborhood—are part of what we're trying to build statewide. Starting in 2008, there was health care home legislation, and a lot of the major systems and smaller clinics have been certified as health care homes. If that is going to be the framework, then, thinking about a hub and spoke model, as the knowledge center where everything needs to connect. If everybody starts making different visits, it could get disjointed and confusing, not just for the patient and the family, but it would be difficult for a payer to say, "Who's creating what value and how do I distribute that value?" So we have to think about how to connect case management in the hospital, in the various post-acute care settings. We need to continue to use that framework of primary care now and in the foreseeable future.

MR. STARNES: What can be gained by patient and caregiver sharing goals for post-acute care? Are we trying to work with the patient to determine an achievable personal goal?

MS. SIMONSON: We have some wonderful pilot work and integration into some health care systems around helping the patient identify life goals and thinking about how that connects when someone has an acute incident or is in care transition. Patient activation, health care coaching, transition coaching can be key to helping the consumer make the best use of the health care team and molding the care plan around those patient goals. I wanted, too, to comment on the framework centrality of primary care. The health care home can be

Home is often where post-acute care takes place.

Dawn Simonson, MPA



a really strong model to work from, but in today's definition of the requirements of a clinical health care home in particular, there is a very light requirement for a health care home's knowledge and connection to the system of long-term services and supports. So we have to think about making that a more meaningful requirement, if indeed the locus of coordination for care is going to exist in the clinical health care home.

MS. KLEFSAAS: Many of us in senior health care and housing offer that whole range of services within our continuum. Because we're often working with the same team members that move across our system, we've got the same medical records, so there's the opportunity for coordination of care. The handoff of information face-to-face between your own team members as individuals move across your continuum of care, maybe going from acute care for an episode, to TCU, and then transitioning back home is beneficial.

MS. BOSTON: With our Return to Community Initiative, we target about 2,000 people a year that should have transitioned out of the nursing home like their peers, but did not. We target them to see if we can assist them and if they still want to move home. On entry into the facility when they get their Minimum Data Set assessment, or MDS, they answer yes, I would like to move home. But when we talk to them at 60 days, 28 percent of them say no, I like it here. People's opinions and ideas evolve.

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MR. STARNES: One challenge we haven't delved into much concerns costs and reimbursements. What are three reimbursement challenges to maximizing the benefits of post-acute care?

DR. FREDERICK: Data can be defined in dollars and cents or by quality measures. Ultimately, the outcome has to be for a population of patients. For that population, we need to see who is doing the best job and getting the best outcomes, and be able to validate that this is working. Remuneration for services should be tied to those outcome measurements, which we don't have. So the next step is, we've got to get them.

MS. BOSTON: When it comes to collecting data about services we deliver, Senior LinkAge Line is considered a national model. We have an immense amount of information about who we serve, especially in our care transitions model. Dr. Frederick is right: We should not be paying for something that does not deliver the highest quality and doesn't meet people's needs. The state is moving in that direction. You'll see that in the next 10 to 20 years.

MS. THURLOW: Getting to a shared definition will eventually lead to metrics. Regarding reimbursement, we're acting as though payment has changed, but it hasn't. We're still in a fee-for-service model. We need to have data, and we need to make sure it's not just hospitals and docs that are part of that shared risk-reward payment, but that it includes the broad continuum of post-acute care providers as well.



MR. STARNES: Sharon, we have a diversity of providers and industry sectors delivering care. Who should have ownership of the care? How does that factor into getting the right data?

MS. KLEFSAAS: We have to continue to allow our customers to have the choice of networks and to make sure we don't lose that as we look at broader health care reform. We have to allow smaller providers of different kinds of post-acute care to participate in the way health care is reformed, because all of them play a role in the services we make available to the broader community. We are still being paid in the old fee-for-service model, but maybe there are shorter-term solutions to how we incent our care facilities. Just like hospitals are penalized for readmission, maybe we should incent long-term care facilities via a payment add-on for preventing readmission. Look at other resources to align incentives of post-acute care providers.

MR. STARNES: What roles can ACOs play in getting the most from post-acute care? Can an ACO help identify who needs post-acute care?

MS. THURLOW: Sure. Is an ACO required to do that? Not necessarily. I have nothing against ACOs, but I don't think it's the only model that can provide care coordination and effective placement. Other experiments in the state that are not necessarily ACOs provide coordination effectively.

DR. KORANNE: Right now in Minnesota, we are looking at "accountable communities for health," so we are leapfrogging over the system ACO and looking at communities. I don't put too much emphasis on the term. However, the payment mechanism and system must think strategically about post-acute care. Recent reports say about

33 percent of Medicare spending is in post-acute care. Most chronic diseases are in elders, and most elders will be or are on Medicare or a state-run program, so ACOs, ACHs, total cost of care, some acronym like that must think about post-acute care.

MR. STARNES: We know there needs to be a reimbursement model to better incent post-acute care. Are there examples of how post-acute care providers could benefit financially from reduced readmissions?

DR. FREDERICK: I want my doctor to be accountable for the care he's delivered to me. To be able to say they're doing it right, you have to have well-accepted outcome measurements. How do you know who's doing a good job? I'm going to cite my experience 10 years ago on a panel to improve diabetes care in Minnesota. We came up with measurements on how many diabetics were being effectively managed. Some of it was process measures, but there also were lab results that showed who was doing the best job. The first year we reported that information to the provider systems, overall optimal management of diabetics was 6.7 percent. We told the docs, "Here are your numbers. We'll measure this next year, and then let's talk about it and see what you've been doing." The next year, the number was 9.6 percent. They must have done something better. Now, instead of 6.7 percent, the numbers of the best clinics are sometimes over 70 percent of patients being optimally managed for diabetic care. Those are what I would call accountable organizations. They've taken the data in front of them, applied it, and they're getting better results. To translate that to this situation, we have to figure out what optimal care is for this group of patients, say, "This is the standard of care," and then measure outcomes and let both the delivery systems involved, and the patients who are consumers of this care, know. Organizations need to be financially rewarded for what they do. Payment's going to come from a pool of dollars. More dollars go to ACOs that are doing the best job; fewer, to ones that aren't. You've got measurable outcomes; you know who's doing the best job. Reward them for it.

Incent long-term care facilities via a payment add-on for preventing readmission.

Sharon Klefsaas

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MR. STARNES: What's a model for getting that pool of dollars into the right place?

MS. KLEFSAAS: Key ingredients are: All caregivers have to align on care practices, what we expect outcomes to be, and in how many days we expect those outcomes to take place. We've talked about needing to have an electronic medical record and sharing information to get outcomes. We have to be willing to share risks with our providers in post-acute care. Whether it's shared risk or shared savings, how do all providers share risks so that we each can sustain our business line but provide the outcomes we're looking for in the most cost-effective way? Where to go from there? Medication error rate, development of pressure ulcers, falls, readmission rates; there's a range of metrics that we need to make transparent, revisit, and adjust our protocols to make sure we are getting the outcomes we want.

MS. THURLOW: Minnesota has a nursing home report card at minnesotahelp.info. My team has been charged with developing a home- and community-based services report card to go to the Legislature this August. The initial services that will be displayed on that report card are registered housing with services, adult foster care, and possibly another service yet to be determined. Ultimately, about 20 different home- and community-based services will be on it. What those measures will be requires consensus from providers, consumers, and state policymakers.

In talking about metrics that help inform a payment system, there's a great template from Boston-area ACOs. They got together with post-acute providers, agreed upon a definition, and discussed what standards to have as collaborators, including appropriate metrics for rehospitalization and med management. Those metrics look different from report cards we have today, which are consumer facing and tell you what services are available. Helpful information, but I'm not sure it gets us to where we want to go in terms of aligning payment incentives with outcomes we desire to improve care, lower costs, and improve consumer satisfaction. That's the conversation we need to have. It's a collaborative effort. It's not just payers making decisions about metrics, and it's not just hospitals and docs making decisions about which metrics work. They may not be the same.

DR. FREDERICK: If a provider is at 30 percent and they go to 50 percent, that's good. But I'd rather go to someone who improved from 70 percent to 71 percent. It doesn't have to be improvement that you measure. You can measure absolute outcomes.

DR. KORANNE: Surgical metrics and falls are metrics every hospital agrees upon, and those can be used in a variety of ways. They can be consumer facing or they can be pay-for-performance, they can be included in ACO. We need to have metrics and we need to pay for those metrics, but there's a step before that. Unless we get organized around metrics, the ACOs don't know what to start collecting and pay for. We need to empower post-acute care providers to start developing metrics that make the most

ty-based services providers. There isn't yet a pool of money to make payments based on achieving metrics goals.

MR. STARNES: Medicare has been working since 2006 on its post-acute care payment reform demonstration project, and there's plenty of data from that. Even though payments vary substantially for similar patients in different post-acute care settings, there is little evidence that payments translate into significant benefits to patients. There is little empirical evidence regarding outcome differences across post-acute care settings, so differences in quality are difficult to notice. Let's talk about what a patient might find helpful.

It's important to have very simple messaging to the end customer.

Rahul Koranne MD, MBA, FACP



sense to them, that line up with consumers' needs, and with governmental and the commercial payers. SNFs need to propose metrics. Then we can debate: Is falls the right metric? Is facility pressure ulcers the right metric? Is readmission the right metric?

MS. BOSTON: There's a big difference between what we need for transparency purposes and the limited amount of information that a consumer wants to look at during a long-term care crisis. We need to deliver them relevant, transparent information about a provider as quickly as possible, because a lot of times, these are very quick decisions that represent a different set of metrics than what the state would use to make payments. These projects will definitely align. There is a pilot effort right now, called PIP—Payment Incentive Program—to make payments for home- and communi-

MS. BOSTON: With the Return to Community Initiative, we've been gathering data about the caregiver experience. Eighty-five percent of caregivers interviewed by Dr. Robert Kane at the University of Minnesota School of Public Health Center on Aging and Dr. Greg Arling at Indiana University Center for Aging Research said, "I just want information." We have to deliver information at the literacy level and decision-making level they can handle. Most of our society has an eighth-grade literacy level. Much of what we are communicating, people aren't going to use anyway. So they're struggling. If there's anything we can do systemically beyond reporting on quality measures that consumers care about, it is to translate our material in a way they can understand.

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MS. SIMONSON: We have to think about what choice means in Greater Minnesota. For an older adult, there may not be a choice, or their choice is focused on what's closest to their home community or to where their daughter lives so she'll be able to visit once a week. What meaningful choice is may depend on where you live and on the availability of care.

model for post-acute care delivery, what do we want to avoid? To start with, is it a conflict for an acute care facility to own a post-acute care facility?

MS. KLEFSAAS: I don't think so. Lots of communities in Minnesota and across the country have that. There are pros and cons to that relationship. Some disadvantages of being connected may be that you have a conceptual model of services of physicians operating in a hospital, and they tend to apply that same kind of thinking—ordering prescriptions, services, and labs—when the patient moves to skilled nursing or a transitional care unit.

Looking at consumer satisfaction data is going to be critical.

Kari Thurlow, JD



MS. THURLOW: Intuitively, we know that the No.1 question is, what are my options as close to home as possible? How often can my daughter visit me? How often can I see my grandchildren? It may not be the No. 1 quality-ranked post-acute provider, but you know what? Post-acute providers who might rank in the middle of our report cards, their consumer satisfaction data is out of sight because consumers are happy with their care. It might reflect the fact that we have, overall, really good quality in Minnesota, but it also reflects that it's meeting their needs. Looking at consumer satisfaction data is going to be critical.

MS. BOSTON: We asked, how would you make a decision about moving? The two things people said: Can my grandkids come to play on a playground nearby, and, will a facility take my dog? We have to meet these people where they are, and that's a challenge.

MR. STARNES: Any time there are new models in health care, we hope we're not repeating the same mistakes that occasioned a need for new models. In creating an ideal

So you might actually have a higher cost of care because of the practices that you're seeing. On the benefit side, not having to be transported to another location is a benefit. Sometimes, sharing the medical record when the two communities are connected to each other is a benefit. Sharing staff, access to lab, X-ray, those ancillary services, is very convenient. If you can manage the cost of those services in the reimbursement model we have in skilled nursing homes through the Medicare system, where it's an all-inclusive payment, that's your challenge: to manage all those services within that daily per diem. Duplication of service costs could arise.

It's all about collaboration and working that out. It's about negotiating payment for those services at a rate that is covered and reasonable under our reimbursement payment on the skilled services side. So there are pros and cons, but I don't think it's a conflict.

DR. KORANNE: Is it a conflict for one part of the continuum to align with another part of the continuum? Employment or having

the same ownership is one way of aligning. Collaboration is another way of aligning. In our system, we are starting to think about not duplicating services or core competencies; that would be the easiest and the best way to reduce social burden. Our last few years of work has been to develop a partnership with post-acute care providers, who know their business best. For a primary care clinic or a hospital to say, "Yeah, but we can do it better," would be foolhardy. The only way to succeed is to align core competencies of each part of the continuum. Honor the value that each part of the continuum brings. Because we talked about bundles of money, outside the health care continuum lies another continuum, where there is some money and lots of duplication, and those are social services. We have to get our act together, but authentic engagement, community conversation, and not duplicating services are the guiding principles.

MS. THURLOW: Keeping the patient at the center of this is key. Some past mistakes have been that we would direct the patient where to go; we need to reverse that. Mrs. Johnson may not want to spend a gazillion hours trying to figure out her options and she may take risks we are not comfortable with. But, it's still her choice.

MS. SIMONSON: Vertical development in silos was a mistake. We have to think about this horizontally, across communities for accountable care. Part of that is complicated by many sectors' duplication, relationships not in place, perhaps not knowing the work of other sectors. This is complex. We have to embrace the complexity. ACO models today encourage more vertical building. Complex issues require complexity in terms of approach.

MS. BOSTON: A mistake I would not want to repeat is people not getting enough information about the financial impact of their long-term care choice. Everybody thinks Medicare pays for it all. They don't understand that if you end up in a post-acute facility or a nursing home, you've got about 20 days of Medicare paying, and then either you're picking up the bulk of the payment or you're spending down to Medicaid very fast, and that means the state's picking up the payment, and that's all of us. They don't meet with the billing office to hear, "Here's your financial situation. Let's do some

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planning.” If that could happen, it would change things for people. It would be more transparent.

MS. KLEFSAAS: The consumer needs to take responsibility, too, for self-management of care, for making reasonable choices aligned with recommended treatment. I would hate to see the sort of pushdown that some of us experienced in the past, where patients are discharged too soon from a hospital system because of pressure that hospitals received. Those of us in long-term care and other settings took those patients when they shouldn’t have been with us yet, because they were discharged sooner than they were ready. That maybe led to a readmission. I would hope we don’t push that same experience down to the next level in transitional care, where, through pressures, we feel we have to discharge people sooner from transitional care or from a home care program before they’re ready, before social and family systems are in place to support them.

MR. STARNES: Let’s think about the role that the physician can have in improving care coordination through the medical home model.

DR. FREDERICK: I don’t think it’ll work. To be accountable, you have to be able to show that you’re doing the job and let patients make decisions based on outcomes and cost.

DR. KORANNE: The primary providers in post-acute care settings, SNFs, are learning from the health home ambulatory model. The Optage model, the HealthEast Medical Care for Seniors model, the Allina model, and the Fairview Transitions model are still using the health care home concept, but are integrated in post-acute care facilities. Sitting in a primary care clinic and coordinating in the nursing home absolutely would not work. But the nurse practitioner or geriatrician seeing a patient in a post-acute care setting is the only way to go. That’s the model we are using. It has to be at different levels, and that’s also something that we are doing at HealthEast, learning as we go with our partner, post-acute care facilities. It’s not just the front line at the bedside with Mrs. Johnson, it’s also at that policy level with administrators and the DONs of the skilled nursing facility.

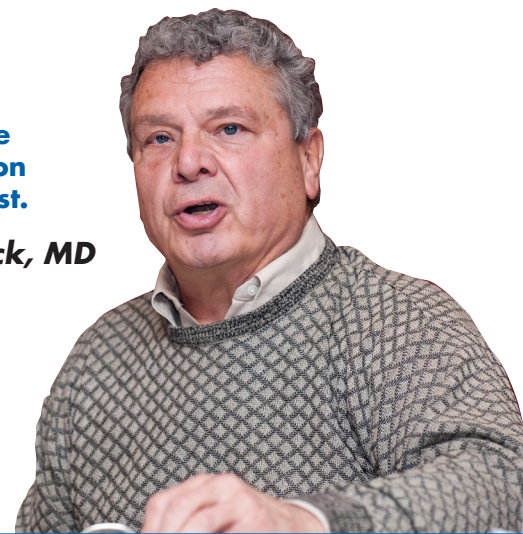
MR. STARNES: One more thing from a provider perspective that we touched on briefly: the role of mental health in the post-acute setting. How are we using it now? How can using it better improve overall outcomes?

DR. KORANNE: Everybody in the room probably agrees this is something that needs a lot of work. Not just in the state but also nationally. We are starting to look at our Medicare Shared Savings data from a Health-East perspective, but it could be easily generalizable. For the Medicare population, adding a mental health diagnosis—I don’t mean full-blown schizophrenia—I mean depression that happens after a cardiac procedure, seasonal variation in mood, stuff like that, has a superadditive effect on diabetes, hypertension, hip fracture treatment. I think the journey has begun to start thinking about it, but the system is in very rudimentary phases and from a SNF perspective, we have psychologists that might come with a month-out appointment for somebody that just came from the hospital. Lots of work needs to be done, and we need to get together on it.

MS. BOSTON: I was at a meeting where we were discussing this very issue in terms of preadmission screening. Because, if you have a mental illness diagnosis, then you get referred for the OBRA level II, which could result in an assessment from the county. Who should get that assessment? The county assessor in the room said, “Well, someone with anxiety or depression isn’t meeting that level for us to do a full assessment.” Of course, the two moms in the room that have autistic kids with anxiety diagnosis said, “You *do* need to do that if they have anxiety, and if they’re in a nursing home, they may need special services and the nursing home may not be aware of it.” It was very interesting to me that autism was seen as “mental illness lite” and wasn’t quite worthy of full assessment. I understand they have resource limitations, but how do we get to a place where somebody that has those basic needs can get consultation and assessment? Maybe by the time they’re discharged, they haven’t even had any consultation.

Let patients make decisions based on outcomes and cost.

John P. Frederick, MD



MR. STARNES: One last question: What must be done to clearly show that post-acute care is realizing its best potential?

MS. SIMONSON: Coming to consensus on a definition. As an Area Agency on Aging, we advocate for a definition that includes care in an institution as well as care at home.

DR. KORANNE: What needs to be done is to have a louder community conversation and to let post-acute care facilities come into their own and share expertise from acute care.

MS. THURLOW: What steps can be taken to ensure post-acute care realizes its full value? Move toward a consensus definition. Agree upon standards and metrics. It’s not just a conversation on one side of the continuum, it has to be all of us working together. Progress toward an interoperable health care exchange. Information exchange is vital to get to where we need to be.

MS. BOSTON: For post-acute care to come into its own, I look forward to seeing the baby boomers hit that system and how it responds.

DR. FREDERICK: Triple-A. It needs to be applied here like it is everywhere else in the health care system.

MS. KLEFSAAS: The patient-centered approach. Listen to what patients say and adapt our models to keep them at the center of it. ■