Using Data to Drive Dramatic Improvement in Albany

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IPRO

Regulation

- Medicare three-day acute care episode stay requirement
- Varied patient assessment tools depending on care setting
- No standard method for authorizing post-acute services; varied insurance requirements
- LTACH 25-day requirement
- Medicare 60-day acute care benefit rule

Cost/Payment

- Cost of patient's care is not fully reimbursed
- Costly medical treatments reimbursed based on provider setting
- Inadequate reimbursement for specialized services (TPN, complex wound care supplies)
- Disincentive for SNF to use the hospice benefit for post-acute care patients
- LTACH is most costly service provider

Care Coordination

- Patients transferred from ICU to post-acute care setting
- One hospital network uses their CAH for patient post-acute care planning for specific patient populations
- Early identification of complex patients who required additional discharge planning
- Relationships between referral sources and hospital case managers

Community

- There are no LTACHs in the Albany HRR
- Limited post-acute care beds that can accommodate clinically complex patients
- Proximity of post-acute care providers drives patient care
- Access to informal community supports

How are the special care needs of the clinically complex patient being met in the Albany Hospital Referral Region?

Workforce

- RN training required to care for special care patients
- Lack of daily access to physicians within SNF care setting
- Hospital CM knowledge of post-acute care service providers
- Shortage of trained workers in rural areas

Policy

- Siloed reimbursement models
- Varied post-acute bed designations: TCU, Swing beds, LTACH, SNFs, IRFs
- NYS DOH Medicaid Redesign Repatriation Program for patients receiving post-acute care in other states
- NYS is a "Certificate of Need" state
- Transforming healthcare environment

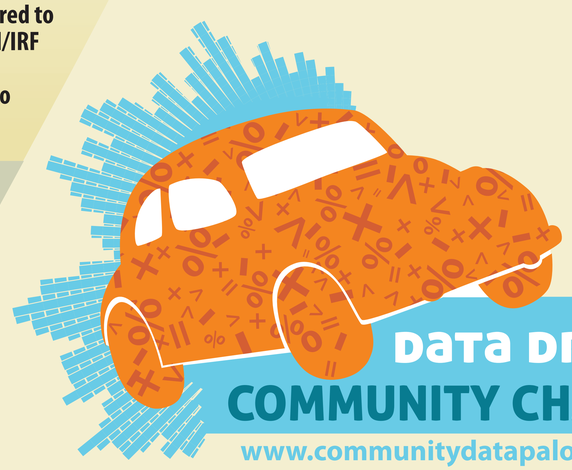
Provider

- CAHs have swing beds for post-acute care
- SNF not able to provide certain treatments (IVs, PICC lines, CADD pump care, vent care, Bi-pap)
- Network case management model for discharge planning
- New program ROI/volume of patients
- Five post-acute care settings may have the ability to care for medically complex patients

Patient

- Once patients are referred out of state, family usually is the catalyst to return to local community
- Patient wants to stay close to home
- Access to family caregivers
- Lack of awareness of community service providers
- Proximity to acute care and ancillary services
- Younger patients are referred to LTACH/IRF
- Primary cause of readmission to acute care is septicemia/infection

Acronyms
• CAH – Critical Access Hospital • CM – Case Manager • LTACH – Long Term Acute Care Hospital • IRF – Intermediary Residential Facility
• SNF – Skilled Nursing Facility • TCU – Transitional Care Unit • TPN – Total Parenteral Nutrition • HRR – Hospital Referral Region



This material was prepared by IPRO, the Medicare Quality Improvement Organization for New York State, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents do not necessarily reflect CMS policy. 10SOW-NY-SSDA-13-03