Coordinating Post-Acute Care Can Generate Savings for Bundled Payments: The LHC Group Case Study

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In January 2015 Health and Human Services (HHS) Secretary Sylvia Burwell announced the department's goal of moving half of Medicare fee for service payments into alternative payment arrangements. These alternative payment arrangements include the use of bundled payments. Starting April 1, 2016 through December 31, 2020 Medicare will pay hospitals in 67 metropolitan areas for inpatient hip and knee replacements plus billed services for 90 days post discharge. HHS is expanding the bundled payment program to include bypass surgery and heart attack admissions in 2017 as well as hip and femur fractures. Actual payments are compared to a targeted payment amount. The targets are initially a mix of hospital specific spending and regional average spending in the hospital's census division. Targets move to the regional average spending in years 4 and 5 of the program. Hospitals and their post-acute care partners either repay (if spending exceeds the target starting in year 2) or shares in the savings if their actual performance is below the projected target.

One of the goals of moving to bundled payments is to develop more effective clinical integration of acute and post-acute care services. To be effective, hospitals will have to rely on their own post-acute care operations or partner with a post-acute care provider. An effective post-acute care partner can improve the quality of care provided and reduce overall spending within the bundle. Three factors can result in lower spending;

- Reductions in length of stay through earlier discharge and placement in less expensive post-acute care settings
- Through clinically appropriate and cost effective post-acute care placement, and
- Reducing hospitals readmissions within the 90 day window.

The remaining part of the blog will provide some detail on an interesting case study of a post-acute care provider (the LHC Group) partnering with a major health care system (Ochsner Health System) to manage hip and knee replacements. These successes are a result of the collaboration between the home health and hospital teams. Through collaboration, the teams develop a shared understanding of capabilities. They are able to clarify alignment of roles and responsibilities, challenge assumptions and introduce consistency in process and decision making. Most importantly, the patient is placed at the center of care. Once the patient decides to pursue surgical replacement of a knee or hip, the team is actively engaged with the patient each step of the way through the day of surgery to post-surgery recovery. The home health care team evaluates, anticipates and mitigates risk before surgery starts and informs and educates the patient and family about the surgery and recovery process. As a result, the patient is brought into the process earlier and is as much a part of the plan of care process as the rest of the team.

The following provides a brief overview of how LHC Group and Ochsner effectively integrated their acute and post-acute care strategies.

Care Mapping

Ochsner Home Health and the Ochsner Orthopedic team deconstructed and reconstructed the entire hip/knee surgery life-cycle, from pre-admission to post-surgery. Every aspect of the process was evaluated –individuals involved, roles, timing, value proposition, desired outcome, and current state. Assumptions were challenged. Therapists, Surgeons, Discharge Planners, Case Management, Schedulers, and staff from LHC Group were participants in this process. The end result was:

- Engagement of home health care with the patient prior to surgery
- Home Health treatment plans customized by physician
- Custom plans loaded into LHC Group’s Electronic Medical Record and available to the therapy team as a starting point for care planning post-surgery
- Set criteria established to determine when a patient could be discharged to home, and the type of post-acute setting to be used
- Clear understanding of the capabilities of types of care and therapy that could be delivered effectively in a home

setting, and the role home health care would play post-surgery
- Commitment that the home health care team would see the patient in under 24 hours from discharge

Patient Engagement Pre-Surgery

The Home Health team visited with the patient in their home, two weeks prior to the scheduled surgery date, and engaged with the patient and family prior to surgery to:

- Inform, educate, answer questions regarding:
  - The planned surgical procedure
  - Post-surgical recovery
  - The role home health will play post-surgery
  - Provide list of key contacts
- Assess home environment
  - Evaluate social and family support structure
  - Evaluate access to appropriate nutrition
  - Evaluate home for fall risk, address issues identified
  - Conduct a medication reconciliation
- Provide assessment summary to Orthopedic team
- Collaborate with Orthopedic team to develop post-surgery care strategy
- This engagement and collaboration occurs in person, via mail and phone

Patient Engagement Post-Surgery

The Home Health team collaborated with the orthopedic team to develop the patient's post-surgical treatment plan. The Home health team member meets with the patient and family post-surgery, reviews the discharge plan, and helps transition the patient to the home setting.

During the first 12 months of this project Home Health and Hospital team met weekly to review and refine all aspects of the process. Now the team meets every other week.

Following metrics were tracked during the first year, and continue to be tracked;

- The number of cases scheduled for surgery
- The number of surgeries completed
- Post-surgical placement setting for each patient (SNF/IRF/Home)
- Days to discharge post-surgery

- Readmissions

Results

Reductions in Length of Stay

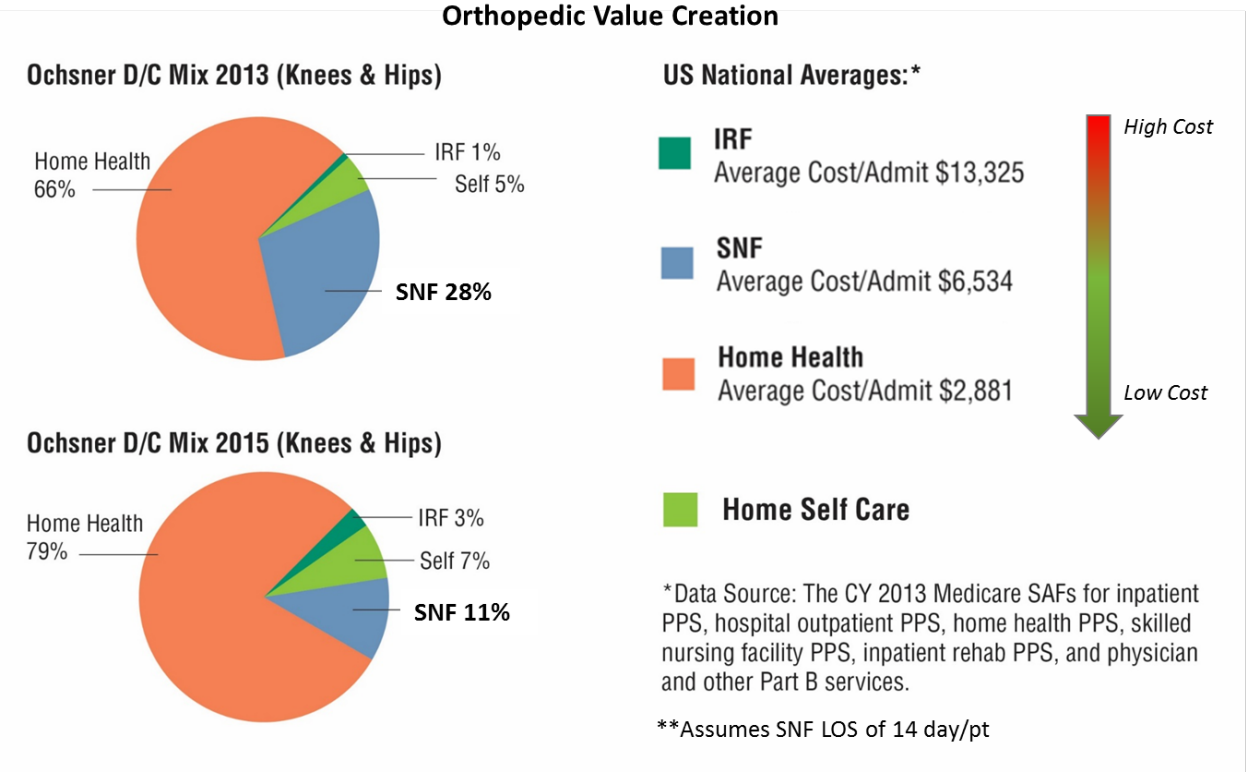
In 2015 inpatient length of stay was reduced by 50 percent compared to 2013 length of stay metrics at Ochsner within the same patient population.

Out of the 284 knee replacement procedures:	**Out of the 146 hip replacements:**
78 or 27.5% were discharged on day 1	90 or 61.6% were discharged day 1
124 or 44% were discharged day 2	29 or 19.8% were discharged day 2
15 or 5.3% were discharged day 3	5 or 3.4% were discharged day 3
6 or 2.1% were discharged day 4	5 or 3.4% where discharged day 4

More Clinically Appropriate Post-Acute Care Placement

The teams also redirected patients to the most clinically effective post-acute site of care (See Figure 1). This resulted in an increase of home health care stays before the intervention of 66 percent to 79 percent with the LHC Group partnership. Moreover, the use of skilled nursing facilities declined dramatically falling from 28 percent before the partnership to 11 percent after.

Figure 1.



Reductions in Hospital Readmissions

Patients also saw a lower-than-average 30-day readmission rate of 0.7 percent for knee replacements and 2.0 percent for hips replacements. The national average for this diagnostic category is 4.8 percent.

Total Savings

Overall the combination of these three changes in patient treatment reduced spending on hip and knee replacement by $3,673 per patient—nearly a 15 percent reduction in the average Medicare payment per 90 day episode. The savings were generated by reduced length of stay which accounted for 54 percent, reduced readmissions 16 percent and reductions in the use of SNFs the remaining 30 percent.

While this is a case study, the process and resulting outcomes are scalable and replicable. LHC Group has deployed this model at Texas Health Resources and Methodist Health Systems in Texas with similar success. Overall the magnitude of the savings shows

the potential of how a delivery system innovation can yield more efficient and more effective health care for patients.