Chip Kahn (00:11):

Hello and welcome to Hospitals In Focus. I'm your host, Chip Kahn. I am sure you are familiar with your local community hospital or what those in the field call an acute care hospital. It's where the babies are born, broken bones are mended, surgeries minor and major are done, and much of the cancer care takes place. But there are conditions that require more than acute care such as strokes where patients will need care and rehabilitation beyond what an acute care hospital may be able to offer.

Chip (00:45):

With us today as an expert in health care policy, Al Dobson. He is here to talk about those patients who need further care after their hospitalizations. Al is one of the foremost health economists here in Washington and spent much of his career studying what we will label here post-acute care, care post-hospitalization. Al, I'm happy to have you here today.

Al Dobson (01:09):

Thank you, Chip. I'm very pleased to be here today. I'm very interested and excited to see that you folks are so interested in PAC care, that is to say care outside of the four walls of the hospital.

Chip (01:22):

As I alluded to for many conditions, health care is a continuum that extends beyond the four walls of the hospital and includes a variety of post-acute care settings. Today, we'll focus on four of those settings. When people hear post-acute care, probably the first thing that pops into their heads is nursing home. The technical term is skilled nursing facility or SNF for short. The other three are inpatient rehabilitation facilities or IRFs, home health, and long-term care hospitals or LTCHs.

Chip (01:59):

Let's begin our discussion of post-acute care by some table setting, and perhaps the best way to understand the differences between these settings is to put this in a real-life situation. Let's take a 65-year-old stroke survivor, for example. What criteria would a doctor use to recommend the best care setting for that person to ensure they receive the right care and are able as fast as possible to return to normal living?

Al(02:29):

Well, the first thing, Chip, that the physician has to understand is his local market. The mix of HHAs, skilled nursing facility, rehabilitation facilities and LTCHs varies widely by market. If there are no IRFs, then SNFs would be the only choice for a stroke aside from extensive referrals to other markets. And of course, the physician will care very much about quality of the facility. He or she will have some experience in the market and the physician will have a strong preference. The physician may also have a physician for the type of PAC care. In this case, perhaps a rehabilitation facility or a skilled nursing facility or perhaps even a LTCH.

Al (03:05):

The facility's experience with stroke in this case would be very important. Some facilities are much more experienced with stroke than others. The motivation of the patient in this case comes in very strong because the motivation of [inaudible 00:03:17] for stroke is particularly noted. Those patients would

want to receive high intensity rehab, that is to say a lot of intensity in a short period of time, could sway the decision to the IRF and less of course there were no IRFs in the local market.

Chip (03:30):

Now we find that many policymakers assume there is substantial overlap between these settings. That they are, to a large extent, interchangeable. What are some of the key distinguishing features of say, an IRF and a SNF?

Al (03:46):

If you've ever been to an IRF or if you've ever been to a SNF, you know they're quite different. They're quite different in character. They're quite different in corporate culture. To start with IRFs, IRFs are paid on a case-payment basis. That means they have to constrain their payments to the dollars they receive for a given case. They typically have shorter lengths of stay. They provide more intensive rehabilitation per day. By law, by statute, they have to have three hours per day for five out of seven days. That's very intensive for rehabilitation.

Al (04:13):

That means that younger and more motivated rehabilitation patients who want to get it over with are very likely to go to an IRF. You're young. This patient would be 65 years old. Let's say this is a tennis player. Let's say he's got a game next week or the week after. This patient is wanting to have high intensity of care. If the patient were much older, that patient might not necessarily be interested in that level of rehabilitation.

Al (04:34):

The strong preference of stroke patients that may push the physician towards an IRF. IRF supply however is limited in many markets and there may not be the possibility to go to an IRF and that I would suggest that you'd either have to go out to the market or go to a local SNF.

Al (04:48):

SNFs, on the other hand, are very different creatures again. They have per diem payments and they have a three-day stay rule. That means that the patient will come out of the hospital after staying for three days and since there are per diem payments, there may be some attempt to have the patient stay longer because when you're paid on each day you might have more days. That means longer length of stay, perhaps less intensive care.

Al (05:09):

Older female population, less able to cope with intensive rehab tends to populate the SNFs. SNF patients for a SNF location. Some patients may want to have slower rehabilitation, they may prefer the SNF. Some may want to, as I said, have more intensive rehabilitation, they may prefer a SNF. SNFs are more widely distributed across the markets in the country, so for most patients the choice may be a SNF just because there's no IRF or LTCH in the local market.

Chip (05:36):

So, Al, SNFs and IRFs really do treat different kinds of patients, don't they?

Al (05:41):

Yes, especially in markets with an ample supply where patient preferences can sort out the choice of the PAC setting, but of course some degree of overlap exists.

Chip (05:51):

If I could ask a follow-up question, what is the expectation of that doctor when he sends that patient to the IRF? How does he expect that patient to be treated in the IRF, and frankly, how fast that patient will get out and get back to normal living?

Al (06:10):

If the physician has worked with an IRF in the past, he'll understand that an IRF is a happy place or an IRF is a go fast place and an IRF is a high-intensity place. He wouldn't likely send a very elderly person to an IRF that has that high-intensity workload. If he were to send a patient to a SNF, he might send an older patient there that can be more leisurely. Maybe end up with the same result, but just not be pushed quite as hard. Some people are willing to be pushed and they're motivated to be pushed and they want to go to IRF. Those patients that aren't quite motivated for a quick turnaround may want to go to the SNF.

Chip (06:44):

Now let's look beyond SNFs and IRFs. Let's turn to long-term care hospitals, also known as LTCHs. They have quite different patients. Can you describe the condition of the average LTCH patient and why LTCHs are particularly suited to care for those patients and really are different than the other two institutions we've been discussing?

Al (07:08):

Absolutely. Again, the LTCHs are paid on case payments, so they have some incentives to constrain their costs. LTCHs have patients for at least 25 or more days. The very fact that the patient's in for 25 days when the typical patient stay about a week, means these are very different patients.

Al (07:26):

Indeed, the patients come from acute care hospital intensive care units. These are the sickest of the sick. They have multiple organ failure, the so-called train wreck patients, where there's a whole lot wrong with these patients and the hospital has essentially passed on the patient to the LTCH because they had them in intensive care where they really weren't receiving medical care particularly and certainly not rehabilitation.

Al (07:51):

Because there's so much multiple organ failure, because there's so much complexity with the patients involved, LTCHs have evolved to a multidisciplinary team approach. That is to say each of the complex bit of needs has to be addressed. Different people are responsible, different physicians and different caregivers, hence the multiple disciplinary team approach. There's high expertise in vent rehabilitation and burn care and other highly severe patients within the team approach. The mix of rehab and medical care in hospitals, LTCHs are hospitals. That are first and foremost hospitals, but they have an enormous amount of rehab.

Al (08:27):

I've talked to the LTCHs folks over the years and they say the minute you show up in a LTCH, rehab starts that day. Particularly, if you've been deconditioned in intensive care unit in a hospital, they want to move these patients and they want to move them fast both medically and clinically. The goal, overarching goal, of the LTCH is to return very ill patients to the community. There's a perception of value in the community LTCHs are expensive, they cost more. Many areas don't have LTCHs. But those that do, the demand for LTCHs seems to have held and I would guess that's because there's a perception of value in the community that LTCHs do return the very ill patients to the community and they're able to take in the patients that are the most sick.

Chip (09:06):

Addressing further this issue of potential overlap between the post-acute settings we are discussing today, now let's go to home health. The notion that a patient can receive all the post-acute care she or he needs at home is obviously very appealing, particularly to the patients. But how realistic is it and what makes a patient a good candidate for home health? And in what cases is home health not a substitute for either SNFs, IRFs or LTCHs?

Al (09:39):

Well, to start with a payment for home health has called episode based, but patients also have to have a caregiver at home. It's very unlikely that the physician would want to send a patient home where there's nobody to take care of them when the home care people aren't there. Having a patient at home, a caregiver at home, whether it's a spouse or whatever, that really helps the opportunity for the patient to receive care at home.

Al (10:05):

The physician has to certify the patient, so the physician makes a decision that this patient is appropriate for care in the home health setting and appropriate for a home health admission. There is a high degree of overlap of SNFs, especially for the orthopedic care and for the joint care. In the home you've got longer length of stay, but in the home setting patients still prefer the home setting, as you'll seed, Chip; and because they prefer it, all else equal, patients would want to go home as opposed to a SNF, as opposed to an IRF. The more complex patients to the IRF and to the SNFs, the less complex patients to the home.

Al(10:40):

Under the alternative payment models we're observing, I think this is quite important. An increase in the use of home health care and less SNF care, especially for joint care, this suggests there was some overlap. But it also suggests we're reducing the amount of overlap in the communities as we pay differently, as we have alternative payment models that are working in our community to bundle payments where we are seeing that we're getting more home care and less SNF care.

Al (11:04):

Stroke patients are more likely to go to rehab, go get rehab at IRFs, or so-called Super SNFs, where are essentially like IRFs. They're much less likely to go to home health. Very few bent patients and extreme trauma patients would show up in home health.

Al (11:18):

Now, one thing that may be a game changer is technology's changing for remote care and we're getting better at remote care. That could increase the amount of home care that's provided and we may be able to treat more complex cases in the home. We'll have to see how that evolves and how good tele-health and all the rest of it works out. But if so, it could be a game changer for where people receive their care.

Chip (11:40):

Al, you mentioned bundling. Can you just take a moment and describe the various kinds of bundling that are gaining interest by policy makers and what the implications that may be for choices about the settings for that period of recovery and rehabilitation for patients?

Al (12:02):

Yes. The idea of bundling is to pay for an entire case from discharge to the hospital on into a post-acute care setting on into the home. Right now, we have so-called BPCI, bundled payment for care initiatives. We also have another thing that looks at mostly joint replacement and we have the accountable care organizations. The idea is, and if you pay for the entire bit of care, and there's a difference in costs of where you send people, for instance, home health is less expensive in SNF, is less expensive in IRF, is less expensive than a LTCH. So if you're paying a fixed amount of money for, say a joint patient, then you're more likely to want to send the patient to a cheaper, less expensive site of care, perhaps home health.

Al (12:46):

The whole notion of bundling is, can we pay one amount for the care? Can we let the decisions the physicians and the physicians and their caregivers and the discharge planners decide is it appropriate to send people to home health or maybe outpatient therapy or do these patients may need to go to facility-based care which costs more but may be more appropriate for the patient? So far, the news is a bit mixed, but it looks as if, as I just said, the alternative payment models are leaning to more people being provided, getting their care in home health and less than the facility-based care, particularly again, for the joint care and the orthopedic care.

Chip (13:20):

Well, bundles sound good in terms of organizing care, but I hope all the providers keep thinking about job one, which is meeting the needs of the patients first.

Al (13:31):

Don't we all, Chip?

Chip (13:32):

Now that we've covered the post-acute landscape and listeners, I hope, have a better sense of each setting, let's discuss the challenges for policymakers. It's clear that the demand for this kind of care we've been discussing today is going to grow as people live longer. An average of 10,000 people a day are hitting Medicare eligibility of 65; and thanks to advances in medicine, the number of people living to age 85 or older will be close to 15 million in 20 years. What do our country's changing demographics mean for post-acute settings? Are healthcare providers able and ready to meet the demand?

Al (14:17):

Well, let's take the obvious first. More people, more demand but it's more complicated than that. It's complicated in many ways. The first is, as I mentioned, that PAC supply, that is to say the mix of home health, SNF, rehabilitation or long-term care varies widely market to market. That is to say, as demand increases, different pressures will be put on different markets depending upon the variability of care.

Al (14:42):

Going back to your example of the 65 year old. What happens to a 65 year old in large part, that depends upon what's available in the market, so discharge planners are going to need to adjust to market conditions. But that's just the start of it. Early on, that is to say as youthful boomers enter into Medicare, increased demand for home health care, especially for those for strong preferences of healthcare will probably increase.

Al (15:06):

What people miss is that when people come into the Medicare program, they're usually pretty healthy. 65 years old now is a pretty healthy patient. 20 years later, they'll be 85 years old. They won't be so healthy. As we start this onslaught of boomers coming into our marketplace, it'll be relatively easy to take care of a lot of ambulatory care, a lot of outpatient care and perhaps a lot of home care. 20 years later, it's a different story. We're going to have aged boomers. They're going to require more intensive care. They're going to probably have relatively less home health care. So as the boomers age, demand for stroke and cardiovascular and other diseases, the elderly will shift patients towards the IRF, the SNFs, if not the LTCHs.

Al (15:46):

One thing that I think is important and we probably don't know how this is going to work out just yet, way in the early days in '83, post-acute care was developed, it was a byproduct of the way we paid hospitals called inpatient prospective payment system. Patients come out of the hospital earlier. They had to go someplace. We essentially developed the post-acute care. As Medicare expands, as more people come into the system, as they age, acute care hospitals may change their models of care to treat more severe patients. They may send the less severe patients to outpatient at PAC [inaudible 00:16:18] because they won't have the capacity to handle everybody in all capacities. This could favor the home health agencies.

Al (16:25):

The supply of home health is highly elastic, that is to say and in answer to your question, can we increase supply, home health with good management and administrative capabilities is able to expand the capacity very quickly to meet increases of demand. Rehab and long-term care hospitals are less so. With SNFs, perhaps somewhere in the middle. We'll probably be able to change the growth of our ability with post-acute care, but we'll have to do it wisely and we'll have to make sure that we have the capacity in place for the elderly, the 85 plus, when they really need the rehabs, the LTCHs and perhaps the SNFs.

Chip (17:03):

Al, thank you so much for this full explanation of post-acute care. And that leads us to the next big question, how do we pay for it? There's a lot of chatter here in Washington about this. We'll discuss those ideas in our next episode. Thanks for joining us, Al. We look forward to continuing this discussion next time on Hospitals In Focus.

Chip (17:29):

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