Discharge with Dignity

For my mom and yours; and for your **bottom-line**

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*CEO. Care taker. Advocate.*

* University of Southern California, Sol Price School of Public Policy
* Founder, National Readmission Prevention Collaborative (2013)
* Founder, National Bundled Payment Collaborative (2015)
* Strategic Advisor/Sr. Health Policy Consultant, Nelson Hardiman Law & Compliagent
Josh Luke, Ph.D., FACHE

- SNF Administrator/AL Executive Director
  - Kindred, Windsor/SNF Management, Life Care Centers of America

- Hospital CEO
  - Memorial Hospital, Western Medical Center Anaheim, Anaheim General

- CEO for Acute Rehab
  - HealthSouth Las Vegas Rehab Hospital

- Vice President Post Acute Services
  - Torrance Memorial Health System
  - Home Health and Hospice
Why I Became A Patient Advocate

Part One: My Story
1998

It Was a Very Good Year
1998 It Was a Very Good Year
The Fee For Service “Free For All”

Provider and physician got paid at every stop:

*Episode–based reimbursement*
Career Change

* My grandmother was ill and being juggled through the system

* Entered AIT program for Life Care Centers of America

* Became a hospital CEO two years later

* * *

* But a lot has changed since then....*
Strategies to Succeed in the New Era

The Generation Gap & Healthcare

When I say jump…

• Greatest Generation
• Baby Boomers
• Gen X
• Millennials
• Gen Zers or “iGens”

The Healthcare workplace and delivery are changing. Are you?
Recommended Reading & Watching on Millennial Impact

* Simon Simonek
  You Tube: Simon Simonek on Millennials in the Workplace

* Maureen A. Bisognano
  New Ways to Lead the Workforce of the Future
  Healthcare Trends & Implications: FutureScan 2017
Understanding Alternative Payment Models

Part Two:
Strategies to Succeed in the New Era
The Transformation of the Acute Hospital:

*Ball Control: Hospital must control all episodes start to finish*

- Coordinating care for improved outcomes:
  - Hospitals must act like health systems
  - Health systems must act like managed care organization
  - Thus, the hospital must act like a managed care organization as well
Financial Incentives to Avoid Unnecessary Hospitalization

* Welcome To The World Of… Admission Prevention

* RAC Audits
* Hospital readmission penalty program
* Accountable Care Organizations
* Bundled Payments
* Medicare Spending Per Beneficiary penalty
* Better, smarter, healthier: In January 2015, HHS announced goal for 30% of Medicare spending in ACO/Bundle by 2016 and 50% by 2018
* Post-Acute Medicare Spending Per Beneficiary penalty: October 2018
It’s an **Insurance Business Model**

*The Insurer is the only bottom line that is being measured*

- Hospitals are no longer profit centers & aren’t intended to be profit centers in value based care

- In fact, hospitals are the largest expense in the new business model

- Health systems practicing Ball Control; manage post acute LOS, do not defer

**Capitalism 101:** The Feds & insurers are not concerned about your businesses success. They need only one provider in each market who can meet their needs at the lowest price available.
What Does This Mean for You?

It’s an **Insurance Business Model**. The Insurer is the only bottom line that is being measured.

- **Hospitals = Last resort**
- **SNF = Second-to-last resort; increase capability to handle medical-surgical level patients**
- **Home health = Networks will be narrowed**
- **Winners = Home care, private duty, and assisted living**
**Options for Direct Transfer from Emergency Department:** Patients with a Medicare benefit can be transferred directly from the Emergency Department to the following levels of care

<table>
<thead>
<tr>
<th>Alternative Level of Care</th>
<th>Pre-Authorization Required?</th>
<th>Doctor's Order Required?</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Observation Floor</td>
<td>No</td>
<td>Yes</td>
<td>High Cost to Hospital; should be last resort</td>
</tr>
<tr>
<td>Physician Office/Urgent Care</td>
<td>No</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Long Term Acute Care (Alt Acute)</td>
<td>No</td>
<td>Yes</td>
<td>New admission criteria makes this process more challenging but still an option if patient meets STACH criteria</td>
</tr>
<tr>
<td>Acute Rehab</td>
<td>No</td>
<td>Yes</td>
<td>Easiest</td>
</tr>
<tr>
<td>Skilled Nursing/Sub-Acute</td>
<td>No**</td>
<td>Yes</td>
<td>** Patients discharged from a hospital or SNF within last 30 calendar days</td>
</tr>
<tr>
<td>Assisted Living/Board &amp; Care</td>
<td>No</td>
<td>No</td>
<td>Cash pay; not a covered benefit; discharge delay</td>
</tr>
<tr>
<td>Home Health</td>
<td>No</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Home Care</td>
<td>No</td>
<td>No</td>
<td>Patient pays; not a Medicare covered benefit but no caps or limits on service</td>
</tr>
<tr>
<td>Hospice or Palliative</td>
<td>No</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Acute Psychiatric Hospital</td>
<td>Yes</td>
<td>Yes</td>
<td>Can vary based state to state</td>
</tr>
</tbody>
</table>
Emerging Trends For Health System Revenue Enhancement

Best Practice Examples

* Health system owned or managed home based services
  - Best Practice: AMADA Senior CARE Dart Program
  - Home health referral only in the home (Fear the LUPA!)
  - Hospitals Buying home care franchises (why buy?)
  - Script to home care first (Patient Choice: Soft steering is educating!)

* Hospitals using Stryker analytics to ensure bundle success

* IDN connectivity: Best Practice: Patient Ping

* Nutritional focus after discharge: Advocate Health and Abbott Nutrition

* Cardiac Bundles: Best practice Sternal Vest

* Remote monitoring: my mom’s safety net by Green Marbles
## Discharge with Dignity™: The Discharge Planners New Role - Adopt a “Home-first” Mentality

### Start from the left side of guide and work your way to the right if a discharge home is not an option

#### The Financial Impact of Post Acute Referral Patterns for hospitals, ACO’s & Bundles

<table>
<thead>
<tr>
<th>Degree of Financial and Quality Penalty to Discharging Hospital</th>
<th>Home Care / Private Duty</th>
<th>Assisted Living</th>
<th>Transitional Care Visit</th>
<th>Chronic Care Management</th>
<th>Home Health</th>
<th>Palliative Care</th>
<th>SNF</th>
<th>Acute Rehab</th>
<th>LTACH</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Start Here</strong></td>
<td>None</td>
<td>None</td>
<td>Negligible (its less than 10% of the cost of home health – and it covers 30 days as opposed to 6-8 weeks for HH)</td>
<td>Negligible</td>
<td>Nominal (should rarely be ordered in acute OR SNF setting; send Dr./NP to the home for Transitional Care visit to assess need for HH)</td>
<td>None NA</td>
<td>Moderate</td>
<td>Severe (only for specialized needs that can’t be met at a SNF)</td>
<td>Severe (LTACH is truly specialized acute care, not post acute care)</td>
</tr>
</tbody>
</table>

<table>
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<tr>
<th>Discharge Level</th>
<th>FO</th>
<th>FOADH</th>
<th>AHD</th>
<th>ADWCD</th>
<th>ASN</th>
<th>LR</th>
<th>A</th>
<th>A</th>
</tr>
</thead>
</table>

| Patient Financial Responsibility | $ | $$ | Nominal | Nominal | Nominal | NA | 20% after 20 days | Varies | Varies |

**FO** – First Option and consideration for all patients
**FOADH** – First Option After Discharge Home; Assisted Living can cause delays in hospital discharge; engage AL before discharge

**AHD** – (Order for) All Home Discharges
**ASN** – Consider as alternative to SNF if skilled need & Home Care not an option
**ADWCD** – (Order for) All Discharges with Chronic Diseases

**LR** – Last Resort if skilled need (if patient is unsafe to go home with resources)

**Source:** Dr. Josh Luke, [www.JoshLuke.org](http://www.JoshLuke.org). For permission to use or re-print, please email lukej@usc.edu
Post-Acute Opportunities & Expectations

* Tools to Implement in facility:
  > POLST, SBAR, Stop & Watch
  > Return to acute log (emergency department) & root cause analysis

* SNF’s skipping home health on discharge to offer non-medical home care
  > Post Acute Medicare Spending Per Beneficiary (Recommended)
  > Cedars Sinai & St. Josephs investing in Home Care; AMADA partnerships, etc.

* SNF’s MUST align with hospital based home health and home care
  > Align with health system owned home health or narrow to 1-3 home health providers
  > Joint venture with non-medical home care

* Outreach to all referral sources with data and consistently on the 15th each month
My Greatest Credential?

Going **Purple** for My Mom.

Raising $20,000 in 2016 to Fight **Alzheimer’s Disease**!

**Values**

- Passion
- Empathy
- Fight
- Use your gifts
- Legacy

#ForMyMom&Yours
Thank you!

Contact me:

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Dr. Josh Luke
- “The Voice of American Healthcare”
- International Healthcare Futurist
- CEO. Caretaker. Advocate.

#ForMyMom&Yours