Discharge with Dignity

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

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Healthcare Futurist
CEO. Care taker. Advocate.

* University of Southern California, Sol Price School of Public Policy
* Founder, National Readmission Prevention Collaborative
* Strategic Advisor/Sr. Health Policy Consultant, Nelson Hardiman Law & Compliagent

While you are silencing your phone, let’s connect on LinkedIn!
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
The Fee For Service “Free For All”

No Accountability. No checks and balances.

Provider & doctor got paid at each stop
Episode–based reimbursement
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
- Proposed Medicare Spending Per Beneficiary post-acute penalty
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.
### 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**
### 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>Start Here</td>
<td>None</td>
<td>None</td>
<td>Negligible</td>
<td>Negligible</td>
<td>Nominal</td>
<td>None NA</td>
<td>Moderate</td>
<td>Severe</td>
<td>Severe</td>
</tr>
</tbody>
</table>

- **None**: None
- **None**: None
- **Negligible**: (its less than 10% of the cost of home health – and it covers 30 days as opposed to 6-8 weeks for HH)
- **Negligible**: None
- **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)
- **None**: None
- **Moderate**: None
- **Severe**: None
- **(LTACH is truly specialized acute care, not post acute care)**

<table>
<thead>
<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>

- **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
- **ADWCD**: (Order for) All Discharges with Chronic Diseases
- **ASN**: Consider as alternative to SNF if skilled need & Home Care not an option
- **LR**: Last Resort if skilled need (if patient is unsafe to go home with resources)

<table>
<thead>
<tr>
<th>Patient Financial Responsibility</th>
<th>$</th>
<th>$</th>
<th>Nominal</th>
<th>Nominal</th>
<th>Nominal</th>
<th>NA</th>
<th>20% after 20 days</th>
<th>Varies</th>
<th>Varies</th>
</tr>
</thead>
</table>

- **$**: Nominal
- **$: Nominal
- **Nominal**: Nominal
- **Nominal**: Nominal
- **Nominal**: NA
- **20% after 20 days**: 20% after 20 days
- **Varies**: Varies
- **Varies**: Varies

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A – Avoid unless specialized need; requires physician advisors approval

FO – First Option and consideration for all patients

AHD – (Order for) All Home Discharges

FOADH – First Option After Discharge Home; Assisted Living can cause delays in hospital discharge; engage AL before discharge

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

ASN – Consider as alternative to SNF if skilled need & Home Care not an option

ADWCD – (Order for) All Discharges with Chronic Diseases

Thank you!

Contact me:

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#ForMyMom&Yours