Post-Acute Care Virtual Summit

May 5-6, 2020

NATIONAL RURAL HEALTH RESOURCE CENTER

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Introduction

The National Rural Health Resource Center (The Center) convened a virtual summit of key stakeholders during May 2020 to examine the current state of post-acute care (PAC) in rural America. The COVID-19 pandemic has brought PAC/long-term care (LTC) into the national spotlight, as a significant percentage of pandemic deaths in the U.S. are occurring in LTC and skilled nursing facilities (SNFs). Summit attendees explored issues, challenges, and strategies related to the integration of rural acute and PAC and considered how rural PAC can be successfully included in a population health and value-payment future.

Executive Summary

Over the course of the two-day summit, participants engaged in a wide-ranging discussion about current and often longstanding PAC-focused issues and challenges confronting health care organizations and communities across the U.S. In particular, the breakout sessions focused on four major topics, identifying both issues and potential strategies and tactical solutions to address those issues. The four topics included:

- Payment
- Community care coordination
- Workforce
- Hospital coordination and post-acute care

Common PAC challenges addressed across the four breakout sessions included the:

- Impact of the shifting payment environment from traditional volume-driven fee-for-service and cost-based reimbursement methods to value-based payment arrangements
- Need to improve access to PAC care and services
- Evolving role of technology, particularly the rapid expansion of telehealth in response to the COVID-19 pandemic
- PAC workforce challenges and opportunities
- Importance of addressing social determinants of health.

As enumerated above, Summit participants identified many potential approaches and solutions to build and strengthen hospital-PAC coordination and integration and community care coordination structures and processes.

In an excellent summation of the participants' overall concerns and recommendations throughout the Summit, one Summit participant noted "All rural

hospitals and health systems have fixed levels of resources. Very few, if any, have the resources to address all the immediate needs of their communities. As reimbursement rules evolve and our rural providers transition to value-based payment models, the development of acute care coordination strategies by rural hospitals is necessary to effectively use scarce local resources. Coordination with PAC providers makes sense for patients as well as for the financial functioning of rural systems of care. Care coordination strategies between rural hospitals and PAC providers include efforts to improve the sharing of clinical information between providers, development of standardized care plans, management of patient transitions, and aligning financial incentives."

This report provides a background on PAC, the Summit participants, process used at the Summit, comprehensive lists of identified strategies and tactics to address high priority rural PAC issues, a discussion on how state Flex Programs can help rural providers address PAC, and a collection of PAC best practices from the field.

Summit Objectives

Summit objectives included the following:

- Identify problems and issues related to rural PAC and aging services, particularly regarding coordination with rural hospitals.
- Identify strategies to improve the coordination of care between rural hospitals and the various PAC services.
- Identify opportunities for rural hospitals to take on new health care roles and responsibilities for the care of older rural citizens.
- Identify potential topics for future research in rural PAC.
- Identify opportunities for state Flex Programs to play in improving rural PAC as part of an overall population health goal.
- Identify models and resources for rural hospitals and Flex Programs to use in improving PAC, as well as improving care coordination across the continuum of community health and social services.

Summit Process

The Summit included an online questionnaire for participants to complete via SurveyMonkey plus two two-hour virtual sessions. Participants were divided into two breakout groups for a portion of each session to do a deeper dive into four selected PAC-focused topics: hospital coordination, community care coordination, payment, and workforce. Over the course of the two days, attendees identified multiple issues and improvement opportunities related to the four primary topics.

The group also discussed a range of potential strategies and tactical actions that could be deployed to address the identified issues.

The two virtual sessions were followed by another virtual meeting approximately six weeks later to review and comment on the draft Summit report. This Summit report is available as a resource for future presentations and training programs for rural providers.

Summit Participants

- Anna Loengard, Caravan Health
- Alana Knudson, Walsh Center for Rural Health Analysis at NORC
- Bill Jolley, Tennessee Hospital Association
- Janelle Shearer, Stratis Health
- John Gale, University of Southern Maine
- Kathryn Miller, Wisconsin Office of Rural Health
- Kevin Stephan, Nod Specialists
- Lannette Fetzer, Pennsylvania Office of Rural Health
- Louise Bryde, Stroudwater Associates
- Pat Justis, Washington State Office of Rural Health
- Pat Schou, Illinois Critical Access Hospital Network (ICAHN)
- Ralph Llewellyn, Eide Bailly
- Roxanne Jenkins, Lutheran Social Service of Minnesota
- Stephen Njenga, Missouri Hospital Association
- Jemima Drake, Mike McNeely, and Tori Leach, Federal Office of Rural Health Policy

Summit Facilitators

- Terry Hill, Executive Director, Rural Health Innovations;
  Senior Advisor for Rural Health Leadership and Policy, The Center
- Caleb Siem, Program Specialist, The Center

Background: Why Focus on Post-Acute Care?

The percentage of seniors in the world's population is growing. According to U.S. News and World Report, the United Nations predicts that one out of every six people globally will be over the age of 65 by the year 2050. In the U.S., that ratio is expected to be more than one in five, driven by an aging Baby Boomer population and advances in medicine and technology that help people live longer. About 16% of the U.S. population was 65 years old or older in 2018, according to annual mid-year population estimates from the U.S. Census Bureau[1]. The median age of America continues to rise - from 37.2 years in 2010 to 38.2 in 2018. The Census Bureau predicts that seniors will outnumber children by the year 2035.

The impact of an aging population has greater ramifications for some states than for others. The percentage of older adults in the population varies considerably state by state, ranging from greater than 20% aged 65 years and above in Maine and Florida to a low of 11% in Utah.[2]

The aging population directly impacts demands on the health care delivery system, particularly due to the high incidence of chronic diseases, injury/falls risk, and behavioral health conditions in this population. Health systems, accountable care organizations (ACOs), and health plans have increasingly recognized the importance of post-acute care (PAC) as a key component of their organization's care continuum, particularly as payers move to value-based payment methodologies. Hospital readmission penalties, episode of care/bundled payment arrangements, and global payment models all necessitate a careful evaluation of the cost and quality of PAC services for health care organizations operating in a value-based payment environment.

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[1]U.S. Census Bureau. *American Community Survey*. 2018. https://data.census.gov/cedsci/table?q=About%2016%25%20of%20the%20U.S.%20population%20was%2065%20years%20old%20or%20older%20in%202018&tid=ACSDP1Y2018.DP05&hidePreview=false

[2] McPhillips, Deidre. *Aging in America, in 5 Charts.* May 2019. https://www.usnews.com/news/best-states/articles/2019-09-30/aging-in-america-in-5-charts

The Center for Medicare & Medicaid Services (CMS) recognizes and defines four Medicare PAC sectors/settings of care:

Medicare PAC Sector/Setting	Facility/Patient Eligibility
Inpatient Rehabilitation Facility (IRF)	• Patient needs hospital level of care and intensive rehabilitation
Long-Term Care Hospital (LTCH)	• Acute Inpatient Hospital level of care needed ○ Average length of stay >25 days
Skilled Nursing Facility (SNF)	• Patient needs short-term skilled care (nursing or rehab) following inpatient hospital stay of at least three days
Home Health Agency	• Patient is generally homebound and needs intermittent skilled care (nursing, physical/occupational therapy (PT/OT), speech, medical social work, or home health aide services)

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In addition to these four Medicare-recognized PAC sectors/settings, many small rural hospitals offer Medicare-covered Swing Bed Services. As defined in the regulations, a swing bed hospital is a hospital or critical access hospital (CAH) participating in Medicare that has CMS approval to provide post-hospital SNF level of care and meets certain requirements. Medicare Part A covers post-hospital extended care services furnished in a swing bed hospital.[3]

Hospitals and CAHs approved to provide swing bed services may use their beds for either acute care or post-hospital SNF level of care. To obtain and retain swing bed approval, hospitals must be in a rural area and have fewer than 100 beds, excluding beds for newborns and intensive-care-type units. CAHs must comply with (42 C.F.R. § 485.645(d)(1–9)) SNF participation requirements. Approximately 1,180 CAHs (88%) provide swing bed services across the U.S. Swing bed services provided in rural prospective payment system (PPS) hospitals are paid for under SNF PPS, while CAHs receive cost-based reimbursement.[4]

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[3] www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/SwingBed Accessed 7-16-2020

[4] "Measuring Outcomes for CAH Swing Bed Patients: Results of a Field Test and Comparison with SNF Patient Outcomes"; Ira Moscovice PhD, Tongtan Chantarat MPH, Michelle Casey

Availability of rural PPS hospital and CAH swing bed services increases Medicare beneficiary access to post-acute SNF care within or near their local community. Swing bed services are also an increasingly important source of inpatient revenue for CAH hospitals, providing an opportunity for increased inpatient average daily census on a sustained basis.

Fee-for-service Medicare requires a three-day qualifying inpatient hospital or stay prior to admitting a beneficiary to a swing bed in any hospital or CAH, or before admission to a SNF. The Medicare beneficiary's swing bed stay must be within the same spell of illness as the qualifying stay.[5]

In 2016, 57 million Americans were covered by Medicare, with 68% in fee-for-service (FFS) and 32% in a Medicare Advantage Plan.[6] A significant portion of health care is delivered in post-acute settings of care, particularly to older adults. Approximately 43% of Medicare FFS patients discharged from an acute care hospital were discharged to PAC in 2016.[7]

A widely quoted report by the Institute of Medicine in 2013 identified PAC as the source of 73% of the variation in health care spending, significantly increasing attention to the cost and quality of PAC services nationally[8]. Further, the September 2017 Medicare Payment Advisory Commission (MedPAC) report to Congress found that PAC had the greatest cost variation among all sectors when compared to acute care and ambulatory care[9].

MS; University of Minnesota Rural Health Research Center, University of Minnesota; December 2019.

[5] (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/SwingBedFactsheet.pdf)

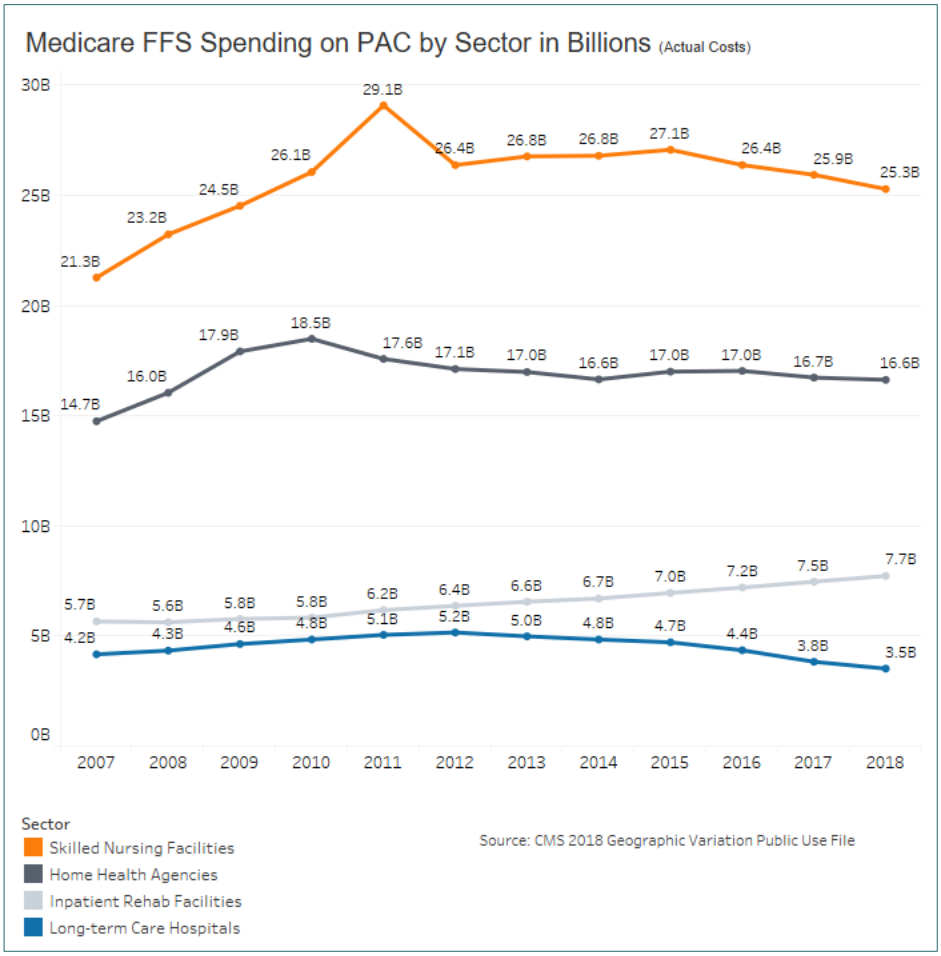
[6] CMS Medicare Beneficiaries at a Glance: Who's Covered by Medicare - 2016

[7] Medicare Payment Advisory Commission- MedPAC Report to Congress: Medicare and the Health Care Delivery System; June 2019; page 273

[8] Institute of Medicine. 2013. Variation in Health Care Spending: Target Decision Making, Not Geography. Washington, DC: The National Academies Press. https://doi.org/10.17226/18393.

[9] MedPAC Report to the Congress: Regional variation in Medicare Part A, Part B, and Part D Spending and Service Use. September 2017.

PAC also represents a significant component of total cost of care. Between 2007 and 2018, Medicare payments to PAC providers rose to just over $53 billion in 2018, as shown in the adjacent graph. This reflects a 15.7% increase in spending over that eleven-year period. Skilled nursing facility expenditures are consistently the highest cost PAC sector, representing nearly 48% of all PAC FFS Medicare expenditures in 2018.



The four Medicare-recognized PAC provider sectors identified above can treat similar types of patients and offer a wide range of skilled nursing and rehabilitation services. However, regulatory requirements vary significantly across the four sectors/settings of care. Medicare FFS payments also can vary substantially across the four sectors, because CMS uses separate prospective payment systems to pay for care in each sector/setting. These variations have made it difficult to compare quality and cost across the four sectors. Likewise, lack of CAH swing bed quality data has made it difficult to evaluate and compare quality outcomes across CAH swing-bed programs and to evaluate CAH swing-bed programs in comparison to SNFs.

To address longstanding concerns regarding PAC cost and quality, the **Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014** required MedPAC to consider and report on development of a unified payment system for PAC providers. In addition, the IMPACT Act mandated the collection of uniform patient assessment information and development and reporting of common quality measures across the four Medicare PAC sectors; the swing bed program was not

included in these requirements. Since their initial report in 2016, the MedPAC Commission has continued to examine various options and issues related to these IMPACT Act requirements.[10]

During 2019, CMS performed field testing of a variety of standardized assessment data elements, with the goal of identifying the best, most feasible elements for standardization to meet IMPACT Act requirements. Multiple new standardized assessment elements are slated to go into effect January 1, 2021.[11] (See Appendix A for additional resources regarding the IMPACT Act).

For the past several years, CMS has paid particular attention to cost and quality in the SNF sector. In July 2018, CMS finalized a new case-mix classification model, the **Patient Driven Payment Model (PDPM).** Effective October 1, 2019, PDPM is now used under the SNF PPS to classify SNF patients in a covered Medicare Part A stay into payment groups, replacing the previous RUG-IV payment methodology. Consistent with CMS's overall goal to continue moving from volume-based to value-based reimbursement for Medicare covered services, the new case-mix methodology uses "clinically relevant factors" rather than volume of services to determine SNF Medicare payments.[12]

The new model includes five case-mix adjusted rate components: the PT and OT case-mix groups, the Speech-Language Pathology case-mix group, the Nursing case-mix group, and the Non-Therapy Ancillary case-mix group.[13]

In addition to PDPM, CMS implemented a **SNF Value-Based Purchasing (VBP) Program** in October 2018, initially focused on reducing hospital readmissions. The SNF VBP Program uses the Skilled Nursing Facilities Readmission Measure (SNFRM), which calculates the risk-standardized rate of unplanned, all-cause inpatient hospital readmissions within 30 days of a SNF patient's discharge from a prior hospital stay. SNFs receive an annual incentive payment based on their performance on the readmission measure. Underperforming SNFs receive a Medicare payment rate *lower* than they would otherwise have received without the SNF Value-Based Purchasing Program. For the first time, SNF reimbursement is

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[10] MedPAC Report to Congress; June 2019; page 277
[11] https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/IMPACT-Act-of-2014/IMPACT-Act-of-2014-Data-Standardization-and-Cross-Setting-Measures
[12] CMS Patient Driven Payment Model: Frequently Asked Questions; revised 2-14-19
[13] MLN Matters- Implementation of the Skilled Nursing Facility (SNF) Patient Driven Payment Model (PDPM); revised 3-14-19

beginning to align with hospital and payer goals to reduce avoidable hospital readmissions, potentially reducing total cost of care and improving quality.

As required by statute, CMS withholds 2% of SNFs' fee-for-service (FFS) Part A Medicare payments to fund the program. This 2% is referred to as the "withhold." CMS redistributes 60% of the withhold to SNFs as incentive payments.[14]

Lastly, the **COVID-19 pandemic** has impacted SNFs and assisted living facilities, resulting in high levels of infection, hospitalizations, and deaths of residents in those settings of care across the U.S. The Kaiser Family Foundation estimated that nursing homes and assisted living facilities accounted for 41% of COVID-19 deaths in the U.S., with some states reporting up to 80% of total COVID-19 deaths.[15] As a result, in mid-May 2020, CMS directed nursing homes to begin notifying residents and their responsible parties about COVID-19 infections and required the facilities to begin reporting data weekly to the Centers for Disease Control and Prevention (CDC), including the number of suspected and confirmed COVID-19 infections and deaths among residents and staff. Infection control methods and practices will continue to be closely scrutinized in these settings of care.

CMS announced the formation of a new Independent Commission in April 2020, that will conduct a comprehensive assessment of the response by nursing homes to the COVID-19 pandemic. Per CMS Administrator Seema Verma, the Independent Commission is "to provide recommendations to further enhance efforts at the federal, state, and local level and help strengthen the Nation's response to coronavirus and keeping residents safe in nursing homes." Members of the Commission were announced in mid-June 2020, with the goal to begin meeting immediately and to complete their report of findings by September 2020.[16]

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[14] https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/SNF-VBP/SNF-VBP-Page
[15] "Feds Cull COVID-19 Data for Deaths in Senior Care," *The Atlanta Journal-Constitution*; May 18, 2020:A3.
[16] (www.cms.gov/newsroom/press-releases/cms-announces-independent-commission-address-safety-and-quality).

Summit Discussion

Summit Questionnaire Results

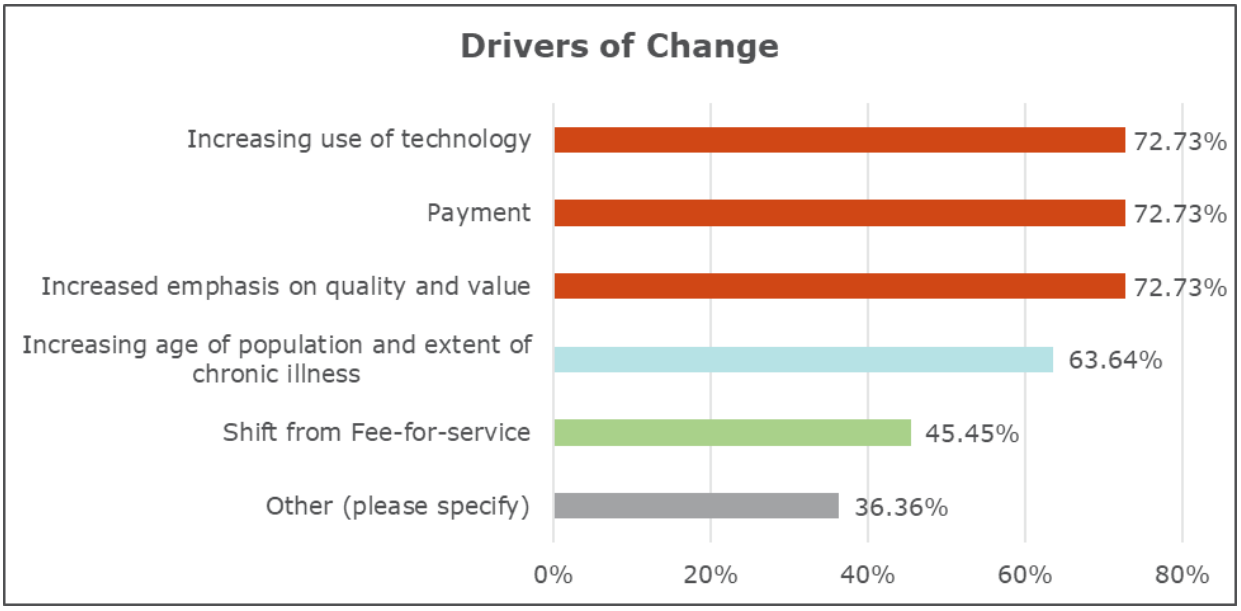
During the Summit, participants reviewed several of the Summit Questionnaire responses, focusing on the following four questions and individual responses. (See Appendix A for the full Summit Questionnaire and Responses.)

Q3. As we look ten years out to 2030, given what you know about the current payment, technology, care management and service delivery trends, what will post-acute care and aging services look like? In a sentence apiece, describe five ways these services and care delivery processes will be different than they are today?

Common themes among responses to this question include:

Q4. Given the trends above in the previous question, what are five important forces driving this change? In other words, what are the drivers of change? Choose all that apply.

Answer choices	Responses	
Increasing use of technology	72.73%	8
Payment	72.73%	8
Increased emphasis on quality and value	72.73%	8
Increasing age of population and extent of chronic illness	63.64%	7
Shift from Fee-for-service	45.45%	5
Other (please specify)	36.36%	4
Total Respondents: 11		

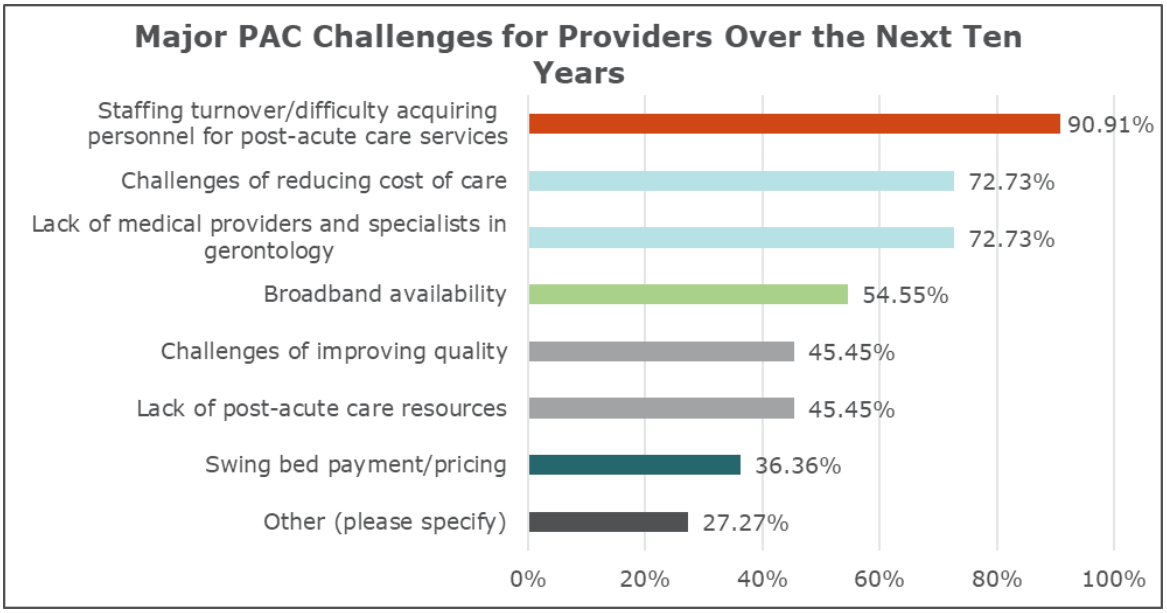


Other Summit Questionnaire responses:

- Limitations of health care and health care providers in rural communities.
- Recognition that we cannot sustain the current model—more cost-effective ways to deliver health and supportive services (not just health care!) will emerge. There will be no going back to business as usual post-COVID-19.
- Consumer demand for continuity of services.
- These are all interrelated but will be driven as all things are by payment. Hopefully, Baby Boomers will demand new models and approaches. And COVID-19 will show us things can be done differently - virtual care and less care - may be the best result of this pandemic.

Q5. As we look to the next ten years, what will be five major challenges rural post-acute care and aging service providers will face? Choose all that apply.

Answer choices	Responses	
Staffing turnover/difficulty acquiring personnel for post-acute care services	90.91%	10
Challenges of reducing cost of care	72.73%	8
Lack of medical providers and specialists in gerontology	72.73%	8
Broadband availability	54.55%	6
Challenges of improving quality	45.45%	5
Lack of post-acute care resources	45.45%	5
Swing bed payment/pricing	36.36%	4
Other (please specify)	27.27%	3
Total Respondents: 11		



Other Summit Questionnaire responses:

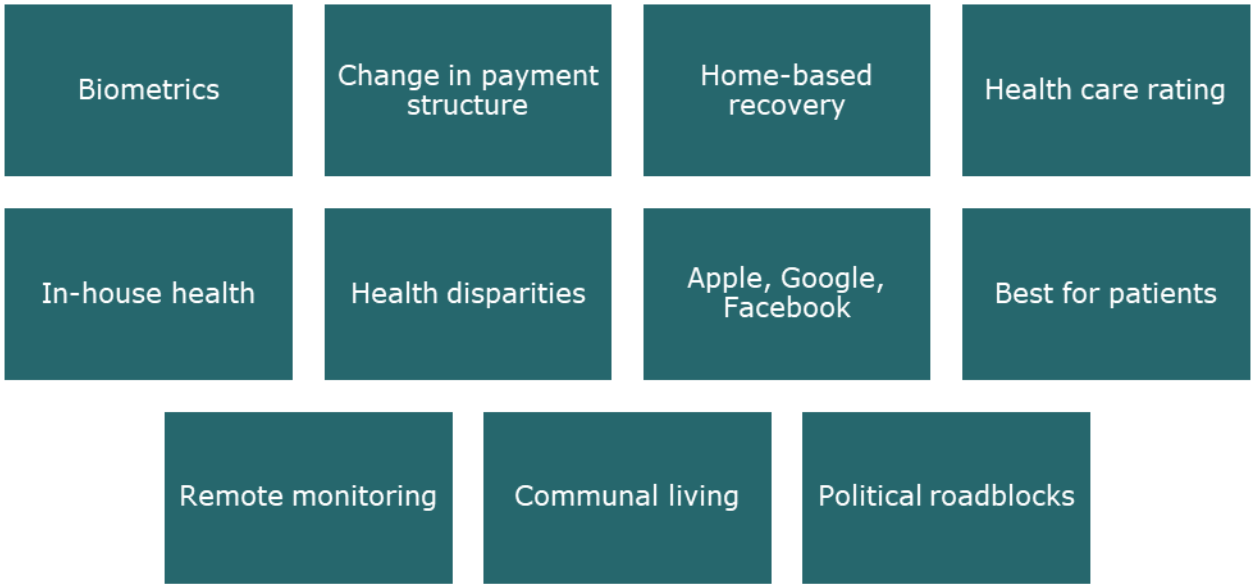
- The social determinants of health have not been adequately addressed to support PAC and aging services. Rural older adults need access to safe, affordable housing, transportation, and nutrition. Six month waiting lists for Meals on Wheels in rural communities should not be acceptable. Rural older

adults also do not have adequate personal financial resources to cover costs of care that fall outside of Medicare. There is a serious lack of health literacy regarding how post-acute and aging services are paid. Medicaid budgets are bursting now; what is going to happen when many of today's Baby Boomers are going to need Medicaid to support their care? States will not be able to sustain these programs.

- Lack of relationships between long-term and acute care providers with home and community-based providers.
- Transportation- not enough options in rural.
- Not only is there a lot of staff turnover in PAC, the pay is incredibly nominal and unfair.
- Exorbitant health care costs.

Q6. What "disruptive" forces (ex. Amazon, CVS and other non-traditional providers) might alter the current trends and challenges you previously noted?

Questionnaire Responses:



Top Priorities for a Deeper Dive

Following review of the Summit questionnaire, participants selected four high priority rural PAC issues to further address in breakout sessions.

- Payment
- Community Care Coordination
- Workforce
- Hospital Coordination

Payment

The payment breakout session identified reimbursement issues as an important driver that will change the way LTC is provided and will overcome obstacles for PAC in rural America. The group envisioned seeing hospitals share payment with PAC; while at the same time, PAC might be under more scrutiny for value, price transparency, etc. The group also considered the issue of health literacy. For example, people do not know what they are responsible for and lack understanding about SNF care. Below are the nine strategies and tactics the group identified to address payment issues for PAC. See Appendix B to review the full notes from this breakout session.

Strategies and Tactics to Address Payment Issues

The payment breakout group then identified several priority strategies and tactics to address current PAC issues and concerns:

1. Look to rebuild the U.S. payment system to truly reflect the Triple Aim, particularly better patient care and better value. (Provider side: Helping providers understand how this benefits them in the long-term and how they can use this from patient/financial perspective).
2. Improve payment for long term care but make it based on value (including workforce, as well as better dialogue about what this means and funding long-term care over time, i.e., Medicaid payments).
3. Pay for the use of technology to serve patients in LTC settings, but also pay for the use of technology to keep people out of institutional care and in their homes for as long as possible. (Use alternative providers in this area, including home caregiver services).
4. Continue funding what is working now in the COVID-19 pandemic with regards to PAC/LTC.

5. Incorporate addressing social determinants of health into payments. For example, allow payments for transportation and housing as part of value-based models.
6. Work out relationships between hospitals, clinics, and assisted living facilities (for temporary care) and build it into the payment system. For example, use assisted living beds as a temporary hotel-type of situation during the COVID-19 pandemic.
7. Provide funding to pay for chronic disease management in nursing homes and assisted living facilities.
8. Use expanded funding for broadband capacity to enhance the use of video and other technical capabilities in LTC settings for both treatment and staff education.
9. Ensure swing bed quality and length of stay results are comparable to or better than the results for SNFs in the rural hospital's service area. Cost per day of swing beds is much higher than cost per day of SNFs. Seek to create greater value for both the patient and the payer, which can create a competitive advantage for the hospital. Incorporate payment calculations that reflect more complex care. Provide a better story about the value of swing beds to demonstrate why cost is different. Collect and report data.
    - See Appendix B for full breakout notes including additional information on two studies were conducted in Illinois and Minnesota in 2018-2019, which compared outcomes for SNFs versus swing bed programs.
10. Incorporate value-based features for PAC and LTC into state Medicaid budgets.
11. Improve payments for rural hospice and home health services, to reflect the far greater geographic travel distances for rural providers.
12. Require post-hospital discharge calls for all patients going to nursing homes within five days and then 35 days to help reduce avoidable Emergency Department (ED) visits and hospital readmissions.

Community Care Coordination

Summit participants were interested in further examining working relationships between community hospitals and other organizations in their communities, including the potential impact on patient care services and care delivery resulting from poor coordination of care across the continuum. Summit participants also identified opportunities to strengthen and improve community care coordination to meet the needs of patients and communities. See Appendix C to review the full notes from this breakout session.

Strategies and Tactics to Address Community Care Coordination Issues

The community care coordination breakout group identified several strategies and tactics to address concerns regarding ineffective community care coordination. The focus was on bring community organization together.

1. Consider forming a Rural Coalition/Network
    - The hospitals could serve as a catalyst or host of this coalition, or the state Flex Program could serve as the host. The coalition would need to consider co-leadership roles and responsibilities with key stakeholders, establish an agreed upon purpose, and prioritize mutually agreed goals and objectives.
2. Identify and address priority health needs of the community.
3. Develop a coalition marketing strategy and enhance marketing of available services and resources in the community.
4. Develop an agreed upon coalition action plan relevant to different organizations within the community.
5. Develop a methodology to collect and analyze available data from coalition stakeholders, including increasing the focus on social determinants of health
6. Create a community profile with secondary data about different sub-populations the coalition may want to target.
7. Assess health literacy of the population(s) served and develop educational outreach campaigns.
8. Create a health care/social services community resource guide.
9. Conduct group assessments/focus groups or convene a patient council to seek and quantify community input.
    - Include the element of person-centered care
10. Help rural ACOs tackle their skilled nursing care costs.

Workforce

Summit participants quickly identified workforce issues as a major ongoing challenge impacting PAC, particularly chronically high employee turnover rates experienced by many PAC entities. Per the Summit questionnaire, more than 90% of the respondents (10/11) identified staffing turnover and difficulty recruiting and hiring employees as one of the top five challenges facing the PAC industry. Seventy-two percent of participants (8/11) identified lack of medical providers and gerontology specialists as one of the top five challenges. See Appendix D to review the full notes from this breakout session.

Strategies and Tactics to Address Workforce Issues

1. Cross train and build public health skills such as contact tracing.
2. Incorporate more efficient architectural design.
3. Develop new strategies to increase supply of nurses and nursing assistants.
4. Invest in staff and provide a "pathway for growth" type program. The reduction in turnover will more than pay for costs of investment in staff education and development and maximize the efficiency of the current workforce. By looking at the analysis of staffing patterns, we can see extreme variations of waste. Create career "pathways to growth"—how you leverage money and education by creating career pathways to invite a greater number of people to enter the workforce and to have them grow into higher positions/stay longer.
    - This encourages career paths for growth, increases longevity of employment and retention, which supports longer and stronger relationships with patients and caregivers
    - Investment pays off in less turnover
    - See example of an employee pathway in the Appendix A at end of this report
5. Use telehealth to ensure that adequate access to gerontologists, mental health providers, infectious disease specialists, etc.
6. Enable broader scope of practice for providers.
7. Support policies for reimbursement or workforce service provisions through telehealth.

Hospital Coordination

The hospital coordination breakout group identified multiple factors for consideration, including that hospitals often hurry to discharge the patient, a lack of communication tools that work, electronic medical records (EMRs) not working together, inconsistent reporting and expectations, low physician engagement, and inconsistent or incomplete medication reconciliation. In many communities, there is a need for more PAC services and an understanding of the hospital's role in PAC. Over time, cost reporting has created incentives for hospitals to move out of post-acute services, i.e., home care.

Hospital coordination has not been a major focus because it "has not been added to our job descriptions". Hospitals may have not bridged the communication gaps and adapted tools. Hospitals need interoperability and to find ways to drive PAC financially. See Appendix E to review the full notes from this breakout session.

Strategies and Tactics to Address Hospital Coordination Issues

1. Improve communication to help providers across the continuum share information and maximize resources that are already available.
2. Increase utilization of telehealth. Review data and utilize technology to build tele-communication systems between hospitals and PAC.
3. Increase the use of Nurse Practitioners.
4. Incorporate PAC into the Flex Program strategies; provide more grant opportunities.
5. Initiate the conversation with the hospital community and patients about anticipated changes and what the future might look like.
6. Identify hospital-based physicians to become Medical Directors of SNFs to facilitate increased communication, coordination of care, and quality of care across the two settings
    a. Collaborate with providers to develop and implement clinical pathways
7. Identify and adopt common performance metrics that can be reviewed frequently to help drive better clinical outcomes and quality improvements across hospital and PAC settings.
8. Integrate mental health and primary care.
9. Utilize care management codes that are not being used. Help providers understand the opportunities to generate/recover revenue.
10. Use data to identify PAC utilization in the area and performance. Develop preferred PAC provider networks. Select best PAC setting for patient's needs.
11. Conduct post-hospital discharge calls to nursing home patients or patients who have gone home, especially for patients with congestive heart failure (CHF) and chronic obstructive pulmonary disease (COPD).
12. Identify PAC services covered by commercial carriers and explore how rural hospitals can become a place of preference. Consider doing hospital outreach to commercial carriers and tertiary care centers, so patients are given opportunity to return to local rural swing bed facilities for their PAC.

Additional Discussion

Flex Programs—How can Flex Programs help rural providers?

The Medicare Rural Hospital Flexibility Program, or Flex Program, was established by the Balanced Budget Act (BBA) of 1997. The Flex Program created critical access hospitals (CAHs) as a Medicare provider type. CAH designation allows hospitals to be reimbursed on a reasonable cost basis for inpatient and outpatient services including lab and qualifying ambulance services that are provided to Medicare patients and, in some states, Medicaid patients. The Flex Program provides funding to state governments or other designated entities to support CAHs in: quality

improvement, quality reporting, performance improvements and benchmarking, designating facilities as CAHs, population health, and the provision of rural emergency medical services (EMS). Example strategies for CAHs and Flex programs include:

- Hospitals applying surgical navigator practices to skilled care
- Demonstrate and provide examples of palliative care benefits
- Encourage/invite PAC to community meetings
    - Community Health Needs Assessment meetings
    - Patient and family advisory council meetings
- Encourage PAC to attend state rural health partner events
- Support the development of multi-disciplinary, communitywide approaches to care coordination across the continuum of care
- Develop programs and services to ensure care coordination strategies between rural hospitals and PAC providers include efforts to improve the sharing of clinical information between providers, development of standardized care plans, management of patient transitions, and aligning financial incentives
- Support development, tracking, and consistent back and forth sharing of quality measures between hospitals and PAC settings

Best Practices from the Field

Proactive, data-driven Care Management activities and functions and implementation of Care Coordinator/Care Manager roles have emerged as important strategies. These strategies help manage the health of populations, particularly high-risk populations such as frail elderly individuals and individuals with multiple chronic conditions. Below are best practice examples provided by the summit participants. "Rural Post-Acute Care: Improving Transitions to Enhance Patient Recovery," is another great resource for rural PAC best practices.[17]

[17] Lukens, Jenn. "Rural Post-Acute Care: Improving Transitions to Enhance Patient Recovery." Rural Health Information Hub. May 2018. https://www.ruralhealthinfo.org/rural-monitor/post-acute-care-transitions/

Successful Care Coordination Examples

A rural ACO CEO Summit participant shared an example of the positive impact of a Care Coordinator who addressed underlying needs of an individual with a history of high ED utilization:

"A Care Coordinator has been working with a 94-year-old patient who had been in the EDR 38 times in one year. The patient was taken by ambulance to the ED closer to her home and the Care Coordinator was not getting the reports, therefore did not know the patient had so many ED visits until reviewing an electronic health record (EHR) report of frequent ED utilization. The Care Coordinator worked with the patient and her niece to get help in the home, meal delivery, and had the patient call the Care Coordinator prior to calling an ambulance. The Patient's ED visits have reduced to only necessary visits (three visits over the past 6 months)."

Closing thoughts from another Summit participant provide an excellent example of a successful multi-disciplinary, communitywide approach to care coordination across the continuum of care:

"The State of Vermont, through its Green Mountain Care Board's Rural Health Services Task Force, has emphasized the importance of care coordination for rural providers and highlighted the efforts of Southwestern Vermont Medical Center, Northwestern Counseling and Support Services, Brattleboro Memorial Hospital, and UVM Health Network Home Health & Hospice (UVMHH) as successful examples of care coordination. Brattleboro Memorial, for example, provides a medical director to nursing homes for LTC patients and sub-acute rehabilitation patients in need of skilled nursing. It recently expanded these efforts to assisted living facilities. UVMHH enrolls patients with complex acute catastrophic conditions in their services when they are discharged from Medicare-eligible skilled home health services. These patients receive nursing, community health worker visits, and tele-monitoring services to manage their conditions and transfers to other settings."

Delivering Whole-Person Care

"Managing post-acute care is critical to the successful recovery of patients and necessary for the financial benefit of accountable care organizations and controlling health care costs. No longer can health professionals ignore PAC and apply a band aid approach to patient injury, condition or illness. Rather, health professionals must care for the whole person, setting, family and how to help the patient achieve optimal health. Chronic care management, comprehensive discharge planning and instructions and follow-up calls can help prevent a return to the ED, hospital, or skilled facility. Most often, it is simple things like medication management or follow-up in the nursing home that make a difference and save an expensive health care cost. We can do better!" (CEO, Rural ACO)

Enhanced Medical Management

In recent years, many hospital systems, ACOs, and health plans across the U.S. have developed and implemented a "SNFist" model, which is similar to the inpatient Hospitalist model. Studies have shown that implementing an onsite medical management model, which teams regularly scheduled onsite SNF physicians (SNFists) with Nurse Practitioners/Physician Assistants and RN Care Managers, can lead to improved clinical outcomes and greater patient/family communication and satisfaction at lower cost.

Specific potential benefits of this model include improved overall quality of care; decreased SNF average length of stay (LOS); better alignment of the residents' goals of care with their plan of care; and increased early identification of resident changes in condition and treatment in place, potentially reducing the disruption of avoidable hospitalizations and ED visits for the resident, as well as reducing total cost of care. Summit participants identified opportunities for future research, including the role of PAC in pandemics; further comparisons of cost and utilization patterns across PAC sectors, including swing bed programs; the use of telehealth/remote monitoring; and the impact of emerging new roles in the workforce, such as Community Companion Services, Community Health Workers, and Patient Navigators, to support aging in place.

Appendix A – Additional References

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Pathways to Growth. Lutheran Social Service of Minnesota. - A Road map to help employees navigate their growth and development in their current role and prepare for career advancement.

2020 MHA Health Summit: Measuring Outcomes for CAH Swing Bed Patients National Study. Stroudwater Associates. April 27, 2020.

2020 Post-Acute Care Pre-Summit Questionnaire. May 1, 2020.

Appendix B – Payment Breakout Notes

Issues Related to Payment

The payment breakout group identified multiple issues, including:

- The impact on access and care delivery:
  - There needs to be a change in care design to keep up with changing payment (care processes will change)
  - Lack of consistent medical management of PAC patients, especially in SNFs
  - Changing expectations of health care delivery
  - Needs of patients do not drive payment models, and rural payment models are problematic
  - People lacking in the necessary health literacy to make appropriate health decisions
  - Social determinants of health have not been incorporated into current payment models (i.e. housing, transportation, nutrition)
  - Rural nursing home closures
  - Medicaid LTC beds are limited
  - Costs that do not show up like keeping family and caregivers nearby in the community
- Technology:
  - We have technology but do not have payment for use of technology.
    - *Note: The COVID-19 pandemic led to rapid increases in the use of and reimbursement for telehealth, temporarily providing expanded opportunities for safe, virtual access to care while reducing direct patient-provider contact. It is widely expected that expanded use of telehealth will continue after the pandemic subsides, necessitating further regulatory and reimbursement changes and development of standardized processes and protocols to ensure consistent, verifiable, high quality virtual care delivery.*
- We cannot track costs due to the lack of interoperability between systems across different settings of care.
  - Hospital payment sharing
  - There is no hospice payment model for rural geographies (capitation could be better and more in line with what would serve people better)
  - State Medicaid budgets
  - Facilities getting penalized on daily costs instead of focusing on PAC. What are the real costs of service? What will provide high quality care?
  - There currently is not a way to demonstrate the value of more complex care in the swing bed setting, such as the shifting of costs for a patient to have a lower number of days of swing bed care versus typically longer nursing home length of stays.

- Hospitals need to be competitive if they get into bundled payment arrangements and/or offer swing bed services.
- COVID-19 might reveal how much we are overtreating people with the cancellations of elective procedures.

Research Note:

Two studies were conducted in Illinois and Minnesota in 2018-2019, which compared outcomes for SNFs versus swing bed programs.

The purpose of the Minnesota study was to:

- Identify measures that could be used to assess the quality of care provided to CAH swing bed patients
- Implement a field test of those measures
- Measure outcomes for CAH swing bed patients
- Compare patient outcomes in CAH swing beds to rural SNF outcomes

To better understand the significance of the swing bed program in rural Illinois, the Illinois Critical Access Hospital Network (ICAHN) partnered with Northern Illinois University's Center for Governmental Studies (CGS) to survey Illinois CAHs regarding the importance of their swing bed programs in terms of financial indicators, quality outcomes, and community benefits.

Both studies reported that swing bed patient hospital readmission rates were lower than SNF patient hospital readmission rates. The Illinois study also showed a significantly lower swing bed average length of stay (LOS) of approximately 10 days versus the SNF average LOS of 26 days. Hospital-based swing bed services also provide 24-hour access to physicians and onsite nursing staff, as well as onsite diagnostic services, while typically allowing patients to remain in their own communities.

See the University of Minnesota Rural Health Research Center study, "Measuring Outcomes for CAH Swing Bed Patients: Results of a Field Test and Comparisons with SNF Patient Outcomes" and the Illinois Critical Access Hospitals report "Exploring the Financial Impact of the Swing Bed Program" for additional information about these two studies.

These findings underscore the importance of collecting and analyzing swing bed performance data to understand and accurately report cost, quality, and outcomes of care in swing bed programs, which is essential in order for rural hospitals to demonstrate the overall value of their swing bed programs in comparison to area SNFs. Additional research is needed utilizing claims-based data to further substantiate these early findings and to perform total cost of care analyses for swing bed patients in comparison to short stay SNF patients.

Appendix C – Community Care Coordination Breakout Notes

Issues Related to Community Care Coordination

The community care coordination breakout group identified the following issues:

- General Concerns:
  - There is inertia and resistance to change for community care coordination
  - Technology (replicated to point of fragmentation)
- Communications:
  - Communication is hard, especially related to transitions of care. This can result in poor patient hand-offs across care settings.
  - There is a strong need to establish relationships and common expectations regarding communications and collaboration across hospitals and community-based organizations.
  - The failure to identify key stakeholders within community care.
  - No consistent communication tools and information required varies from place to place.
- Service Delivery:
  - The challenges of overcoming fragmentation of services.
  - There is a lack of understanding of what resources are available in the community, and the various roles and responsibilities across organizations within the community.
  - The scarcity of resources makes receiving help difficult and the duplication of services creates waste.
- Patient Needs/Care Delivery:
  - Impact of social determinants of health
  - Variable eligibility criteria for services
  - Vulnerable populations; patients not always able/willing to self-advocate
  - Failure to consider the patient's perspective - lack of person-centered orientation
- Financial Impact:
  - Studies have shown that poor transitions of care and lack of care coordination negatively impact total cost of care and health outcomes, i.e., high ED utilization increases total cost of care and results in episodic, fragmented care delivery
  - Failure to meet patient needs and preferences undercuts organizational viability by reducing local utilization of services
  - Helping PAC patients with medications (i.e., schedule, dose, affordability)

Appendix D – Workforce

Issues Related to Workforce

The workforce breakout group identified the following issues:

- Scope of Practice/Provider Licensure
  - There is a wide variation in scope of practice in different states, as some states are more restrictive in how nurses practice.
  - Translation of licensure from state to state is inconsistent, and there is a need for more relaxed requirements for those willing or needing to move across state lines.
- Public Health Infrastructure
  - In the past, there has been a lack of robust public health infrastructure in rural communities and not enough close connections between hospitals, LTC providers, and public health programs.
  - There are opportunities for cross-training and leveraging skill sets in the community for contact tracing, but current funding level is a barrier. Enhancements would help cross-training to leverage this important workforce that is trusted in the community.
  - Tribal systems often operate separately from the rest of the community. There is an opportunity to build support, connection, and inclusiveness for tribal systems within the public health process and include them in training developments. Past examples of this practice include inviting the tribal systems in for nutrition systems during COVID-19 and incorporating technology and family caregivers.
- Maximizing Workforce:
  - Recruiting is difficult for rural PAC providers. This issue could create an opportunity for providers to work more with academic partners to increase capacity.
  - Increase training options for certified nursing assistants and other technicians working in PAC.
  - Offer care coordination certification programs.
- Provider Access
  - There is a lack of gerontology expertise and providers within the rural workforce. Technology could help bring more of these experts into the workforce, as teleconsultations open-up the possibility of increasing access to gerontologists in these facilities. Rural providers also do not always need to offer full time coverage.
  - Especially in rural areas, there is a lack of access to mental health resources and providers.
- Bigger Picture
  - Policy changes are needed, including reimbursement and workforce service provisions through telehealth
- PAC Facility Architectural Design
  - Some PAC facilities currently suffer from inefficient architectural designs and excess open spaces.

Appendix E – Hospital Coordination

Issues Related to Hospital Coordination and Post-Acute Care

The hospital coordination breakout group identified the following issues:

- Overall:
  - There is a general lack of ownership, momentum, and engagement regarding the role of coordination between the hospital and PAC. There is often a negative connotation towards PAC, specifically LTC facilities and nursing homes.
  - PAC has been historically considered a less important service.
  - Rural ACOs are negatively impacted by the high cost of skilled nursing care and a lack of coordination between primary care and specialty care.
- Care Delivery:
  - Not addressing the patient through the entire continuum of care (providers not following through entire continuum; have not looked at patient-centered care).
    - Many rural hospitals have opportunity within their delivery system to ensure better transitions of care and to support the continuum of care.
  - An increased focus is needed on rehabilitation (rehab) and communicating with other providers. An example of this could be stroke care through a rehab department.
  - Integrating the mental health aspect within primary care
  - Select best PAC setting for patient's needs
  - Geriatric outpatient mental health group therapy is an effective strategy in rural areas.
- Financial/Reimbursement:
  - Acute care is what hospitals are paid for. PAC is not a priority or considered part of the acute-care system.
  - There is a lack of reimbursement options and financial reimbursement alignment and incentives.
- Technology:
  - Technology has not been adapted to ensure that there are good care transitions from hospital to PAC settings.
  - There are silos of care and technology disconnects as each setting of care has different systems and interoperability issues.
- Workforce:
  - Staff are not used to working with partners in PAC settings. There is a hierarchy of status and a lack of understanding and changing expectations.
  - There is a lack of staff time for workforce in nursing homes and PAC to communicate with hospitals. We need talented champions and "out-of-the-box" thinkers to change these processes.