Integrating Acute to Post Acute Care Settings: Where Do We Go From Here?

Length: 1.5 Hours

Target Audience: C-Suite Executives, Service Line Leaders, and Department Managers

Description: Management of populations of patients through integrated post acute care models can not be done by a simple referral. As our populations change, so must the delivery of healthcare services along the care continuum. Acute Care Hospitals are faced with ever more regulatory requirements and expanding financial penalties all in an effort to elevate the Standard of Care across the healthcare system on a national scale. These regulatory requirements and the corresponding financial penalties are not new phenomena. Most hospitals aggressively develop performance improvement plans that center on the resolution of these deficits for minimization of potential financial exposure. We are now in a new wave of financial penalties to Acute Care Hospitals with the Medicare payment reductions for returns to acute within 30 days of discharge. These current reductions are unique in that they are driving focus for Acute Care Hospitals to work collaboratively with members of the post acute care continuum to cohesively manage patient populations through increasingly more aspects of a patient’s post acute care progression. Long Term Acute Care Hospitals (LTACs), Inpatient Rehabilitation Facilities (IRFs), Home Health Agencies (HH’s), and Continuing Care Retirement Facilities (CCRCs) will play an even greater role in supporting our Acute Care Hospitals in the management of patient populations through the continuum of care.

Faculty: Moderator plus two to three panelists. The moderator should be a high-level healthcare executive with good knowledge of post-acute services and in-depth experience with the acute care segment.

Panelists should be composed of a variety of leaders from the post-acute care organizations. Consideration of panelists would be those from Long-Term Acute Care Hospitals, Short-term Rehabilitation providers, Skilled Nursing Homes, Assisted living, Continuous Care Retirement Centers, and Home Health Agencies.
Topics for Discussion:

- Journey of a patient through the Post Acute Care (PAC) Continuum Healthcare of Services.
  - Delineation of services between LTACs, IRFs, HHs, and CCRCs.
  - Care coordination along the PAC.
  - Partnering along the care continuum for enhanced outcomes.
- Drivers of Post Acute Care collaboration
  - Planning with the patient strictly focused on the next transitional step.
  - Team based approach in Care Transitions with Nurse case managers, Administrators, Physicians, Patients, Payers, Nurses, Therapists, Insurance companies, and Government responsibilities.
  - Information and/or communication is often lacking from the Acute Care Hospitals.
  - Clinical benchmarks to monitor patient improvement that will facilitate movement along the care continuum.

Questions for Discussion:

1. What does care collaboration along the Post Acute Care continuum look like?
2. How do you achieve “buy in” from partners along the continuum of care?
3. What are the common challenges in gaining and preserving funding or authorization for Post Acute Care?
4. What are “typical” re-admission rates to hospitals by post acute care providers?
5. What are some “best practices” with post acute care providers to enhance collaborative relationships with providers up stream in the Acute Care Hospitals and with providers downstream along the Post Acute Care Continuum?

Materials for Distribution:

Pomeranz, R., Ritchie W., (Summer 2012, Volume 71), Integrating Acute and Post-Acute Care: The Emerging of the Sectors. Strategies for Health Care Leaders. Cain Brothers

Additional Resources:

Butcher, L. (January 2013) Hospital Strengthen Bonds with Post-Acute Providers. Hospitals & Health Networks

Cantulpe, R., (June 2012), Creeping Toward Care Coordination. Health Leaders