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Facing Health Care Reform: Approaching Change with Optimism

By Susan Heck

Organizations face many challenges as the government continues to implement health care reform across the country. Whether one views the current landscape as a challenge or an opportunity is truly a matter of perspective. Oscar Wilde, a famous Irish writer and poet, once said, "The optimist sees the donut, the pessimist sees the hole." To be successful, health care leaders must choose to see the donut in the day-to-day reality of implementing change.

For cardiovascular (CV) program administrators, there are three particular areas of regulatory change that may significantly impact program performance and overall organizational success: value-based purchasing, 30-day readmission penalties, and the 2-midnight rule. Corazon believes CV administrators will need to create or maintain a focus on managing and improving clinical processes in order to achieve quality outcomes, efficient care, and patient satisfaction, all of which are closely interrelated. Likewise, efforts to design new care processes that extend the traditional boundaries of acute care beyond the hospital stay from home-to-home will become increasingly important in this burgeoning age of reform.

The Patient Protection and Affordable Care Act (PPACA), was initially enacted into law in March 2010. Over the past four years, hospitals and health systems have experienced varied challenges related to implementing elements of the PPACA, the most significant health care reform since the adoption of the Medicare payment system in 1965. As the changes continue to affect the health care system at large on a national scale, individual organizations must find ways to adapt to the changes and challenges, most particularly in terms of clinical quality, operational efficiency, and fiscal viability, while adhering to the newly enacted "rules" for care delivery.

Value-Based Purchasing

The value-based purchasing (VBP) program established through the PPACA is now in its third year of implementation. A Centers for Medicare & Medicaid Services (CMS) plan, it established reimbursement incentives aimed at driving care to meet established targets. Hospitals that meet the achievement and improvement targets will receive increased reimbursement, whereas those that fail to meet these targets will incur decreases in reimbursement. For this reason, the VBP aspect of health care reform requires attention from administrators and caregivers alike, especially in the cardiac specialty, where admissions comprise as significant portion of the overall hospital DRG mix. Additionally, hospitals are experiencing increased complexity and acuity of all inpatient episodes of care, which is often influenced by underlying cardiovascular disease.

Since its initial introduction, the achievement targets of the VBP program have continued to evolve. The focus for 2015 includes measures for clinical processes of care (20% weight), patient experience (30%), outcomes of care (30%), and efficiency (20%). The withhold percentage increased to 1.5%, and will be applied to the base operating CMS DRG payment amounts for each affected hospital. By 2017, the withhold percentage will increase to 2%. Payment adjustment factors have focused on patient experience, but over time, more weight will be given to outcomes and efficiency measures. For example, in 2016, outcomes of care and efficiency will comprise 75% of the weighting within established domains. A renewed focus on quality assessment in the cath lab and across the entire CV program can be foundational to the achievement of outcomes improvement. Additionally, programs must focus on improving quality while decreasing costs — processes that are often linked. Programs must work to manage cost, efficiency, and quality effectively in order to demonstrate value in the new regulatory environment.

30-Day Readmission

In addition to the VBP program, PPACA established the Hospitals Readmission Reduction program in 2013. In its first year of implementation, hospitals with an excess number of patients returning to the hospital within 30 days of discharge following treatment for heart attack, heart failure, or pneumonia incurred up to a 1% penalty on Medicare reimbursement. In 2014, this penalty threshold increased to 2% for these three patient discharge diagnoses.

More recently, providers have been challenged with the addition of two new measures: readmission for chronic obstructive pulmonary disease and total hip/knee replacements. In addition to the new measures, the penalty threshold applied to Medicare reimbursement has increased to 3% this year.

For many hospitals, these discharge diagnoses can comprise a significant portion of admissions. For instance, heart failure is in the top five discharge diagnoses for nearly every acute care hospital in the country. Cardiovascular programs have long focused efforts on decreasing length-of-stay for the heart attack and heart

failure patients; now, organizations must broaden focus to confirm that these patients are well prepared for discharge, and have health care support systems to keep them from returning for additional care.

The 2-Midnight Rule

The 2-midnight rule, as created through the CMS 2014 Inpatient Prospective Payment System Final Rule, is yet another example of regulatory oversight instituted by PPACA. This rule can be challenging in that it has been viewed as penalizing providers for driving efficient patient care processes.

The 2-midnight rule mandates a review of appropriateness of any admission to inpatient status for cases with an expectation of care spanning at least two midnights. The rule requires documentation of medical necessity for care with an expected duration of two or more midnights in order to qualify for inpatient admission. If the physician expects the medically necessary treatment to require less than two midnights, CMS guidance is to treat the patient as an outpatient. Additionally, if the physician is unable to determine the expected length of care needed, CMS guidance advises that the physician may order observation services, and reconsider providing an order for inpatient admission at a later point in time. With a significant difference in reimbursement of inpatient vs outpatient discharges, clearly the shift to fewer inpatient discharges will impact hospital revenues.

For example, the 2-midnight rule presents a significant challenge for providers that offer diagnostic catheterization, percutaneous coronary intervention (PCI), and electrophysiology services. Given the relatively short inpatient stays related to these procedure types, this rule has the potential to dramatically impact the finances of cardiovascular programs. Strong and accurate documentation has always been important, but this rule highlights the need to clearly record the patient history and comorbidities, severity of signs and symptoms, current medical needs, and the risk of an adverse event to justify an inpatient admission.

Of note is that the 2-midnight rule does not include exceptions based on the intensity of care needed. Thus, the need for a brief period of care in an ICU setting does not mean that the patient is exempt from the 2-midnight rule. This can be a significant qualifier, particularly for the primary PCI population. Attention to documentation related to care necessity will be critical to appropriate classification as an inpatient admission.

The 2-midnight rule and guidance related to its application has been under increasing scrutiny. To manage this effectively, hospitals must educate physicians related to the nuances of the rule, and hardwire processes related to appropriate documentation.

The role of case management in assisting physicians with the oversight of the cardiac procedural population can be essential for effectively and appropriately classifying the patient's stay as either inpatient or outpatient, while understanding the resulting implications of either choice.

Corazon believes the 2-midnight rule has many repercussions for hospital operations, and can have a direct impact on the profitability of many of the procedures provided in the cath lab for both the hospital and the patients. The shift to outpatient billing has created significant dissatisfaction for some patients, who may now face higher co-pays. They may be confused by the outpatient bill, especially if they are cared for in the inpatient setting. Working to manage patient expectations, and then effectively communicating the outpatient classification and what it means for them will be key to eliminating this scenario as a dissatisfier.

Preparing for the Future

When faced with the challenges ahead, Corazon believes programs must get "back to the basics" to ensure core operations are sound. Many times, providers can be distracted by preparing for what is to come, straying from the proven principles and practices that drive clinical quality or operational efficiency. Rather than focus solely on the potential impact of the 2-midnight rule or a VBP program, we advise clients to maintain a focus on elements of their fundamental business while looking to the future.

In cardiovascular program management, providers should work to maintain core elements of an operationally sound program, such as on-time case starts, solid pre-admission testing (PAT) processes, and efficient room turnover times, while also being mindful of the impact the 2-midnight rule will have on their program's finances.

Initiating data capture related to cath lab start times for the first case of the day and subsequent cases, documentation of the root cause of all delays and the time associated with room turnover can be a helpful exercise in understanding cath lab efficiency. Likewise, an analysis of cases that arrive in the lab without a history and physical, an unidentified need for hydration prior to procedure, or an unidentified dye allergy can be an important exercise in understanding breaks in the PAT process. Each of these situations can cause delays in the cath lab, and work should be completed to assure that a sound process is in place.

These efforts will not only improve efficiency and processes of care, but have the potential to positively impact patient satisfaction as well. The modern patient and family have very high expectations that transcend industry norms of the past few decades. Today, these savvy health care consumers expect high efficiency, easy access, and transparent information during every encounter.

In an effort to improve access and satisfaction, some CV programs are evaluating options for Saturday and Sunday elective diagnostic test times and/or evening hours for cardiology visits. An evaluation of the basics related to the patient's need for information pre- and post-procedure should also be considered. Programs must evaluate the content, timing, and method of patient and family teaching. In fact, assuring that the patient is well informed, and prepared for the procedure and discharge can ultimately affect their satisfaction with the care received. The

adoption of follow-up phone calls, for instance, can be a vehicle to reinforce learning and proactively assess symptoms that might indicate post-procedure complications.

The patient education and follow-up strategies above can also have a direct impact on the rate of readmission within 30 days. Additionally, the coordination of care, as patients transition from the acute care setting to home or other levels of care, is no doubt an important component of the full care continuum. Nurses and case managers should focus on creating discharge plans that address the needs of all patients, with particular attention given to those at high risk for readmission.

In a role that is ever evolving, a nurse navigator can serve to provide a bridge between the acute care setting and home. This model is the basis of many heart failure programs, and has been effective for reducing 30-day readmission rates in this population. The issue for most programs is that the model is not scalable, and requires significant additional resources to manage expanding volumes and care needs for heart failure.

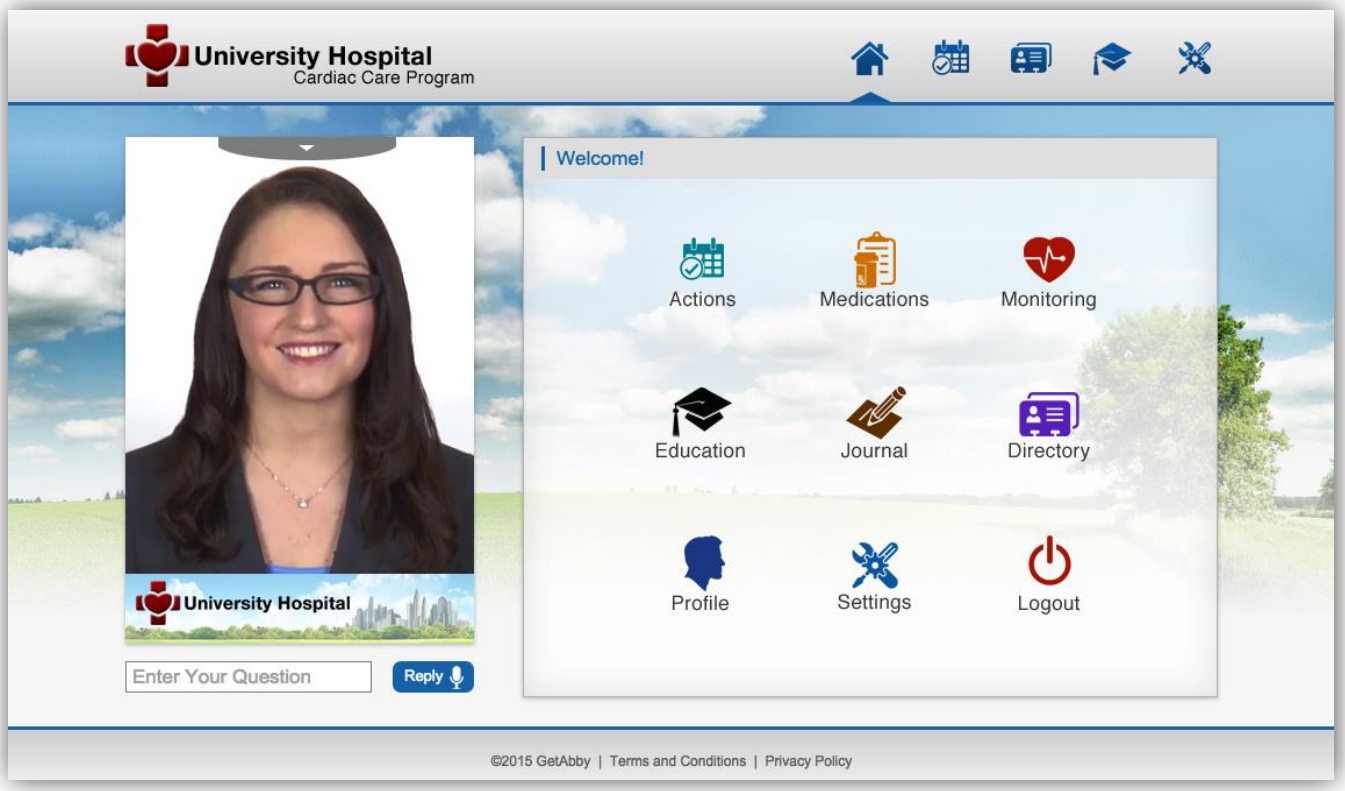

Figure 1. A screenshot of the industry's only human-avatar-led nurse navigator program, GetAbby. In partnership with Corazon, GetAbby is working to help hospitals reach the goal of expanding coverage while using technology instead of human resources.

In an effort to address the scalability of the nurse navigator model, Corazon has been working with several programs to evaluate the addition of technology in the form of a human avatar (Figure 1). The avatar technology provides interactive disease management via phone, web, or mobile devices, and educates, monitors, reminds, and rewards patients to keep them on track to a healthy lifestyle and potentially decrease hospital readmission.

The evolving regulatory environment in health care requires providers to understand the impending changes while also working to manage the program in the present. Operating status quo is no longer an option. Rather, progressive providers are those that improve operations within the present system, while crafting inventive solutions that best position their cardiovascular programs for the future of what's to come. Whether through new technology, innovative strategies, or improved processes, programs must change, along with the industry rules and regulations, so as to not only survive amid increasing regulatory activity, but also thrive for the benefit of the patient.

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