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The Health Information Technology Landscape For Long-Term and Post-Acute Care

INSIGHTS FROM THE THIRD HEALTHCARE PILLAR

Eight industry executives were invited to participate in a stakeholder discussion of today's landscape for health information technology for long-term and post-acute care. The discussion took place in June 2012 concurrent with AHIMA's 8th annual LTPAC HIT Summit, and was sponsored by WoundRounds®, the point-of-care wound documentation and prevention solution.

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Long-Term and Post-Acute Care
The Lagging "Third Pillar" of Healthcare

The purpose of this paper is to provide insights from thought leaders in long-term and post-acute care (LTPAC) into the current landscape for health information technology (HIT) and the implications for policy makers and providers.

In its *2010-12 LTPAC HIT Roadmap[1]* the LTPAC HIT Collaborative articulated a vision of long-term/post-acute care as the nation's "third healthcare pillar," with a focus…

> *"…that demands an application of health IT towards shared care, transitions of care, and person-centered longitudinal health and wellness records to ensure a person receives affordable, quality and coordinated care when they need it, where they need it."*

Indeed, the need for promoting HIT across all care settings, and most importantly across the aging services spectrum, is well documented:

- Seniors consume more than 50 percent of healthcare services and dollars.[2]
- LTPAC providers account for 12% of all Medicare spending.[3]
- 35% of Medicare beneficiaries discharged from short-term acute hospitals are referred initially to post-acute settings.[4]
- An estimated 60 percent of medication errors occur during times of transition.[5]

The absence of incentives for LTPAC is also well documented. "The US government has dedicated substantial resources to help certain providers, such as short-term acute care hospitals and physicians, adopt and meaningfully use electronic health record (EHR) systems."[6] Yet, adoption rates among inpatient providers ineligible for financial incentives (i.e. long-term acute care hospitals, rehabilitation hospitals and psychiatric hospitals) are, "dismally low: less than half the rate of short-term acute care hospitals." The study concludes,

> *"By leaving out ineligible providers, the nation risks building a new digital divide in which key providers, which already have low levels of electronic clinical data, may fall further behind."*

Revolving Door of Rehospitalization

Lack of care coordination and perverse financial incentives contributes to the increased rate of hospital readmissions. CMS's reimbursement model creates a "Revolving Door of Rehospitalization from Skilled Nursing Facilities."[7] By 2006, 23.4% of all hospital discharges to skilled nursing facilities returned to the hospital at a total cost of $4.34 billion. In effect, Medicare payment policies encourage readmissions, not coordination of care.

The policy focus has shifted away from reducing hospital lengths-of-stay to reducing avoidable hospital admissions.

Today, policy makers are exploring options to address the underlying causes of the rising readmission rates including:

1. Payment incentives and penalties
2. Increased regulatory reporting
3. Grants and demonstration projects

Incentives and Penalties

Beginning fall 2012, hospitals with the highest 30-day readmission rates for three conditions (congestive heart failure, pneumonia and acute myocardial infarction), will face a 1% reduction in total reimbursement. Penalties will grow to 2% in 2013 and 3% in 2014. By 2015, reductions will be more significant and other conditions will be added.

CMS is also exploring new payment models, including bundled payment for full episodes of care and Accountable Care Organizations, which will require greater collaboration and coordination of care, including evidence-based protocols that standardize care. While initial focus is on hospital reimbursement, LTPAC providers can expect to see increased regulatory scrutiny and penalties.

Regulatory Reporting

CMS currently mandates site-specific patient assessment tools, including the Minimum Data Set (MDS) and the Outcome and Assessment Information Set (OASIS). Today, 100% of nursing homes and home health agencies automate and transmit these CMS required assessments. Ironically, current transmission formats for MDS and OASIS do not adhere to accepted IT formats and content standards.

Beginning October 2012, inpatient rehabilitation facilities and long-term acute care hospitals must comply with additional requirements designed to standardize the collection of information on patient acuity and outcomes.

One focus area is tracking pressure ulcers that are new or have worsened since admission. Compliance requires significant effort, as LTC providers are learning with MDS 3.0. Yet, the value of the data is unclear since the instrument does not take into account the complexity of matching specific wounds from one site of care to another.

Grants and Demonstration Projects

Federal agencies are offering numerous grants totaling more than $1 billion to explore new models of reimbursement, care transitions, and care delivery. Unfortunately, LTPAC providers are generally treated as subjects, not recipients, of these grants.

Nowhere is this better exemplified than CMS's Initiative to Reduce Avoidable Hospitalizations among Long-Stay Dual-Eligible Residents.[8] This initiative is funded by grants totaling $128M, but is only available to eligible, independent, non-nursing facility organizations (referred to as "enhanced care and coordination providers"). The grants are directed to non-provider organizations that duplicate services provided by LTPAC staff, which is neither scalable nor affordable.

Insights on the HIT Landscape

Eight industry leaders in health information technology participated in the discussion and offered their insights into today's LTPAC HIT landscape.

The executives, from leading LTPAC organizations, are acutely aware of today's realities: scarce resources to deal with increasing complex case loads, increased demands from regulators, and the advent of new reimbursement models. Despite these realities, the participants are optimistic about the value of HIT and believe LTPAC providers must move ahead, making smart technology choices and acting proactively to increase the value they bring to the table.

Making Smart Technology Choices

Choosing an EMR— Panelists agree that "one size doesn't fit all" when it comes to HIT. Smart organizations align HIT selection with the business needs. There are multiple enterprise vendors that could do the job; the choice often comes down to organizational fit and what the users feel best meet their needs.

> *"The core EMR won't do everything, but it should be good enough to meet 80% of the need. Then implement best-of-breed solutions that can demonstrate genuine ROI to fill in the rest."*
> - Scott Mintz, Consulate Health Care

Dealing with Short Planning Cycles — While HIT is a long term strategy, panelists suggest shorter planning cycles that cumulate to the long term vision. This allows the HIT organization to be flexible in morphing business needs, especially when changes in reimbursement seem to occur annually.

Engaging the Leadership Team and Board — Participants agree that it can be a catch-22 with their boards. Some board members believe that LTPAC is behind the curve in HIT, yet are hesitant to fund it. Others have acute care experience. Their expectations come with hospital-sized IT budgets, which are sorely lacking in LTPAC. Regardless, participants advise keeping HIT front and center with the leadership team and boards.

Making practical choices — One organization was focused on the nursing workflow, which prompted the need for wireless kiosks. It made so much sense for their organization that their vendor had to find a way to support wireless.

Staffing for Success — Participating CIO's know that implementing complex software is a full time focus. Resources are limited in their facilities, so having dedicated implementation teams is often unrealistic.

Pacing the Implementation — Several panelists noted that they are implementing new systems over a period of years, not months. Progress comes slowly due to limited financial resources, shifting operational priorities, and general user acceptance and change management challenges.

Bring Solutions to the Continuum

LTPAC must move quickly to position their facilities to local hospitals and physician groups that are forming ACOs. Providers need to demonstrate how they will improve on key factors, like re-hospitalization, and improve patient outcomes across the continuum.

> *"Now the requirement is to take the whole continuum; to make partners out of all the care centers."*
> - Marty Diller, Complete Healthcare Resources

Demonstrate Measurable Value — Engage by understanding and managing toward the outcomes and measures that are the focus of the hospital or ACO. Show them how you will improve those key factors and how you'll improve outcomes across the care spectrum.

> *"If you play a passive role, you'll be dictated to. Bring better outcomes and you'll earn a seat at the table."*
> - Loren Claypool, Extendicare/VCPI

LTPAC providers also bring value to acute care through their knowledge of the patients and patient experience:

> *"They have a 10-day relationship with the patient. We have a 10-year relationship. We know the patient better."*
> - Chuck Czarnick, Brookdale Senior Living

Prepare to be Accountable — One participant shared that the local hospital sends out report cards showing rehospitalization rates among area LTC providers. Quality and performance are important to that acute care facility, "even if they can't generate electronic discharge orders."

Get to Interoperability — LTPAC facilities have many internal processes to improve before they can pursue external interoperability. Yet, panelists agree that they need to move ahead.

> *"Technology has leapfrogged these last couple of years. Interoperability is important, but it's a problem that's never going to go away as new technologies continue to come."*
> - Chuck Czarnick, Brookdale Senior Living

Tips for Change Management

Discussion participants agree that helping staff accept technology and incorporate it into their work processes is a fundamental challenge for all organizations. Even when implementing the same tool, with the same people rolling it out, results can vary across the same campus. Their recommendations:

Create a Compelling Vision — It's communicating where the technology fits into the bigger story and getting staff to understand that they are "part of the success ride."

Engage the End Users — Creating the momentum means involving the line people.

> *"New technology can minimize end-user pain. Find out what the nurses hate, listen to them and get what they want."*
> - Karen Page, White Oak Management, Inc.

Empower Champions of Change — It's important to engage Directors of Nursing in the process and enlist them as champions of change.

> *"You have to take as much time building people as you do in selecting the system."*
> - Keith Mutschler, Nexion Health Management

Implications for Policy Makers

Eight years ago, a collaboration of long term care and aging services stakeholders founded the Long Term Care Health Information Technology Summit and published its first Roadmap for the advancement of health IT in long term care. Looking back at the 2005 HIT Roadmap one might say, the more things change, the more they stay the same:

> *"The national health IT agenda has primarily focused on acute care, primary (ambulatory) care, and the development of regional health information exchange organizations (RHIOs). Issues relating to LTC and an aging population have somehow slipped between the seams of the national health IT agenda."*

The Need to Extend Incentives to LTPAC

Financial incentives for use of EHR's continue to accrue to acute care hospitals and physician groups, not to long-term and post-acute care providers. LTPAC is marginalized in grant programs and burdened with regulatory reporting requirements that drain resources and add costs that would better be devoted to improving care transitions and outcomes.

The Need for Data Sharing and Data Standards

Data sharing is essential to improving care coordination and reducing costs. New models of reimbursement and care delivery will require "wired" LTPAC services and inter-operability.

Today, there are no commonly agreed-upon, unambiguous clinically relevant definitions for data or for mapping such data to existing standards.[9] Clear guidance and a single standard for exchanging information are needed.

Services for seniors are growing exponentially. Incentives must be in place to reduce the variation in HIT adoption and fund integration of data across all care settings. Now is the time for policy makers to redress their delayed attention to supporting HIT adoption and interoperability in LTPAC.

Implications for LTPAC Providers

Patients who receive LTPAC services obtain care from a diverse group of physicians, clinicians and specialists, and experience frequent care transitions. Yet, this vital segment lags in its access to the IT systems, resources and incentives available to other segments.

For many LTPAC providers, the cost of HIT implementation and the additional need to effectively exchange information is a significant barrier to interoperability. Using simpler and more cost-effective methods for exchanging information, such as the Direct Messaging Protocol[10], is one way for LTPAC providers to practically deal with the challenge of longitudinal coordination of care.

Whatever the ultimate solution, the view from these stakeholders is that LTPAC providers must:
1. Make smart technology choices now
2. Bring data and results to the table
3. Lead the discussion of care transitions and coordination of care
4. Advance their cause locally and nationally through the LTPAC HIT collaborative

The collaborative that came together voluntarily in 2005, created the first HIT Summit and Roadmap. They did so without the inducement of Federal grants or incentives. But the landscape has changed and it is uneven.

Today, an expanded collaborative of committed LTPAC providers can offer a growing body of experience for improving care transitions and coordination. At this critical time, the public and private sector should redouble its efforts to ensure that the nation's "third healthcare pillar" is able to fully participate in the information-enabled health care system of the future.

End Notes

1   The 2010-12 LTPAC HIT Roadmap is available at: http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_047579.pdf
2   Keehan SP, Lazenby HC, Zezza MA, et al. Age Estimates in the National Health Accounts. *Health Care Financing Review* 2004 Dec. 2; 1(1); Web Exclusive.
3   Medicare Payment Advisory Commission, (June 2010) *Data Book: Healthcare Spending and the Medicare Program*, Washington D.C.
4   RTI 2009: *Examining Post Acute Care Relationships in an Integrated Hospital System.*
5   JD Rozich and RK Resar, "Medication Safety: One Organization's Approach to the Challenge," *J. Clin. Outcomes Manag.* 8:27-34 (2001).
6   *Health Affairs,* March 2012, 31:3)
7   *Health Affairs,* January 2010, 29:1
8   http://innovation.cms.gov/initiatives/rahnfr/
9   Erik Pupo, Specialist Leader, Federal Healthcare Consulting, Deloitte Consulting, erpupo@deloitte.com
10 For more information on the Direct project, visit: http://directproject.org/

This Whitepaper is sponsored by WoundRounds®, the point-of-care wound documentation, care management & prevention solution that empowers nurses to deliver better wound care in less time. WoundRounds users report improved time savings, reductions in facility-acquired pressure ulcers, lower wound care costs, and reduced risk and liability. In short, WoundRounds is helping healthcare providers do more with less.

For more information about WoundRounds, please visit: www.woundrounds.com or contact

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The LTPAC HIT collaborative includes:

The American Health Information Management Association (AHIMA); American Health Care Association (AHCA) and the National Center for Assisted Living (NCAL); LeadingAge and Center for Aging Services Technologies (CAST); National Association for Home Care and Hospice (NAHC) and the Home Care Technology Association of America (HCTAA); National Association for the Support of Long Term Care (NASL); and the American Society for Consultant Pharmacists (ASCP).

For a copy of AHIMA's 2012-2014 LTPAC HIT Roadmap, visit: **www.ahima.org**

Spotlight on The Participants

Linda Kloss, MA, RHIA and WoundRounds would like to acknowledge the participation and contributions of the industry leaders who shared their valuable insights during the discussion:

- **Loren Claypool** is CIO of Extendicare and Vice President & Managing Director at VCPI, which provides solutions for business and IT.

- **Chuck Czarnik** is the Senior Director of Systems and Processes /HIT Strategy at Brookdale Senior Living, the nation's largest owner and operator of senior living communities and senior-related services.

- **Marty Diller** is CIO at Complete Healthcare Resources, Inc., a consulting and management services firm which works with senior care providers.

- **Deborah Green** is Vice President of Health Information Management Solutions at the American Health Information Management Association. Formerly she was CIO for LaVie.

- **Scott Mintz** is Vice President of Business Systems at Consulate Health Care which provides outsourced IT and business solutions.

- **Keith Mutschler** is Vice President and Treasurer at Nexion Health Management, provider of nursing and rehabilitation services.

- **Karen Page** is the Information Systems Director for White Oak Management, Inc., providers of long term care in the Carolinas.

Moderator Linda Kloss is President at Kloss Strategic Advisors, Ltd; a consultancy offering thought leadership, policy and strategy guidance and consulting in healthcare and information management. Formerly Ms. Kloss was CEO of the American Health Information Management Association.

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