FROM THE EDITORS’ DESK

Postacute Care: Reasons for Its Growth and a Proposal for Its Control Through the Early Detection, Treatment, and Prevention of Hospital-Acquired Disability

Andrea L. Cheville, MD, MSCE, Jeffrey R. Basford, MD, PhD

From the Department of Physical Medicine and Rehabilitation, Mayo Clinic, Rochester, MN.

Abstract

Postacute care costs have doubled over the past decade and now account for 17% of Medicare fee-for-service spending. Costs are forecast to continue to rise, paradoxically in large part in response to federal policies and efforts to control health care costs. This commentary introduces a potential solution to this situation and is divided into 4 parts. The first provides a brief review of the policies fostering this growth. The second assesses how the responses of health care providers, while inherently rational, are destructive to the system. The third identifies hospital-acquired disability as a modifiable driver in this scenario, and the fourth discusses how an improvement in detection and a redistribution of hospital-based rehabilitation services may be able to reverse this unsustainable growth.

Archives of Physical Medicine and Rehabilitation 2014;95:1997-9
© 2014 by the American Congress of Rehabilitation Medicine

Postacute care (PAC) accounts for 17% of Medicare fee-for-service spending, with roughly 40% of beneficiaries discharged from prospective payment system hospitals requiring PAC services. A more than doubling of PAC costs over the past decade, their continued rise, and extensive regional variation have attracted political attention, with policy makers identifying PAC as an opportunity for cost savings. Few, however, have considered how federal policies and the efforts of health care providers to maintain their profit margins contribute to this expansion.

Medicare’s disproportionately high rates of reimbursement for interventional procedures shape providers’ priorities. For-profit and not-for-profit acute care hospitals alike have responded by building facilities that support the performance of lucrative, high-throughput procedures. The result has been a radical lessening of hospitals’ perceived role in convalescence.

Healing takes time, especially for aged and medically complex patients. Historically, their recoveries began in the same facilities as their surgeries and procedures. Diagnosis-related group (DRG)-based reimbursement, by linking hospital profit margins to reduced lengths of stay, changed this and led hospitals to more aggressively attend to and prioritize rapid dismissals. Though indisputably successful, and at times beneficial, these efforts have come with consequences. In the pre-DRG era, hospital-based allied health staff managed the recoveries of patients who simply required more time and support. The advent of DRGs spurred a redirection of their focus more to patients on postprocedural care pathways and those with the potential for “timely” home dismissals. This shift in priorities has lessened the attention paid to maintenance of function among slowly improving patients and contributes to their increased requirements for PAC.

The staggering magnitude of hospitalization-associated disablement has been recognized for over a decade—the capability for independent self-care deteriorates in over 40% of elderly patients while hospitalized—and few concerted efforts have been made to address the forces that promote decline. This dearth is striking as early mobilization programs, even when delivered to severely ill, intensive care unit–based patients, enhance clinical outcomes. Many factors (eg, aging of the population, increasing multimorbidity, and older and sicker patients undergoing aggressive interventional treatments) are projected to increase. Nonetheless, policy changes directed toward a more effective focus on
the preservation of a hospitalized patient’s function may improve patient care and reduce our reliance on PAC without undermining the drive to shorten lengths of stay. To succeed, policy makers must consider a number of key factors.

First, acute care hospitals experience few financial repercussions for allowing patients to become deconditioned because the hospitals are able to transfer debilitated patients to PAC facilities largely without consequence, apart from transfer-adjusted case weights, regardless of the extent of avoidable functional losses. Penalization for acquired pressure ulcers has spurred some reexamination of mobilization practices but has not led to serious changes in hospital practice.

Second, early mobilization is perceived to increase a patient’s fall risk, and falls are feared for their financial and legal ramifications. Care necessitated by trauma from falls is no longer reimbursed by the Centers for Medicare and Medicaid Services. Hospitals are therefore motivated to reduce the incidence of falls by constraining patient mobility. However, the success and safety of intensive care unit—based early mobilization programs suggest that this undue caution may not be warranted even among the most debilitated patients.9,10

Third, maintenance of nutrition and sleep hygiene, both essential if patients are to have the energy and resilience to mobilize, are frequently neglected dimensions of care. Nutrient intake well below patients’ maintenance energy requirements occurs during as many as half of hospital stays. Sleep deprivation, in addition to its adverse physiological effects, undermines patients’ cognition, coordination, and balance, all essential to their functioning.

Fourth, physicians, apart from a few disciplines (eg, geriatrics, rehabilitation), tend to assume limited ownership of the need to promote and enforce an expectation of regular patient mobilization. For the most part, mobilization has been delegated by default to already overburdened nurses, allied health professionals, and therapists, which has proven ineffective and implies that mobilization is a lesser dimension of care.

Fifth, hospital-based therapists are not encouraged or, at times, even permitted to treat vulnerable patients. Therapists’ productivity is measured in relative value units that are not disability adjusted. Medically complex patients are slower and more challenging to mobilize, making them less appealing to therapists under performance scrutiny. Further, therapy sessions delivered to hospitalized Medicare beneficiaries are bundled, nonreimbursed charges, while outpatient therapy remains largely fee-for-service. Consequently, hospital-based therapy departments become more financially viable when they treat a higher proportion of outpatients. Additionally, Medicare’s requirement that hospitalized patients have a “skilled need” to qualify for therapy services leads therapists to spend over 25% of their effort documenting such needs, in lieu of treating patients, and prevents treatment of vulnerable, yet better functioning, patients until they deteriorate to the point that they develop a skilled need.

Last, the patients’ own contribution to their disablement is seldom addressed. An unwillingness to walk with nursing or participate in therapy is rarely noted in the medical record or acted on. This is not a minor issue because a patient’s refusal may stem from remediable sources such as inadequately controlled pain, depressed mood, or altered mental status, which should be sought for and aggressively treated. Furthermore, patients who appear to be falling off well-established recovery pathways (eg, after a total knee replacement) because of lack of effort may, as well as hospitals, need to face the possibility of suffering financial repercussions. Patients who refuse to mobilize during a hospitalization contribute to their eventual requirement for PAC and often incur limited financial consequences.

What can be done? There are compelling reasons for hospitals to focus their energies and resources on preventing hospital-acquired disability. One is obvious. Any effort by the government to restrict the growth of PAC will in turn limit the ability of acute care hospitals to expeditiously discharge poorly performing patients. Hospitals’ bottom line may suffer through increased overall lengths of stay and bottlenecks to the admission of patients requiring more highly reimbursed procedures. The impact of this scenario is conjectural. However, there are near-term consequences as well. Disability increases the likelihood of a patient’s being readmitted within 30 days of discharge,11 and the diagnoses for which Medicare will no longer reimburse 30-day readmission costs are slated to expand. Further, the reimbursement by episode of care mandated by the Affordable Care Act and being trialed by the Centers for Medicare and Medicaid Services’ Bundled Payments for Care Improvement Initiative will force acute care hospitals to share the costs of protracted convalescence for acquired disability with their PAC counterparts and has the potential to radically change provider incentives and behaviors. However, an awareness of these initiatives has not as yet spurred broader implementation of empirically validated early mobilization approaches.

To gain traction, promobilization policies would be enhanced by objective means of characterizing and tracking the function of hospitalized patients. However, busy hospital-based workflows can only accommodate brief functional assessments. Comprehensive inventories, such as the Continuity Assessment Record and Evaluation Item Set,12 may take up to 60 minutes to administer and are therefore poorly suited for the repeated clinical assessments needed to direct care. A precise system for rating and monitoring function with the efficiency to feasibly integrate into work clinical flows not only would provide a substrate for policy change, but could be linked to easy-to-implement, cost-effective individualized treatment plans. The strength-, balance-, and stamina-enhancing activities integral to such plans are not complex and are already being performed in restricted settings by less skilled staff under therapist supervision. Most importantly, objective longitudinal ratings will be essential to benchmark institution-, unit-, and provider-level mobilization activities; promote caregiver and patient accountability; and develop empirically based process measures.

The development, implementation, and routine use of functional rating will require buy-in from disparate stakeholders with competing interests. History suggests that payer mandates may most effectively catalyze the needed level of cooperation. Payers baulk at PAC costs even though their policies contribute to PAC expansion. Therefore, it is critical that Medicare and other payers entertain policy changes that target acute care hospitals, in concert with efforts to reduce PAC reimbursement.

Keywords
Function; Healthcare utilization; Policy; Post acute care; Rehabilitation; Reimbursement

List of abbreviations:
DRG diagnosis-related group
PAC postacute care
Corresponding author

Andrea L. Cheville, MD, MSCE, Mayo Clinic, 200 First St SW, Rochester, MN 55905. E-mail address: Cheville.andrea@mayo.edu.

Acknowledgment

We thank Kurt Kroenke, MD (Indiana University School of Medicine), for his advice on this article. Dr Kroenke received no compensation for his contributions.

References