NEBRASKA HEALTH NETWORK | METHODIST | Nebraska Medicine

Post-Acute Care
Overview

WHAT IS POST-ACUTE CARE?

Post-Acute Care is an all-encompassing umbrella that includes everything from long-term acute care hospitals, inpatient rehabilitation facilities, skilled nursing facilities and home health agencies.

NEARLY HALF
OF ALL MEDICARE BENEFICIARIES
UTILIZE POST-ACUTE CARE
FOLLOWING HOSPITALIZATION

POST-ACUTE CARE ACCOUNTS FOR MORE THAN
$2.7 TRILLION
PERSONAL HEALTH-CARE EXPENSE
source: American Hospital Association

FROM 2001 TO 2014,
MEDICARE SPENDING
ON POST-ACUTE CARE
GREW 102%

SKILLED NURSING FACILITIES

According to the JAMA Internal Medicine, **40%** of older patients receive post-acute care after hospitalization, and of those, nine out of 10 are discharged to a SNF or supervised home care.

Post-Acute Care
- Inpatient Rehab Facilities
- Long-Term Acute Care Hospitals
- Home Health Agencies

WHAT DOES SKILLED CARE MEAN?

Skilled care services are medical care that can only be done by a skilled, trained and licensed nurse or therapist. If the care can be done by a home health aide (someone who assists with the activities of daily living, like dressing, eating or bathing) or by a person who doesn't need to be licensed, it's not considered to be skilled care services.

WHEN SHOULD A PATIENT BE ADMITTED TO A SNF?

Admission to a SNF is medically necessary when all of the following criteria are met:

- The patient is medically stable
- Skilled care services are medically necessary and those services cannot be provided at home
- Skilled care services are provided under the supervision of a physician by a qualified and licensed SNF
- Care plans specify realistic goals and discharge plans
- One or more skilled therapies or skilled nursing services must be provided daily
- Skilled care services are expected to result in a measurable and significant improvement in the patient's condition within a reasonable length of time

HOW IS SKILLED CARE PAID FOR UNDER MEDICARE?

Medicare Part A, which is the hospital insurance, pays for a limited number of skilled care days, called a benefit period. A benefit period begins on the first day of a hospital admission or a skilled care admission.

FIRST SKILLED CARE STAY + **SECOND SKILLED CARE STAY** = **100 DAYS**

A benefit period ends only after the Medicare patient has been discharged from skilled care and remains at home for a consecutive 60-day period. If the patient is readmitted to the hospital or to the skilled facility within that 60-day period, those days are added to the days of the first skilled stay and all become part of a single benefit period.

Under original Medicare, patients do have out-of-pocket costs associated with stays in a skilled facility. These co-insurance costs occur with each benefit period, even if a patient has multiple benefit periods in the same calendar year:

DAY 1-20	$0 Co-Insurance
DAY 21-100	$176 Co-Insurance Per Day
DAY 100+	Patient Is Responsible For All Costs

THE NHN APPROACH

NHN is aggressively pursuing a post-acute care strategy to improve care coordination, improve quality outcomes and lower utilization and cost.

KEY METRICS

- Lower Length of Stay
- Decrease SNF Utilization
- Generate Shared Savings

NHN's plan includes three key elements:

Create Preferred PAC Network

A high-performing PAC network enables NHN to:

- Closely monitor care provided to our patients after discharge
- Establish relationships with providers and SNFs that consistently provide high-quality care
- Provide opportunities for collaboration and best practice sharing across the entire care team.

Measure and Report Performance

Increased transparency and performance reporting improves NHN's ability to work with high-performing care partners. It also strengthens a SNF or home health agency's ability to perform by integrating them into the overall care strategy for each patient and increasing their visibility to key performance metrics.

NHN will utilize many of the same performance measures currently used by Medicare including star ratings for skilled care facilities on their Nursing Home Compare website. These performance measures include:

- Preventable hospital readmissions
- Emergency department visits during a skilled care stay
- Patient falls that result in injury
- Medicare spending per beneficiary for patients admitted to skilled care

Collaborate with PAC to Manage Care

A successful PAC strategy requires dedicated personnel to help oversee and drive care coordination. These individuals will work closely with SNFs and home health partners to strengthen care coordination by increased communication and performance reporting.

Post-Acute Care Education Module

For the full Post-Acute Care Education Module, go to *NebraskaHealthNetwork.com/pac-module.* If you are interested in learning more about the NHN and how it can impact your work contact us at 402-559-6464 or visit NebraskaHealthNetwork.com.