Inpatient Rehabilitation in the Era of Population Health Management:

*Why We Must Change*

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2017 UDSMR® Annual Conference

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**What we will cover**

- Reform
- Redesign & Role
- Trust & Talking
- Recommendations
My goals for today

- Recognize population health conversation is already occurring
  - In the courses of this meeting
  - In the hallways and meeting rooms of your institutions
  - In your clinical practice
- Provide fuel for the conversation
  - The stakes for our field and you are high
  - The time is urgent – MedPAC ready now
- Provide additional clarity
- My perspective only as a fellow journeyer

The upheaval of reform

- Most tumultuous time in modern health care
- Looking back: growth & reimbursement…

1965 - Medicare & Medicaid
  - Cost plus 2%
  - Growth of 13% per year

1983 – DRGs – retrospective to prospective
  - Growth slows from 9.9% to 5% per year
The upheaval of reform

2010 – PPACA and (Patient Protection and Affordable Care Act)
2015 – MACRA (Medicare Access and CHIP Reauthorization Act)

- Payment for volume to payment for value
- No longer the more we do the more we get paid
- ACO, VBP, BPCI, APM, MIPS, and coming… Site Neutral Pay

Providers scrambling to…
- Realign
- Cut cost without diminishing quality

If it doesn’t add value…
redesign it or stop doing it!

My perspective

Rehabilitation experience
- Leader and provider
  - IRF: free-standing and hospital-based within an IDN system
  - Subacute rehabilitation
  - Private practice single specialty PM&R group
    - Four acute hospitals & 10 subacute facilities

Hospital & health system experience
- Care redesign: acute & post-acute
- Home health

Apply to post-acute care continuum not OP MSK & interventional
Advocate Health Care

### Advocate Health Care
- **13 Hospitals**
  - 10 acute care hospitals
  - 1 children’s hospital
  - 1 critical access hospital
  - 1 clinically affiliated hospital

### Post-Acute Care
- Post Acute Network > 30 SNF affiliates
- Home health care
- 2 physician groups (>1,500 physicians)
- 250 sites of care
- 34,000 Employees

### Advocate Physician Partners
- 11 PHOs
- 4,900 Participating Physicians
- Largest ACO in US - 709,000 covered lives
- Nationally recognized CI Program
- Leader in Population Health management

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### Advocate Continuum of Care

<table>
<thead>
<tr>
<th>Provider</th>
<th>ADC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advocate Hospitals</td>
<td>2,126</td>
</tr>
<tr>
<td>Advocate at Home (Home Health, Hospice, RT/DME, Home Infusion)</td>
<td>9,925</td>
</tr>
<tr>
<td>Advocate Post Acute Network (SNF, LTACH, Physician at Home, Palliative)</td>
<td>1,245</td>
</tr>
<tr>
<td>Advocate Rehab Network</td>
<td>93</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>13,389</strong></td>
</tr>
</tbody>
</table>

Advocate Post Acute represents an ADC of 11,254 or 84.1% of Total ADC
Commitment and caution

Pursuing the Triple Aim
– Better care
– Better outcome
– Less cost

Caution re: minimizing cost
– Unanticipated, untoward impacts
– Medical complications
– Unachieved function
– Additional costs

Physiatrists’ role in post-acute care

“Physiatrists have the knowledge and expertise to serve an important patient care and leadership role in all post-acute care (PAC) settings, including Skilled Nursing Facilities (SNFs).

Physiatrists are optimally suited by way of their unique combination of medical and functional knowledge and expertise to achieve the highest functional outcome for patients at the least financial cost to our society.”

American Academy of Physical Medicine and Rehabilitation 2016 Position Statement
“Physiatrists Role in Skilled Nursing Facilities”
Sutton’s Law & health care redesign

“Because that’s where the money is!”

<table>
<thead>
<tr>
<th>MSPB Period</th>
<th>Highest (NJ)</th>
<th>Average (US)</th>
<th>Lowest (OR)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1–3 Days Before Admission</td>
<td>$239</td>
<td>$252</td>
<td>$224</td>
</tr>
<tr>
<td>During Index Hospitalization</td>
<td>$10,017</td>
<td>$10,122</td>
<td>$10,945</td>
</tr>
<tr>
<td>1–30 Days After Discharge</td>
<td>$9,508</td>
<td>$7,984</td>
<td>$5,844</td>
</tr>
<tr>
<td>Complete Episode</td>
<td>$19,764</td>
<td>$18,358</td>
<td>$17,013</td>
</tr>
<tr>
<td>Percent Post Acute Spend</td>
<td>48.1%</td>
<td>43.5%</td>
<td>34.4%</td>
</tr>
</tbody>
</table>


The Triple Aim & health care value

The Triple Aim
– Improving care
– Improving health
– Reducing cost

Health care value = \( \frac{\text{outcome}}{\text{cost}} + \text{experience} \)

Population health management
Population health changes

**CMS and other payers shifting**
- *From* - fee-for-volume
- *To* - fee-for-value

**Utilizing risk shifting** (and potential benefit) **to provider**
- MSSP (Medicare Shared Savings Program)
- ACO (Accountable Care Organization)
- BPCI (Bundled Payment for Care Improvement Initiative)
  - Mandated CJR (Comprehensive Care for Joint Replacement)
  - Adding hip fracture and cardiac care

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Sutton’s Law & population health

Sutton’s Law applied to the care continuum
+ population health management
= **Post-acute care is in the crosshairs!**
Redesigning post-acute care

• What will redesigned post-acute look like?
• Who is – and will be – redesigning post-acute care?
• Where does inpatient rehabilitation fit in?
• How do we individually and collectively think and feel about these changes?

The physiatrist role across the care continuum - today

Evolving models of care and unestablished role for physiatrist

Long, stable history with established role for physiatrist, mandated by CMS as IRF “gatekeeper”
Population health changes and who will decide about physiatrist participation? – future

“Bed level” rehabilitation increasingly shifting from IRF to SNF/SAR

Referring physician refers to physiatrist

Physiatrist mandated by CMS as “gatekeeper”

Referral to physiatrist increasingly constrained by policy makers (via guidelines or protocols) with value (or cost) as predominant determinant

Home Health

Outpatient

Who will lead the SNF/SAR team?

SNFist role emerging
– Growing need
– Varied specialties

Number of SNFs: 15,600 (CMS, 2015)

Hospitalists (Society of Hospital Medicine survey)
– 52,000 estimate
– 30% some post-acute care now
– 58% say hospitalists should be in post-acute
Who will lead the SNF/SAR team?

Potential hospitalist/SNFist supply
≈31,000

Physiatrist supply
≈ 9,000 (AAPM&R)

Need
≈ 15,000

Physiatrists will necessarily share clinical care and team leadership within SNF/SAR setting

Shifting point of control

• Probable effects on post-acute care of moving to population health management
  – Less IRF utilization
  – More SNF/SAR utilization

• Point of control shifting from referring physician to post-acute policy makers
  – Criteria for whether or not to involve physiatrist
    Note: initial CJR bundle impact

• Guiding forces
  – Cost containment
  – Evidence?
Where’s the evidence? IRF vs. SNF

• Lower extremity joint replacement studies  
  *Equivocal*
  – No significant difference *or*
  – Inconsistently in favor of IRF

• Stroke and hip fracture studies  
  *In favor of IRF*
  – Better functional outcome
  – Higher discharge to home
  – Lesser mortality

Where’s the evidence? IRF vs. SNF

Potential explanations for observations

• Differences in patient characteristics
• Differences in provision of care
  – Amount of therapy
  – Physician-led care
Where’s the evidence? IRF vs. SNF

Dobson | DaVanzo, 2014
Comprehensive, cross-sectional, longitudinal, & claims-based study

Rehabilitation in IRFs leads to:
- Lower
  - Mortality
  - Readmissions
  - ER visits
- More
  - Days at home
  - Cost

Caution: pre-ACA, 2005–2009

Where’s the evidence? SNFist

• Few studies: varied models & mixed results

Two studies…
• Large academic system
  geriatrician/NP model vs. standard care
    - Decreased LOS
    - Trend toward lesser readmissions
• Nursing home:
  post-acute hospitalist vs. community based
    - Increased laboratory costs
    - No reduction in falls
    - No report on length of stay
Where’s the evidence?

Physiatrist vs. Non-physiatrist

Important implicit elements in these prior studies
- IRF care
  – Includes physiatrist: clinical care & team leadership
- SNF care
  – Physiatrist not required
  – Physician (SNFist) specialty variable
- Pre ACA impact care models

No studies differentiating physiatrist vs. non-physiatrist physician role or impact within the SNF setting

Shifting our identity – portrayed in stark contrast

- What is our role?
  – For individual patients
  – For society
- How does population health affect our role?
- How do we balance the tension of individual benefit and societal cost?
- This tension touches our values and may threaten our perceived role and identity

So… how do we see ourselves and how do we look to others?
### How We See Ourselves vs. How Population Health Leaders See Us

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<tr>
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<th>How Population Health Leaders See Us</th>
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<tbody>
<tr>
<td>Advocate for the individual patient</td>
<td>Advocate for the individual patient - not health care value oriented</td>
</tr>
<tr>
<td>Advocate for inpatient rehabilitation (IRF) over subacute (SNF) rehabilitation</td>
<td>Requestor of more intense care without attention to cost</td>
</tr>
<tr>
<td>Protector against the System who will seek to deny access to care</td>
<td>Advisor (at times) regarding appropriate level of care</td>
</tr>
<tr>
<td>Appropriate determiner of level of care for patients with disability</td>
<td>Too willing to see patients “too often” without adequate consideration of value added</td>
</tr>
<tr>
<td>Appropriate clinician and leader for interdisciplinary care team for patients with disability</td>
<td></td>
</tr>
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### Building trust – starting with ourselves

- Must address our mutual distrust
- Accept the reality of population health and payment-for-value
- Face our stories about the “big bad system” – true & untrue
- Reframe our perspective on population health management
  - Partner not adversary
  - Jointly redesign post-acute care
- To meet our patients’ needs
  - Not discarding our commitment to advocacy
  - Willing to be a part of the “mess”
Having Crucial Conversations

- New skills and knowledge needed for…
  "Crucial Conversations"
  - High stakes
  - Varied opinions
  - Strong emotions
- Think outside our normal comfort zone
- Be willing to innovate how to be a meaningful partner at all post-acute levels

Building trust – Shared meaning

- Creating larger pool of shared meaning
- All participants feel safe enough to share their perspective or meaning

"The more we add of each person’s meaning, the more information is available to everyone involved and the better the decisions made.”
Building trust – Shared meaning

Shared Meanings
- Triple Aim
- Evidence
- Experience

lead to increased Trust

Physiatrist

Population Health Leader

Being a part of the conversation – demonstrating our value

• Enter with commitment to Triple Aim
• Be willing to be honest, have constructive conflict and build trust
• Look for and define common ground
• Explain value-based physiatrist capability
  – Highest functional outcome
  – Least financial cost
  – Managing resource utilization of costly therapy
• Manage ourselves with value in mind
**Framework for Value Conversation**

**Co-create care path and physiatrist role**
- Patients appropriate for physiatrist involvement
- Determining next care level
- Coordinating the interdisciplinary care team
- Appropriate therapies
  - Intensity and frequency to achieve functional goals
  - Especially in the SNF setting
- Frequency for physiatrist patient visits & follow-up
- When to sign off from patient’s care
- Responsibilities in handover to next level of care

**Where do we go from here?**

**Our choices are clear**
- Stick with what we are doing … or
- Accept emerging reality & change ourselves
  - Beliefs
  - Attitudes
  - Knowledge
  - Practice
  - Even personal and professional identity

So that …
Where do we go from here?

We can thrive as partnered *clinicians* and *leaders* in the ongoing care of our patients

Recommendations

To our research colleagues

- We need comparative effectiveness research
  - Assessing the benefits of the physiatrist’s role in direct clinical care and team leadership
  - Particularly within the SNF level of care
- Not whether physician-led team care provides benefit
- Rather, about physiatrist-led team care…
  - Performance compared to non-physiatrist lead teams
  - With focus on optimizing the selection, timing, frequency and duration of therapies
Recommendations

To our physiatrist leaders in health care

• Know your local hospital & post-acute care environment

• Intentionally develop positive working relationships with decision makers about physiatrist involvement
  – ACO
  – PHO
  – Physician groups: larger employed or private especially those taking risk

• Prepare for & engage in the physiatry value conversation

Recommendations

To our individual practitioner colleagues

• For those of us in the latter years of practice
  – “Riding it out” is not unreasonable

• For those of us who will be in the population health storm

“Don’t lose heart!”

You can choose to see all of this as malevolent and resist changing or choose to be a flexible learner, advocating for your patients while being an active participant in the change.
The words of Victor Frankel

“Everything can be taken from a man or a woman but one thing: the last of human freedoms — to choose one’s attitude in any given set of circumstances, to choose one’s own way.”

THE CHOICE IS OURS

Thank You!