

Why Not Home?

A Study of the Impact of an Effort to Reduce Postacute Expenditures

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ABSTRACT

Purpose of Study: Accountable Care Organizations (ACOs) aiming to reduce healthcare expenditure adopt strategies targeting costly postacute service utilization, asking “why not home?” as a part of the hospital discharge planning paradigm. This study examined the impact of an interventional approach to implement evidence-based interventions to improve transitions of care to the least restrictive next site of care on the rate of skilled nursing facility (SNF) admissions per 1,000, SNF length of stay (LOS), and total SNF cost.

Primary Practice Setting: The impact of the interventional approach for an ACO-attributed Medicare population, analyzing Medicare Shared Savings Plan Part A and Part B beneficiary claims data, was examined.

Methodology and Sample: A pre-/postintervention analysis was conducted, for dates of service 12 months pre- and postintervention for patients admitted to any hospital within the integrated health care system. The outcome variables were defined as SNF admission rate, SNF LOS, cost of care (total SNF cost, SNF cost per admission), and hospital LOS prior to SNF discharge.

Results: There was early evidence of the effectiveness of the multifaceted interventions that involved the delivery of interprofessional team member education focused on the tenets of value-based care and discharging patients to the least restrictive setting, as appropriate. In the normalized data review, it was noted that the rate of SNF discharges per 1,000 patients changed from 73 per 1,000 patients in the preintervention period to 70 per 1,000 patients in the postintervention period. The total SNF cost in the postintervention period only increased by 3%, with a difference of \$616,014, despite the 10% increase in the total ACO-attributed patient population during the same period.

Implications for Case Management Practice: The results of this study imply that a multifaceted intervention with aims to shift the transitional care planning paradigm toward discharging to the least restrictive next site of care is an effective strategy for ACOs with aspirations to improve the utilization and expenditure in the postacute setting. The analyses suggest that providing education to interprofessional team members that reinforces the tenets of value-based care and the importance of asking, “why not home?” for every hospitalized patient, and leveraging technology-based insights positively impact discharge rates to SNF and other ACO outcomes.

Key words: *Accountable Care Organization, discharge planning, postacute utilization, SNF utilization*

Accountable Care Organizations (ACOs) seeking to decrease health care expenditure may endeavor to decrease the use of institutional postacute care. The implementation of transitional care planning strategies that consider the question, “why not home?” for every patient discharging from the hospital, embraces the spirit of discharging to the least restrictive next site of care. Previous studies indicate that reductions in skilled nursing facility (SNF) spending increase as ACOs mature, partly as a result of efforts to decrease rates of discharge to the SNF setting of care (McWilliams et al., 2017). Claims-based data analyses can be leveraged to inform multifaceted interventions and to inform and drive change. The purpose of this study is to investigate how an intervention to transform the transitional care approach

to align with discharging patients to the lowest level of care, as appropriate, impacts patient outcomes.

Our previous retrospective cohort study analyzed the association between discharge dispositions of home health (HH) compared with SNF, and the outcomes of readmission rates and cost of care, specifically for Medicare ACO patients discharged from the hospital (Chovanec et al., 2021). Our data analysis

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The authors report no conflicts of interest.

DOI: 10.1097/NCM.0000000000000519

revealed that there are lower readmission rates and cost of care for individuals discharged to home with HH compared with SNF, even when considering diagnosis and risk level (Chovanec et al., 2021). Discharges to SNF are more likely to be readmitted to the hospital within each time frame (30, 60, and 90 days). The difference between readmission rates for HH compared with SNF was statistically significant at the 30-day time frame. ($p < .000$) (Chovanec et al., 2021). When reviewing specific diagnoses, including joint replacement, pneumonia, and urinary tract infections, it was noticeable that SNF discharges have higher 30-, 60-, and 90-day readmission rates (Chovanec et al., 2021). The cost of care was lower for the HH discharge disposition, with an \$8,678 per patient difference between the care for patients discharged to HH and SNF levels of care, with the differences between the two groups being statistically significant (Chovanec et al., 2021). In the summary of our results from the analysis, implications were suggested for employing a transitional care planning approach that prioritizes discharging patients to the least restrictive next site of care, and implemented multifaceted interventions in one integrated health system toward that aim.

There is evidence in the literature to support interventions to ensure patients receive the right care, in the right setting, at the right time. A previous study found a prevalence of approximately 10% of nursing home residents that have minimal care needs, which could adequately be met in the community setting, suggesting implications for ensuring a least restrictive setting for care (Mor et al., 2007). The overuse of SNF services is complicated by subjectivity and variation in the determination of discharge disposition, as evidenced by a study of similar surgery patients that found that 61% of patients discharged to SNF could be matched to a clinically indistinguishable patient who was discharged home with HH (Balentine et al., 2018). It is important to understand how changes in discharge disposition decisions will impact quality of care and patient outcomes. A study of a cohort of 114 ACOs found that participation in the ACO was associated with a 9% reduction in postacute spending that was largely driven by fewer discharges to SNF level of care, without an impact to quality of care outcomes (McWilliams et al., 2017). This finding is

in alignment with the results of our previous study, as it was found that patients discharged to the SNF level of care were nearly five times more likely to be readmitted within 30 days, compared with patients discharged to HH (Chovanec et al., 2021).

There is a strong evidence base to support implications for a discharge planning approach that prioritizes discharge disposition decisions that allow the patient to receive services in the lowest level of care, as appropriate, to meet the care needs. However, there is an apparent gap in the literature, as there were no studies identified that described the interventions used to drive the practice change, and the impact of the interventions. The purpose of this study is to examine the impact of the interventional approach to increase the emphasis on evidence-based interventions to improve transitions of care to the least restrictive next site of care on the rate of SNF admissions per 1,000, SNF length of stay (LOS), and total SNF cost, pre- and postintervention for the 12-month period before/after July 1, 2018, for a population of Medicare patients attributed to an ACO.

DATA AND METHODS

Interventions

The multifaceted, strategic approach to ask the question, “why not home?” throughout the discharge planning process for hospitalized patients, was initiated in one integrated health system on July 1, 2018. The dissemination of the results from the previous study was pivotal in the effort to create a compelling argument for change. The ACO leaders facilitated education for interprofessional team members, transforming the transitional care planning approach, and deployed predictive analytics to link readmission risk to mitigating interventions.

Interprofessional Team Education

Providing education for interprofessional team members, with an emphasis on discharging to the least restrictive next site of care, was a significant step toward the aim of the interventional approach. A previous study found that patient status assessments and subsequent discharge recommendations can vary among interprofessional team members, even

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when there are similar scores on quantitative assessment tools (Grimmer et al., 2004). Another study that sought to clarify the differences in perspectives among interprofessional team members relative to discharge planning assessments found that, generally, physicians and nurses focus on body functions, physical therapists focus on activity and participation, and social workers focus on environmental factors (Mizuma et al., 2020).

Prior to the intervention, the authors recognized the variances in discharge disposition recommendations and difference in perspectives relative to next site of care selection among our team members, similar to the evidence derived from the literature. The authors had a sense that a common approach was to aim for the highest level of care a patient may need following the hospital stay, compared with ruling out home as the appropriate disposition prior to moving to the next higher level of care. ACO claims and utilization data were used to define the problem, and recognized that the SNF expenditure per beneficiary was consistently higher than the all-ACO average. A detailed report of the drivers of SNF expenditure showed that the LOS in SNF and payment per SNF episode were in line with the all-ACO average. However, the volume of discharges from the hospital to SNF level of care exceeded the all-ACO average each quarter. This data suggested implications for improved strategic alignment between team members, taking into account each of the interprofessional team members' assessments, findings, and recommendations in the development of the discharge plan. The ACO leaders intended to drive alignment relative to the overarching aims of transitional care planning, transforming the paradigm to reinforce the

significance of discharging to the least restrictive next site of care through an educational campaign.

Interprofessional bedside caregivers were targeted for the educational intervention, engaging them in the campaign and soliciting their feedback relative to perceptions, barriers, and solutions to drive the change. In each of the hospitals, the existing infrastructure of nurse and social work care managers to drive the change was leveraged. The team members who received the education had varying levels of expertise, years of experience, and educational levels. The format of the education sessions were the same for each group of learners. Over a 12-week period, education was delivered in 12 in-person team meetings through 30-minute presentations to audiences of therapists, discharge planners, hospital leaders, and physicians in each hospital throughout the integrated health care system. It was estimated that approximately 334 staff members attended an in-person session, targeting these professionals for the educational intervention based on their contributions to driving discharge disposition recommendations. There were no overhead or additional costs for this intervention.

The education was developed and delivered with consideration to the tenets of interprofessional collaboration, value-based care, and transitional care management. The internal study findings that discharging to the least restrictive next site of care resulted in decreased readmissions and improved outcomes were highlighted (Chovanec et al., 2021). The facilitators partnered with HH team members, providing education on the capabilities of HH to care for high complexity and acuity patients. The presentation materials included context and background relative to the unsustainable trend in health care spending, ACO performance, and emphasized the importance of reducing variation in practice and balancing the prudent use of health care dollars with positive patient outcomes. The facilitators guided discussion about implications for transitional care planning, including delineating these considerations for interprofessional practice:

1. Performance of a comprehensive assessment of risk;
2. Appropriate next site of care setting selection;

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3. Transitional care management after hospital discharge;
4. Provision of patient and family education to support self-management;
5. Ensuring timely primary care or specialist follow-up;
6. Connectivity to resources and services; and
7. Readmission prevention strategies.

Generally, the educational sessions sparked engaged dialogue about the campaign, and the overall reception and disposition was positive. The team members' commitment was solicited in the effort to ask, "why not home?" for each hospitalized patient, eliminating home as the appropriate next site of care prior to suggesting the next highest level of care setting. During the study period, reinforcement of the transitional care planning approach with all team members continued, in an effort to sustain the overwhelming initial interest and engagement. Leaders addressed the campaign as a standard agenda item during team meetings and huddles, soliciting feedback from staff members relative to the successes and challenges of the approach. The interprofessional team members and leaders remained focused on building and sustaining momentum.

Leveraging Predictive Analytics for Readmission Prevention

The "why not home?" campaign was complemented by the introduction of a predictive analytics model used during the hospital stay, to determine the risk for unplanned readmission. Prior to the implementation of this model, providers, care managers, and therapists relied on their own subjective and objective assessments of the risk of readmission and provided recommendations for interventions without an algorithm to guide decisions. The readmission risk model was embedded into the electronic health record, and determined risk for readmission based on 27 variables that were identified to have the highest predictive value. The health system designated thresholds based on risk, ranging from good, high, and warning to the highest level of risk, defined as danger. Within the electronic health record workflow, the discharge planner or other interprofessional team member

could easily identify the factors contributing to the risk score.

For patients with an unplanned readmission risk score in the danger, or highest risk, threshold, an algorithm with associated interventions for implementation was delineated and connected to a care plan template. Each of the interventions in the algorithm was developed to mitigate the risk in the home setting of care, for implementation as appropriate. The frontline staff, leaders, and multidisciplinary teams were involved in the development and implementation plan for the daily transition rounds, and facilitated the eventual implementation. The readmission risk score was discussed during interprofessional daily transition rounds. The care managers and other team members would individualize the care plan interventions, including ensuring follow-up appointments are made prior to discharge, developing a plan to ensure that medications are obtained at discharge, reviewing the discharge medication reconciliation list for accuracy, providing accurate and complete discharge instructions, ensuring hand-off to the next level of care provider, and conducting a follow-up phone call within 48 hours of discharge. The utilization of the predictive analytics model and the deployment of transitional care management interventions to support the highest risk patients discharged to the home setting were in alignment with the aims of the project.

Data

For this interventional study, the authors analyzed Medicare Shared Savings Plan Part A and Part B beneficiary claims data paid through March 21, 2020. A pre-/postintervention analysis was conducted, comparing dates of service 12 months pre- and post-July 1, 2018, for patients admitted to any hospital during the study period. The authors targeted the 13 hospitals within the largest integrated health system that serves the geographical region relative to the ACO for the intervention. The flagship hospital is a 794-bed hospital that is also the largest acute care facility in the region, and each of the hospitals serve a combination of urban, suburban, and rural communities. The health system is a not-for-profit, mission-based

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organization that values delivering the right care, at the right place, at the right time, and the right cost, as evidenced by its partnerships with area nonprofit organizations to help advance community advocacy programs that support communities across north-west Ohio and southern Michigan. For this study, the diagnoses and demographics for the population over the 24-month period were entered into the Centers for Medicare & Medicaid Services (CMS) 2016 version 22 Statistical Analysis System (SAS) program to calculate the risk scores. The study received Institutional Review Board approval.

Independent variables, including demographics (age, gender), diagnoses, and risk level, were studied for the pre- and postintervention periods. The CMS Hierarchical Condition Category (HCC) risk adjustment model was leveraged to compute the risk scores for the analysis. The HCC score considers diagnoses and demographic information to modify the monthly capitation rate to reflect the anticipated cost. The CMS-HCC risk model generates risk scores to forecast medical expenses and adjust reimbursement (CMS, 2014).

The outcome variables were defined as SNF admission rate, SNF LOS, cost of care (total SNF cost, SNF cost per admission), and hospital LOS prior to SNF discharge.

SNF Admission Rate

The study group used a formula to determine the SNF admission rates per 1,000 patients. Calculating admissions per 1,000 for both the pre- and postintervention data allows for the normalization of data over time. This technique was used to account for the variability that may result in the claims data through a 12-month review period, such as seasonal inconsistencies or trends.

SNF Cost and LOS

The study group identified all acute SNF claims within 0 or 1 day after an acute hospital stay for the dates of service to calculate the cost of SNF care and LOS in the SNF setting.

Hospital LOS Prior to SNF Discharge

To calculate the hospital LOS prior to the discharge to the SNF, the claims were evaluated to determine when the inpatient hospital stay commenced. The SNF admission dates were equal to the inpatient discharge dates. These data points were used to determine the hospital LOS.

Statistical Analyses

Descriptive statistics were used to assess demographics and clinical characteristics. Data were normalized

for the number of SNF admissions. Continuous variables are presented with their mean and standard deviation (SD). Differences between the groups on the continuous variables were measured by the Student's *t*-test or the Man-Whitney *U* test, based on the variables' distribution. For the categorical variables, χ^2 was performed. All *p* values were derived from two-sided tests, and results were considered as statistically significant at a *p* value below .05.

RESULTS

Patient Demographics

Preintervention, 1,388 patients had 1,857 SNF admissions, compared with 1,376 patients with 1,940 SNF admissions postintervention. The total Medicare ACO-attributed population increased by 10% (2,597 members) in the postintervention data analysis period, compared with the preintervention period.

The average age was 80 ± 11 years preintervention and 79 ± 11 years postintervention, and there was no statistically significant difference between the two groups in regard to age ($p < .341$). Females counted for 58% of the SNF admissions both pre- and postintervention. The average CMS-HCC risk score for patients discharged to SNF was 1.68 ± 1.64 preintervention and higher at 1.96 ± 1.77 postintervention, with a statistically significant difference between the two groups ($p < .000$). In regard to clinical diagnoses, congestive heart failure was the main diagnosis for admissions to SNF both pre- and postintervention, followed by injury and poisoning—external causes, which largely consisted of femur fractures (see Figure 1).

SNF Admission Rate

The SNF admission rates were similar pre- and postintervention with 73 SNF admissions per 1,000 patients preintervention, whereas the postintervention rate was 70 SNF admissions per 1,000 patients (see Figure 2).

SNF Cost and LOS

Preintervention, the total SNF cost was \$18,595,348, whereas postintervention it was \$19,211,362, a 3% increase (see Figure 3). The SNF cost per admission preintervention was \$10,014 and postintervention was \$9,903, a 1% decrease, but the difference was not statistically significant ($p < .504$).

The difference in SNF cost per admission was likely attributed to the difference in the average SNF LOS, which was 30 ± 54 days (median = 19 days) preintervention and 27 ± 34 days (median = 18

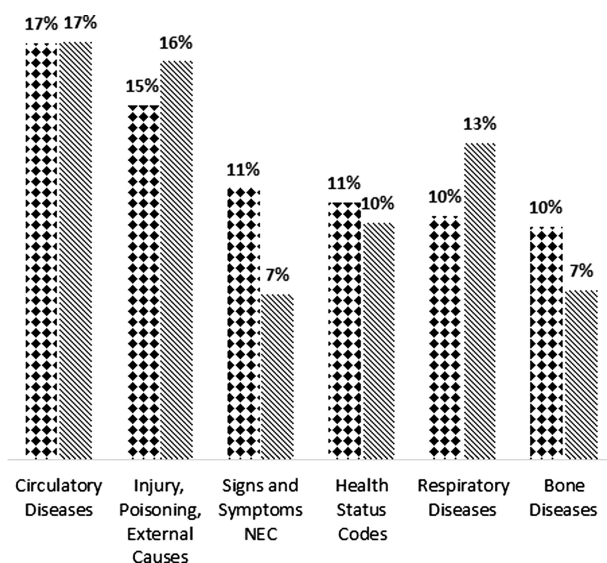


FIGURE 1
Percentage of all skilled nursing facility admissions by admitting diagnosis. Preintervention (•), postintervention (▨).

days) postintervention. However, the difference in SNF LOS was not statistically significant ($p < .434$).

Hospital LOS Prior to SNF Discharge

For the total of 3,797 SNF admissions, there were 3,297 prior hospital admissions. The average hospital LOS before an SNF stay was 7 ± 6 days (median = 5 days) preintervention, and 8 ± 11 days (median = 5 days) postintervention, and the difference was statistically significant ($p < .020$).

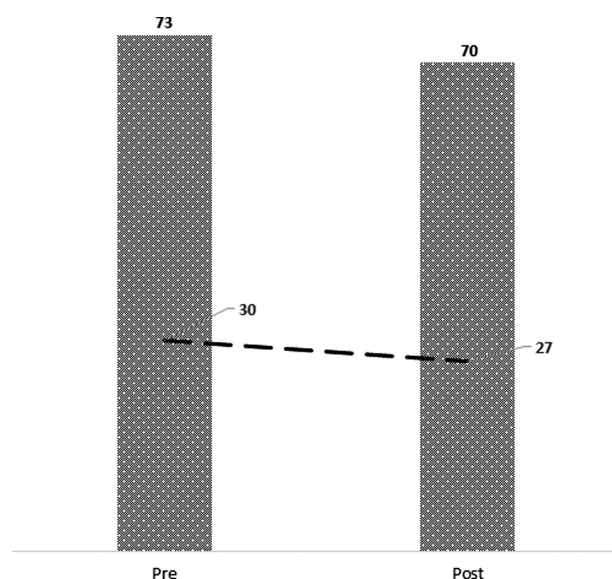


FIGURE 2
Skilled nursing facility admissions/1,000 and average length of stay. Admits/1,000 (▨), average length of stay (—).

DISCUSSION

The data analyses revealed early evidence of a paradigm shift within the integrated health system and ACO, indicating a change in interprofessional team discharge planning practices. The most compelling indicator of change was revealed in the analysis of the SNF discharge rate and volumes. Prior to the initiation of the intervention, there were 1,857 SNF discharges from the hospital. The raw volume of SNF discharges increased 4% in the postimplementation period, at 1,940 SNF admissions. It is important to review the volumes of SNF discharges in the pre- and postintervention data sets within the context of the changes to the total ACO-attributed Medicare patient population, which increased by 10% or 2,597 patients, in the postintervention period. The membership variation was largely a result of the ACO attribution methodology change from prospective to retrospective that occurred during the same measurement period. In the normalized data review, it was noted that the rate of SNF discharges per 1,000 patients changed from 73 per 1,000 patients in the preintervention period to 70 per 1,000 patients in the postintervention period. This is indicative of a substantial change in the discharge planning and disposition patterns, in alignment with the aim of the intervention to discharge patients to the least restrictive next site of care, as appropriate.

The data analyses comparing the difference in the postintervention period for the total SNF cost for the ACO Medicare population provided further evidence of the successful intervention. The total SNF cost in the postintervention time only increased by 3%, with a difference of \$616,014, despite the 10% increase in the total ACO-attributed patient population during the same period. It was estimated that the greatest cause of the relative decrease in SNF cost for the ACO was the decreased rate of SNF discharges per 1,000 patients, and a direct effect of the intervention. However, it is important to note that there were critical policy changes made during the period immediately following this study that could have influenced the SNF cost per patient and SNF LOS, which would also have an impact on the total SNF cost for the population studied.

The CMS replaced the previous SNF Prospective Payment System Resource Utilization Group with a new payment model, called the Patient-Driven Payment Model (PDPM), effective on October 1, 2019 (CMS, 2019). Fundamentally, the PDPM presented a significant change in SNF reimbursement, in alignment with the principles of value-based care and incentivizing SNFs to provide care that is individualized for the patient, effective, and efficient (Strunk,

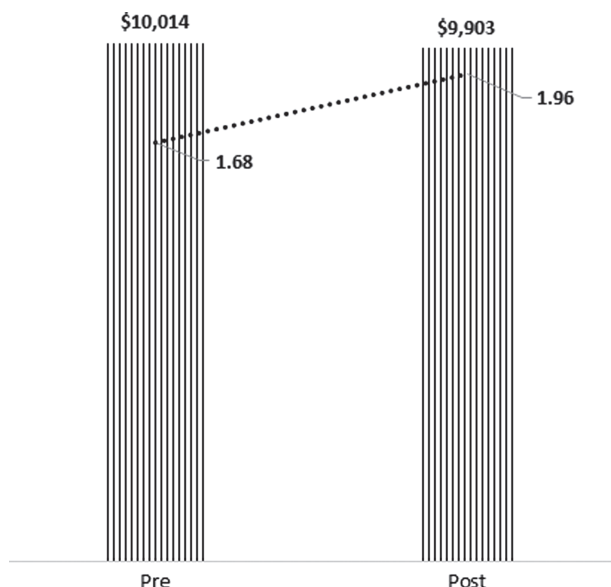


FIGURE 3

Skilled nursing facility cost per admission and average CMS-HCC risk score. Cost/admit (|||||||), average risk score (*****).

2020). Although the changes to the PDPM did not go into effect until after the study's postintervention period, it was suspected that SNFs represented in the analysis were starting to shift their care delivery strategies in advance of the PDPM effective date. Although the outcomes analyzed for patients discharged to the SNF level of care were likely not a direct result of the campaign to ask, "why not home?" for every hospitalized patient, it is interesting to note the differences in the pre- and postintervention period data sets. The data analysis showed that the CMS-HCC risk score increased from 2.66 to 2.70 for patients discharged to SNF level of care, which suggests that patients discharging to SNF are more complex. This is especially interesting, as the CMS-HCC risk score increased by a mere 0.081 during the same period for the total ACO population. Despite the relative increase in the risk level of the patient population discharged to SNF, the results indicated that there was a 1% decrease in the cost per SNF admission, which may have been affected by the 10% decrease in the average SNF LOS. It will be important for ACOs to continue to monitor the outcomes for patients discharged to

SNF level of care, as SNFs continue to drive changes to improve care delivery strategies to align with the value-based principles reflected in the PDPM reimbursement model.

Transitional care planning encompasses activities and interventions that are completed in preparation for the discharge and transfer of care from the acute care setting. The results of this study imply that a multifaceted intervention with aims to shift the transitional care planning paradigm toward discharging to the least restrictive next site of care is an effective strategy for ACOs with aspirations to improve the utilization and expenditure in the postacute setting. The analyses suggest that providing education to interprofessional team members that reinforces the tenets of value-based care and the importance of asking, "why not home?" for every hospitalized patient, and leveraging technology-based insights positively impact discharge rates to SNF and other ACO outcomes.

Limitations

There were a few limitations for this study. For the pre- and postintervention analyses, the study could not control for all variables, which may have influenced the results. Factors including patient preferences and variability in interprofessional team member practices could have impacted the discharge disposition and outcomes for the ACO Medicare patient population. The intervention was not completed in a discrete timeline. Although the intervention commenced on July 1, 2018, the education and discussions with interprofessional team members were ongoing throughout the pre- and postintervention periods, in an effort to sustain momentum and drive rapid change. Another limitation was that this study was not designed to address the impact on other clinical outcomes. The results of the analyses should be interpreted directionally, in consideration of these limitations.

The change in readmission rates for the same population in the pre- and postintervention analysis was not studied, and whether the discharge to HH setting affected the readmission rates for the patients included in the review. Our previous retrospective study showed that patients discharged to the SNF setting were almost five times more likely

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to be readmitted to the hospital, compared with patients discharged to the HH study (Chovanec et al., 2021). Although the study group did not analyze the readmissions rates for this interventional study, the authors suspected that our earlier results are transferable. Further research is needed to determine the impact of the change in the discharge planning paradigm to the outcome of readmissions.

Since the time that this study was conducted, considerable implications for further research in the area of discharging to the least restrictive next site of care have risen. Since March of 2020, the world is experiencing a global pandemic of COVID-19. The CMS has waived the requirement for patients to have a 3-day hospital stay prior to discharge to SNF (CMS, 2020), to ease the administrative burden and allow caregivers to focus on patient care and to expedite discharges from the hospital setting. There are implications for ACOs to study the impact of the loosening of requirements for discharge to the SNF setting, and whether it results in an increase in the SNF discharge rate. Additionally, the hospital LOS was longer in the postintervention period. This could be interpreted to imply that discharging patients to home requires a longer hospitalization, and further research is needed in regard to improved hospital LOS management for patients discharging to home settings.

IMPLICATIONS FOR CASE MANAGEMENT

There is early evidence to support the efficacy of the implementation of a transitional care planning approach that asks the question, “why not home?” for hospitalized patients, in an effort for ACOs to decrease postacute care-related expenditure and promote positive patient outcomes. The findings of this pre-/postintervention study support the efforts to ensure patients are discharged to the least restrictive next site of care. The ACO leaders implemented a multifaceted intervention to educate interprofessional team members on the value-based tenets relative to transitional care planning and leveraged predictive analytics to identify and mitigate risk for unplanned readmission. Following the intervention, the rate of SNF discharges per 1,000 patients decreased by 5%, even as the total ACO-attributed Medicare patient population increased by 10%. The postintervention differences in total SNF cost, which were impacted by the SNF discharge rate, SNF LOS, and SNF cost per patient, insinuate that the intervention strategy was successful in the transformation of the discharge planning paradigm. The implications from this study are profound, in support of ACOs adopting transitional care planning strategies that emphasize the

importance of discharging to the least restrictive next site of care.

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This Continuing Education (CE) program is provided by Lippincott Professional Development and has been preapproved by the Commission for Case Manager Certification (CCMC) to provide CE credit to Certified Case Managers (CCMs) for 1.0 contact hours. This CE program is approved for meeting the requirements for certification renewal.

Registration Deadline: January 1, 2023

Continuing Education Information for Certified Professionals in Healthcare Quality (CPHQ):

This continuing education (CE) activity is provided by Lippincott Professional Development and has been approved by the National

Association for Healthcare Quality (NAHQ) for 2.5 CE Hours. CPHQ CE Hours are based on a 60-minute hour. This CE is approved for meeting requirements for certification renewal.

This CPHQ CE activity expires on January 1, 2023.

Continuing Education Information for Nurses:

Lippincott Professional Development will award 2.5 contact hours for this continuing nursing education activity.

LPD is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

This activity is also provider approved by the California Board of Registered Nursing, Provider Number CEP 11749. LPD is also an approved provider by the District of Columbia, Georgia, and Florida CE Broker #50-1223.

Registration Deadline for Nurses: January 1, 2023

Disclosure Statement:

The author and planners have disclosed no potential conflicts of interest, financial or otherwise.

Payment and Discounts:

- The registration fee for this test is \$24.95
- CMSA members can save 25% on all CE activities from *Professional Case Management*! Contact your CMSA representative to obtain the discount code to use when payment for the CE is requested.

DOI: 10.1097/NCM.0000000000000547