# MEDICALLY COMPLEX:
## Driving positive patient outcomes in post-acute care

In recent years, the medical complexity of patients in acute and post-acute care (PAC) settings has increased markedly. The term "medically complex" covers a wide range of patients and conditions. It typically refers to patients who have multiple healthcare needs and require medical and social services support from several providers and caregivers.

Medically complex patients may enter a PAC facility with a primary diagnosis such as acute myocardial infarction, chronic obstructive pulmonary disease (COPD), congestive heart failure, sepsis, and wounds. Beyond the primary diagnosis, however, the many comorbid conditions that these patients have—from five to as many as 20—define them as medically complex. They are more likely to have chronic, progressive illnesses or experience life-threatening complications.

### Fragile states: understanding the complexities

As hospitals face growing cost pressures to decrease the length of acute hospital stays, many patients are being discharged while they are still in a medically fragile state. PAC facilities, including long-term care hospitals, inpatient rehabilitation facilities, and skilled nursing facilities (SNFs), are often the next destination.

Medically complex patients transferring from acute care to a PAC facility face numerous challenges. Typically, they are taking several medications that need to be closely coordinated. Many are suffering from anxiety, confusion, or depression. Stays in acute care hospitals may have left them sleep deprived, malnourished, or ventilator-dependent. Some do not have the support systems needed to ensure that they comply with clinical orders and guidelines. Often they have functional limitations and need assistance in performing activities of daily living, such as eating and getting dressed.

### SALIENT STATS

By 2050, the U.S. is projected to have 88.5 million citizens age 65 and older—more than double the number 40 years earlier.

The incidence of medically complex conditions has doubled with each decade, in line with the growing aging population and increased availability of critical care services.

Each year, more than 10 million Medicare beneficiaries—almost 42 percent—are discharged from acute care hospitals into PAC settings.

Almost 20 percent of Medicare patients are readmitted within 30 days after hospital discharge. The total cost of their readmission is $15 to $20 billion each year.

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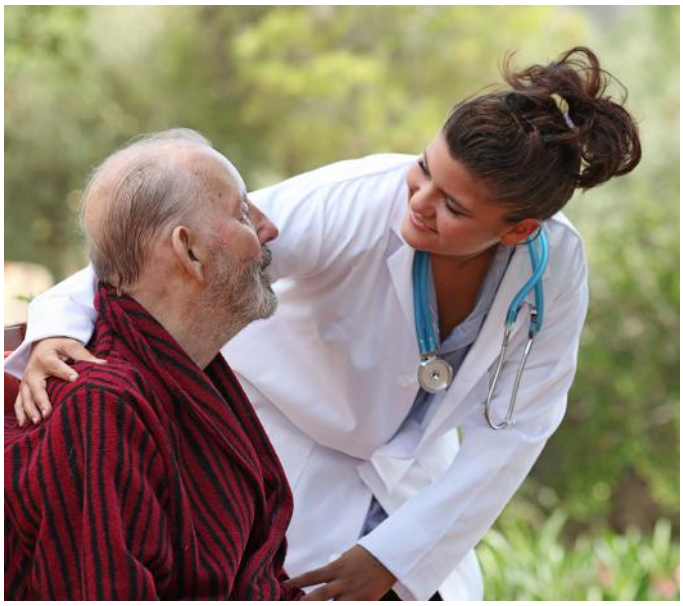

PAC providers offer these patients additional high-intensity monitoring, specialized treatment, innovative rehabilitation therapies, advanced technologies, and integrated support to recover from an acute illness or surgery and return to an optimum level of function. Research has found that patients who receive post-acute care after a major health episode improve faster than patients discharged to their homes without follow-up.

## Changing currents: navigating new payment models

Historically, care delivery and communication among primary care physicians, specialists, and PAC providers has been disjointed, resulting in poorly coordinated and more costly healthcare. The primary care physician refers the patient to the hospital, the patient is treated in the hospital by hospitalists and specialists, and the patient is discharged into a PAC facility, often without the benefit of knowledge transfer to PAC attending physicians and clinicians.

In an effort to improve care coordination, prevent unnecessary readmissions, and drive better clinical outcomes, value-based payment models are proliferating. Medicare's payment adjustments for hospitals with high rates of readmission have brought new incentives to acute care providers to work closely with PAC providers. Also, bundled payment arrangements, such as the Bundled Payment for Care Improvement Initiative and the new cardiac bundled payment from the Centers for Medicare and Medicaid Services, are holding hospitals financially accountable for entire episodes of care. Recent legislation, such as the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 and Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act), provides further incentives for acute care and PAC providers to share responsibility for the patient journey in all care venues. As hospitals and accountable care organizations face increased financial risk, they will continue to look to PAC providers to help meet cost, quality, and patient satisfaction goals.

## Coordinated care: taking a patient-centric approach

Traditionally, management of medically complex conditions has been a disease-driven approach, in which the clinical focus has centered entirely on the condition. Today's approach is an integrated one that not only treats the condition but also focuses on the whole patient.
Treatment goes far beyond the physical to address patients' mental and emotional states as well as needs for lifestyle changes and continuous education on their medical conditions.

Through collaborative models, multidisciplinary teams of physicians, nurse practitioners, physician assistants, rehabilitation specialists, and other clinical staff work together to holistically manage these patients, decrease the risk of adverse events and hospital readmissions, and speed recovery. Teams develop evidence-based care pathways to support staff decision-making, provide sophisticated levels of care and rehabilitation services, and deliver a full compendium of medical treatments, from ventilator weaning and dialysis to intravenous therapies and complex wound care management. Optimum care also requires monitoring each patient's overall sense of well-being, with a focus on mobility, nutrition, fluid electrolyte balance, adequate sleep, emotional support, and avoidance of drug side effects and interactions.

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In their stay at a PAC facility, patients should expect and receive:

- A well-coordinated transfer from their acute experience into post-acute care
- Knowledge transfer of their conditions and needs from acute care to PAC
- Post-acute care oversight by a "SNFist"—a post-acute physician whose duties in the PAC space mirror those of a hospitalist in the acute setting
- Consults by specialist physicians when clinically indicated, for example, infectious disease, pulmonologist, cardiologist, and neurologist physicians
- Post-acute clinical and rehabilitation services that prepare them for discharge to home
- A well-coordinated transfer from post-acute care to home, including home health arrangements, durable medical equipment, and assistance with follow-up primary care physician and specialist appointments

# BEST PRACTICES
## addressing medical complexities

Leading-edge PAC facilities are providing systematic and coordinated care for patients with the most predominant medical complexities, including heart disease, lung disease, chronic wounds, and sepsis.

### Heart disease

Cardiovascular disease is the leading cause of death in the U.S. Yet advances in treating acute cardiac events, such as myocardial infarction and congestive heart failure, and in fine-tuning surgical procedures, such as coronary artery bypass grafting and heart valve surgery, have resulted in steadily higher survival rates—and a surge in admissions to post-acute care. After treatment or surgery, these patients are often frail and face a difficult recovery.

Best PAC practices in cardiac care include providing:

- A specialized heart care team, including a consulting cardiologist who evaluates cardiac patients and offers recommendations to prevent a return to the hospital.
- Skilled services that help the heart patient regain functional abilities and improve prognosis for a full recovery.
- A personalized care plan that matches the patient's needs, including risk levels and functional abilities.
- Physical activities, such as range-of-motion exercises.
- Cardiac-specific education to help patients and their families better understand their condition, medications, and steps in recovery.

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HEART DISEASE

## SALIENT STATS

Every 25 seconds, an American suffers a coronary event.

More than 2 million people in the U.S. suffer from acute cardiac events each year. More than half are older than 65.

One in five patients with congestive heart failure returns to the hospital within 30 days of discharge.

Over the past 15 years, spending has more than tripled for heart attack patients and more than doubled for heart failure patients.

Almost 78 percent of healthcare providers identify heart failure as a top condition guiding their efforts to reduce readmissions.

## Lung Disease

Lung diseases, such as pneumonia, COPD, emphysema, chronic bronchitis, restrictive lung disease, and atelectasis, are critical health challenges that can result in serious complications if not properly treated in post-acute care. Pulmonary programs at PAC facilities aim to help medically complex patients with acute or chronic lung disease reach their maximum potential lung function.

Best PAC practices in lung care include providing:

- An interdisciplinary team of clinicians, along with physical, occupational, and speech therapists and social workers, who deliver respiratory services tailored to each patient's needs.
- Weaning of the patient from a mechanical ventilator and reduction of oxygen dependence.
- Physical therapy to improve lung function and strengthen breathing muscles.
- Patient and family education that addresses breathing, energy conservation, and medication management.
- Dietary consultations.
- Counseling to help manage anxiety, depression, and other side effects of chronic lung disease.

LUNG DISEASE

### SALIENT STATS

Pneumonia and COPD are the third and fourth leading causes of hospital readmission for Medicare patients—costing the program millions each year.

As many as 24 million adults have COPD.

About 10 percent of patients with acute respiratory failure become chronically, critically ill.

## Chronic Wounds

Chronic wounds impose a significant burden on patients, families, and the healthcare system. Millions of chronic wound cases occur each year in the U.S., and the numbers are growing.

After hospitalization, many patients need a specialized wound care program. The most common wounds encountered in post-acute care are surgical site wounds, pressure sores, vascular ulcers, and diabetic ulcers. Typically, these wounds are difficult to heal because an underlying state of inflammation blocks the healing process.

Best PAC practices in chronic wound healing include providing:

- Wound care physicians with expertise in successfully treating chronic wounds.
- An interdisciplinary team—including clinical, rehabilitation, wellness, and nutrition specialists—trained in chronic wound management to monitor wound sites for signs of infection and manage the healing process from start to finish.

- Clinical practice guidelines and standardized procedures to document wounds, track recovery, and achieve improved outcomes.
- Preventative interventions, from nutrition to pressure-reducing devices such as specialty mattresses.
- Advanced therapies to relieve pain, restore mobility, and prevent infection.
- Patient and family education to identify barriers to effective treatment and prevent wound recurrence.

### Sepsis

Sepsis is defined as the body's overwhelming response to infection that can lead to tissue damage, multiple organ failure, and death.

Although difficult to predict, diagnose, and treat, sepsis is often accompanied by an altered mental state and confusion, a fast respiratory rate, and low blood pressure. Research has found older adults—particularly SNF residents—have a disproportionately high incidence of and morbidity from severe sepsis.

Patients at the greatest risk of developing sepsis are those who have been recently hospitalized or recently treated for an infection, are immunocompromised, have an indwelling catheter, have an unhealed wound, or are immobile. Early identification is critical to reducing death from sepsis.

PAC best practices in identifying and treating sepsis include:

- Prevention.
- Early detection and Intervention with antibiotics and fluids.
- Frequent monitoring of vital signs.
- Development of a sepsis protocol, with training provided to all clinical staff.

CHRONIC WOUNDS

## SALIENT STATS

About 6.5 million Americans suffer from chronic, non-healing wounds at an annual cost of $25 billion.

Each year, 2.5 million pressure ulcers are treated in the U.S. in acute care facilities.

Diabetes, a source of chronic wounds, affects about 9 percent of the total U.S. population—an estimated 29 million people—and 26 percent of Americans over 65.

An estimated 25 percent of all diabetics will develop a diabetic foot ulcer.

**Older adults, particularly SNF residents, have a disproportionately high incidence of and morbidity from severe sepsis.**

## SALIENT STATS

Sepsis is the tenth leading cause of death in the U.S. and the leading cause of death in non-cardiac intensive care units.

More than 1.6 million Americans are diagnosed with sepsis each year—one every 20 seconds, and the incidence is rising 8 percent every year.

62 percent of people hospitalized with sepsis are re-hospitalized within 30 days.

As many as 80 percent of sepsis deaths could be prevented with rapid diagnosis and treatment.

Sepsis causes more readmissions—12.2 percent—than any of the other conditions used by CMS to levy readmission penalties, including heart failure (6.7 percent), pneumonia (5 percent), COPD (4.6 percent), and heart attack (1.3 percent).

# TOWARD TOMORROW: BUILDING A HEALING BRIDGE

With more and more patients requiring continuously coordinated care across the continuum, PAC providers are no longer a sidecar to the healthcare delivery system. They are leading players in helping patients with medically complex conditions decrease risk, increase strength, and return to maximum function. By serving as a healing bridge between acute care and a return to the home environment, PAC teams will continue to advance the goals of patient-centered, value-based care: proactively engaging patients, improving health outcomes, and breaking the cycle of unnecessary hospital readmissions.

### StoneGate Senior Living Can Help

StoneGate Senior Living offers skilled healthcare, rehabilitation, assisted living, and memory care in 43 communities throughout Texas, Oklahoma, and Colorado. As post-acute care continues to play a central role in the future of healthcare, we are expertly equipped to manage the most medically complex patients.

Our interdisciplinary care teams address each patient's unique medical and functional needs, uniting best practices with a dynamic, patient-centered approach to promote healing, ensure the best possible outcomes, and improve quality of life overall.

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