

The Journal

Emerging Trends in Post-Acute Care: Controlling Costs and Enhancing Quality through Collaboration

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The high drama surrounding the healthcare reform debate throughout the last year suggests that the idea of controlling the cost of healthcare delivery is a recent revelation. However, while efforts to control costs without any deterioration in quality of care predate recent events, the Patient Protection and Affordable Care Act (the "PPACA", signed into law on March 23, 2010) formally recognizes the need for cost-containment measures and encapsulates certain concepts whose efficacy has been clearly demonstrated in recent years. At the core of these emerging trends is the concept of "continuum of care", which is a significant departure from "traditional" care models that focus on excellence in isolated settings—the hospital, nursing home, outpatient facilities, and so forth—with little or no connectivity between these units of care as the patient moves from one to another in the treatment lifecycle. Moreover, the traditional definition of post-acute care implies care for elderly patients after they leave the hospital. In contrast, the emerging model encompasses all age groups, creating a new care category with high variability in care requirements. This article describes how these various sites of care are converging into a comprehensive care program that is patient-centered rather than site-centered, and the implications this will have on merger and acquisition (M&A) transaction activity. ▶

First, some history. Similar to healthcare delivery systems in the industrialized world, the U.S. system is structured as a third-party payment system (i.e. payment for services is borne in large part by payers, rather than the patient). However, the U.S. system is characterized by two “parallel” payers, each with a different demographic focus—a government-sponsored segment and a commercial segment. With the advent of Medicare in 1965, the payer system became permanently bifurcated into an expansive system of both federal and state-level government-sponsored programs which address the needs of the elderly and needy populations, and commercial indemnity plans, most of which are employer sponsored. The government-sponsored segment largely remains a “safety net” program. However, the commercial payer system has evolved from a choice-restricted, utilization-controlled structure with low or no co-pays in the 1960s and 1970s, to the current system that recognizes and accommodates some patient choice, with higher (and increasing) co-pays, thereby shifting part of the cost burden to the patient. However, due to its indemnity roots, the commercial payer system is essentially a risk-management system that bases its payment rates on historical, rather than predicted events. Historically, the payer system as a whole has not attempted to influence patient behavior to reduce future risk (and hence cost), relying instead on the curtailment of current reimbursement rates to healthcare providers as the primary cost-management tool.

This thinking is beginning to give way to a more forward-looking approach to patient care, leading to two new initiatives to help reduce overall healthcare costs in the U.S. First, while the U.S. leads the rest of the world in cutting-edge medical diagnostics and treatment, the traditional approach to patient care in America has been reactive, focusing only on curing, rather than preventing, disease. The new patient-centered care philosophy focuses on proactively integrating prevention and wellness into the care model in an effort to keep people healthier. Second, with the average per-day cost of inpatient care doubling in the last 10 years, it is imperative that the length of hospital stay be reduced. Under this initiative, post-discharge care and coordination is now recognized as an integral element of the overall economics of care delivery. It is this second initiative that we will be focusing on here.

Consider this: a recent article in the New England Journal of Medicine analyzed Medicare claims from October 2003 through December 2005 and found that of approximately 12 million patients, 19.6 percent were rehospitalized within 30 days, 34.0 percent were rehospitalized within 90 days, and 56.1 percent were rehospitalized within one year. Half of the patients readmitted within 30 days had not seen a physician during that time, and for patients who returned after a surgery was performed, 70.0 percent were admitted for an unrelated medical condition. For the overall Medicare population, most estimates of the cost of these readmissions, many of which are likely preventable, are around \$20 billion per year.

The evolving model of post-acute care is being driven in part by proposed legislation that changes the current fee-for-service payment system to a “bundled” system, in which the reimbursement rates for hospital care and post-discharge care would be bundled into a single payment. In other words, there would be a “flat” payment for hospital care and post-discharge care in a Skilled ►

Nursing Facility, Inpatient Rehab Facility, Long-Term Acute Care Hospital, or home. This idea is an extension of the current Diagnosis Related Groups structure of bundling payment for groups of diagnoses and associated treatments while the patient is still in the hospital. Moreover, strict quality and outcomes metrics would be in place, and the hospital would receive lower or no payment if the patient is readmitted within predefined time periods. The goal is to establish a direct link between cost and quality of care. The result of this type of payment system would be the creation of “Accountable Care Organizations” that will be characterized by an integrated network of physicians, hospitals, and post-acute providers, all sharing in cost savings while improving clinical outcomes.

Reimbursement and regulation are not the only factors shaping post-acute care. Advances in diagnostics and supportive technologies allow vital care to be delivered outside the hospital, thereby shortening or eliminating hospital stays. For instance, minimally invasive techniques enable surgery to be performed without the need for overnight stays. Additionally, the rapid development of care management information systems not only facilitate the efficient management of a patient’s in-hospital treatment program, but also enable connectivity with care providers after discharge. These sophisticated systems enable accurate implementation and continuous monitoring of treatment protocols—medications, pre- and post-surgery care, infection control, safety, and so forth. They also ensure minimization of billing and coding errors as well as compliance violations. The creation of “Health Information Exchanges”—the capability to efficiently move clinical information across disparate healthcare information systems—would allow the coordination of teams of caregivers focused on individual patients irrespective of their site of care.

This concept of “patient-centered care” is closely related to the evolving model of primary care. The so-called “medical home” concept, which originated in the 1960s, is a collaborative approach to primary care in which every patient is cared for by a physician who leads the medical team (including specialists and other caregivers) that coordinates all aspects of preventive, acute and chronic needs of patients using the best available evidence and appropriate treatment across the continuum of care.

As a result of these trends, the current system of patient care in America is facing obsolescence.

Today, the most dramatic change in the current system of patient care in America is in the skilled nursing sector. The role of the traditional nursing home as a destination for any elderly person who is not sick enough to be in a hospital, or well enough to be in another living arrangement such as home or assisted living, is giving way to highly specialized facilities that provide care at acuity levels approaching that of hospitals. These “transitional care” facilities are generally in the vicinity of hospitals and provide care to patients who almost meet the conditions for being in a hospital. These facilities allows hospitals to significantly reduce their average length of stay while improving patients’ clinical outcomes since specialized care is provided and infection rates and other adverse events are drastically reduced. In a bundled payment system, this would be a tremendous advantage for the hospital.▶

Related to this is the equally important trend of the retrenchment of acute care hospitals into their core competency—acute (and hence higher reimbursement) care. Reversing the trend of the 1990s when acquisitions by hospitals of businesses such as senior living, rehabilitation and home health were driven by the need to diversify service offerings in the face of declining reimbursement and limited access to capital, some hospitals are exiting, either through divestiture or joint ventures, businesses that they believe to be non-core.

Many of these trends are already having significant repercussions on M&A activity. Barely three years ago, healthcare M&A was dominated by transactions involving providers of facility based care. Today, there is an acceleration in M&A and joint venture activity that is based on the overarching thesis that growth in the emerging healthcare delivery model will be defined not by the accumulation of physical assets, but by improved collaboration among all participants—providers, payers and consumers, resulting in compelling mutual clinical and economic benefits. Acute and post-acute providers are racing to create integrated care networks, and those that are able to establish these structures first, with the best participants and technology, will be able to compete most effectively in this new era of patient-centered care. ■

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