Eli's Rehab Report

Survival Strategies: 3 Moves That'll Spell Success in Post-Acute Bundling

Out-of-the box thinking is key to post-acute rehab's survival.

Post-acute payment bundling isn't a done deal in lawmaking land, but experts say you should still get your ducks in a row now. Try these tips:

1) Track your readmissions and work on boosting outcomes. Nationwide, about 18 percent of all admissions to post-acute are readmitted, and policymakers think the number should be around 5 percent, says **Fran Fowler, FAAHC,** managing director of Health Dimensions Group in Atlanta. So zero in on your problem areas now, and fix them.

If the post-acute bundling policy takes effect, hospitals might start choosing specific business partners to administer post-acute care, and they'll choose partners who have demonstrated great outcomes, Fowler says.

Insight: "A key to avoiding readmissions is to have integrated health records between the acute and post-acute system and better physician communication," says **Tom Clarke,** president and CEO of Kissito Post Acute. "The smart facilities will realize it doesn't do any good to blame each other for the readmissions -- the question is, how can we collaborate?"

2) Investigate new business models. "The small IRF unit is destined to go out of business," observes **Lyndean Brick, JD,** senior vice president of Murer Consultants, Inc. in Joliet, Ill. So if you're running a 24-bed unit with only seven beds filled, reach out to other post-acute providers and investigate partnerships, or merge with another IRF, she suggests.

"I think we're returning to our roots in rehabilitation. And that means larger units, more centralization, and not thinking that SNFs are bad places [for intensive rehab]," Brick says.

"I believe the industry is eventually going to see multiple levels of care in one entity that has post-acute case management," Fowler predicts.

Pioneer: Some companies have already dabbled in innovative waters. Clarke's company, Kissito, owns postacute facilities that are developing SNF-LTACH integration models, which he argues can offer an IRF level of care at a lower cost.

3) Get creative with how you deliver rehab. This means getting watching your cost efficiency too. "If you can get a patient home at 5:00 pm instead of 11:00am the next day, then get her home," Brick says.

And think outside the box for better ways to deliver care. For instance, Brick recalls traveling to Germany and studying how the rehab model there was much more aggressive in incorporating the family into rehabilitation.

Bottom line: Don't be stuck in old habits that aren't working. "Rehab is a wonderful specialty, but many providers tend to hang onto the past, so it's very difficult to see how you can accomplish the same outcomes from a slightly different change in perception," Fowler says.

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