Building an Integrated, Future-Focused Post-Acute Care Model

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ideas. answers. action.

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CALIFORNIA HOSPITAL ASSOCIATION

Leadership in Health Policy and Advocacy

Evolving Healthcare Economics

Reality	Choice	Strategy
Health Services 2.5% Margin		Integration
		Bigger
Goal		Reduce Cost Profile (Units and Price)

Consumer Purchasing Behavior

=

Value at What Cost

Hospital and Health System Major Pressures

Credit Rating Requirements

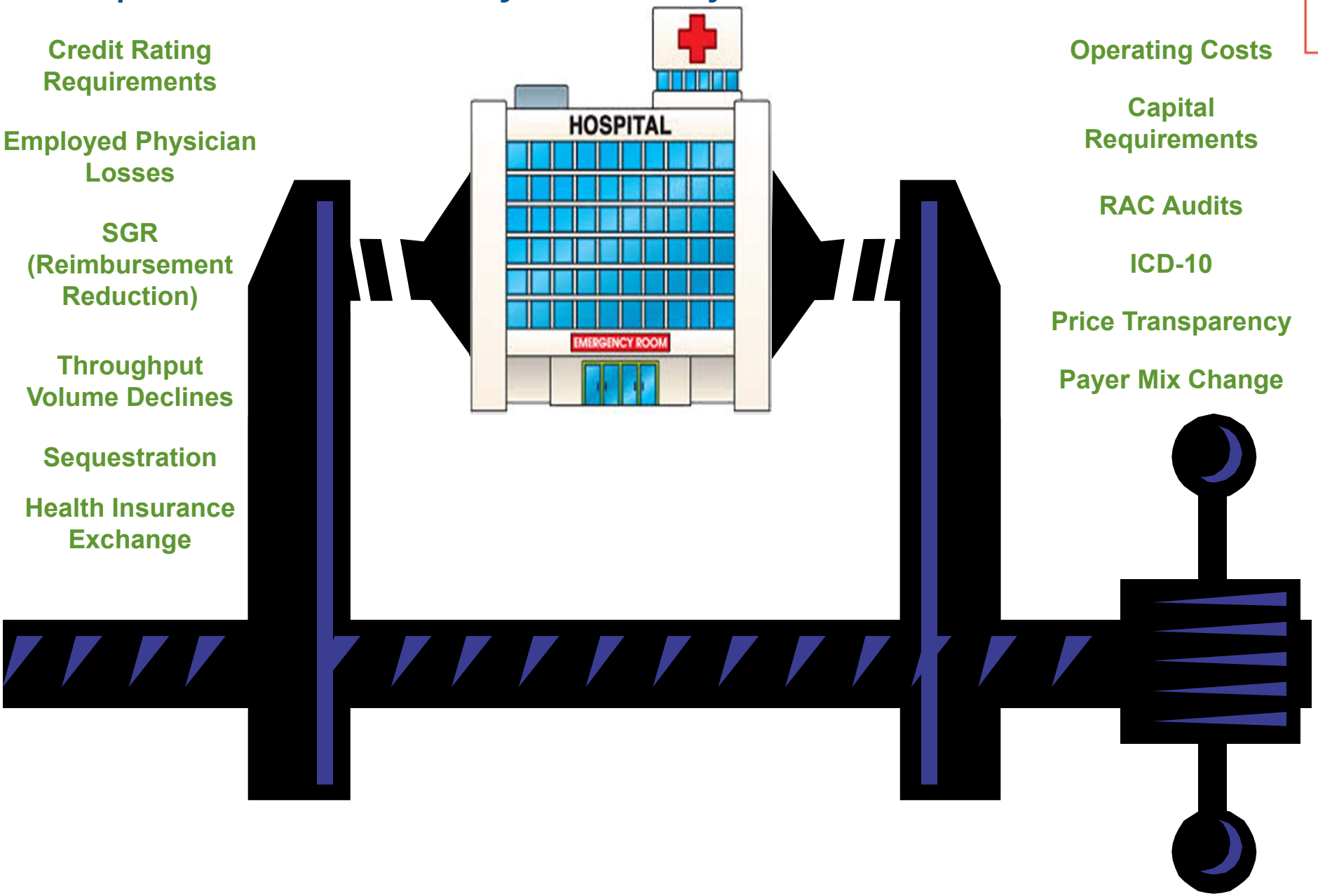
Employed Physician Losses

SGR (Reimbursement Reduction)

Throughput Volume Declines

Sequestration

Health Insurance Exchange



Operating Costs

Capital Requirements

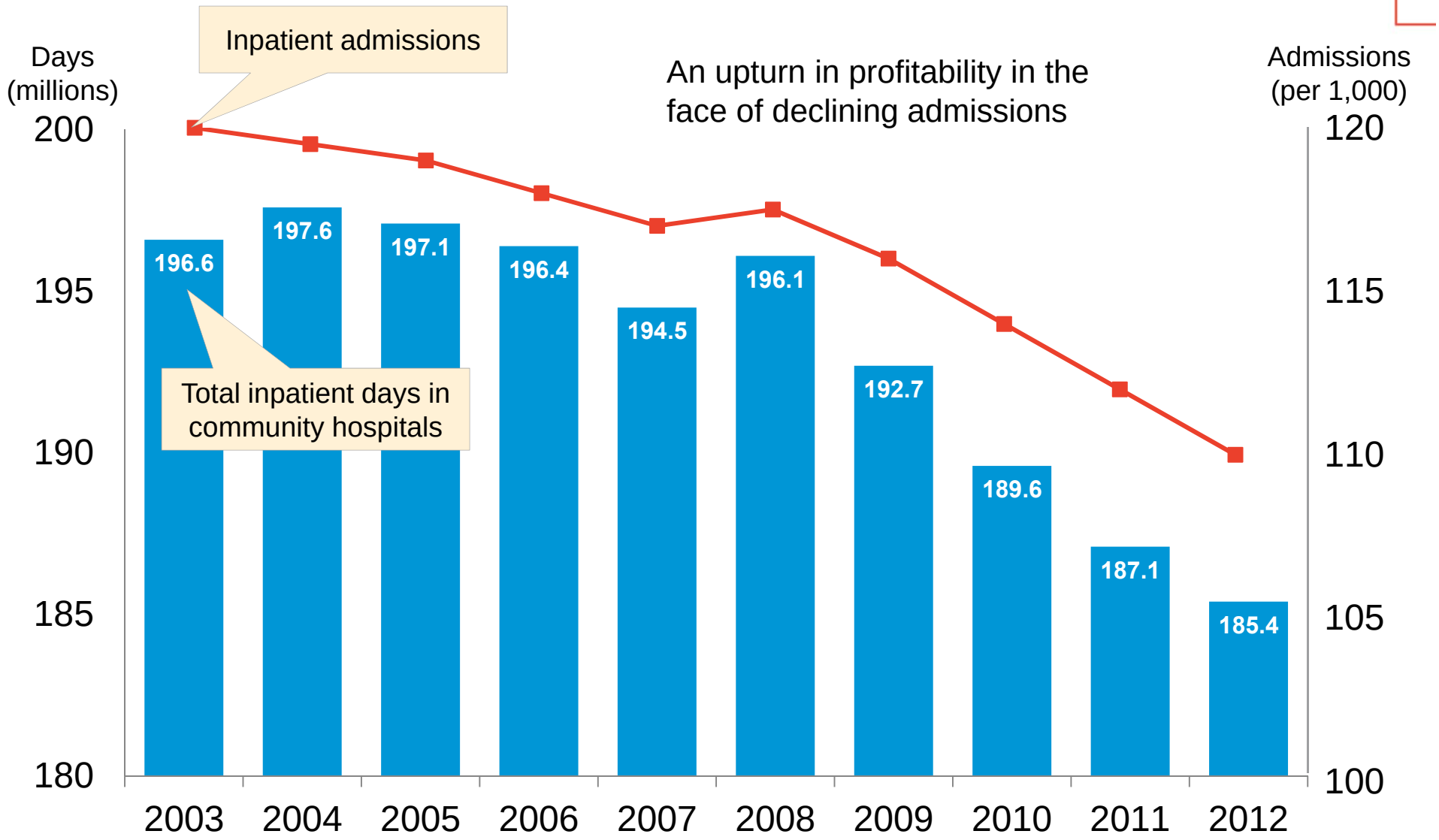
RAC Audits

ICD-10

Price Transparency

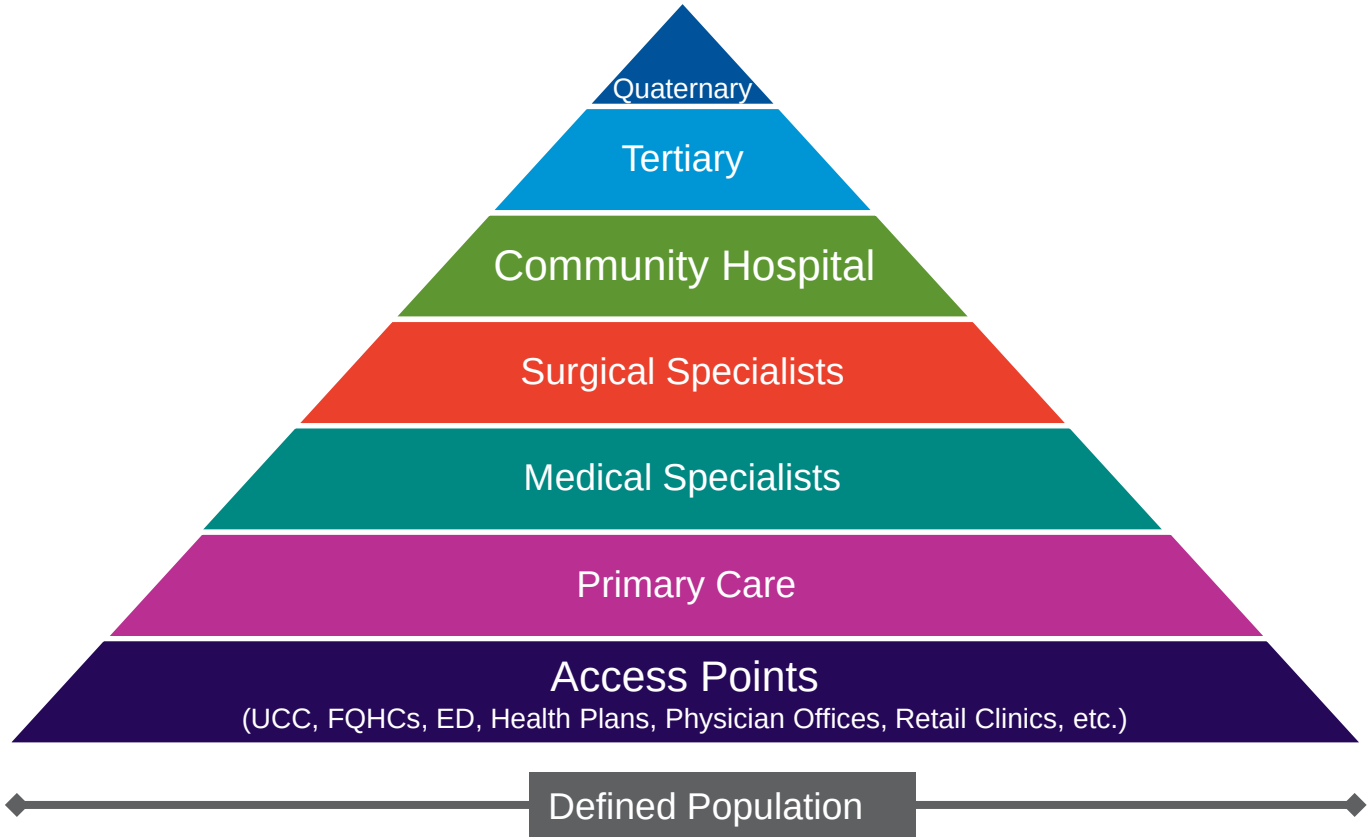
Payer Mix Change

Trends in Inpatient Utilization in Community Hospitals



Source: Avalere Health analysis of American Hospital Association Survey data, 2012

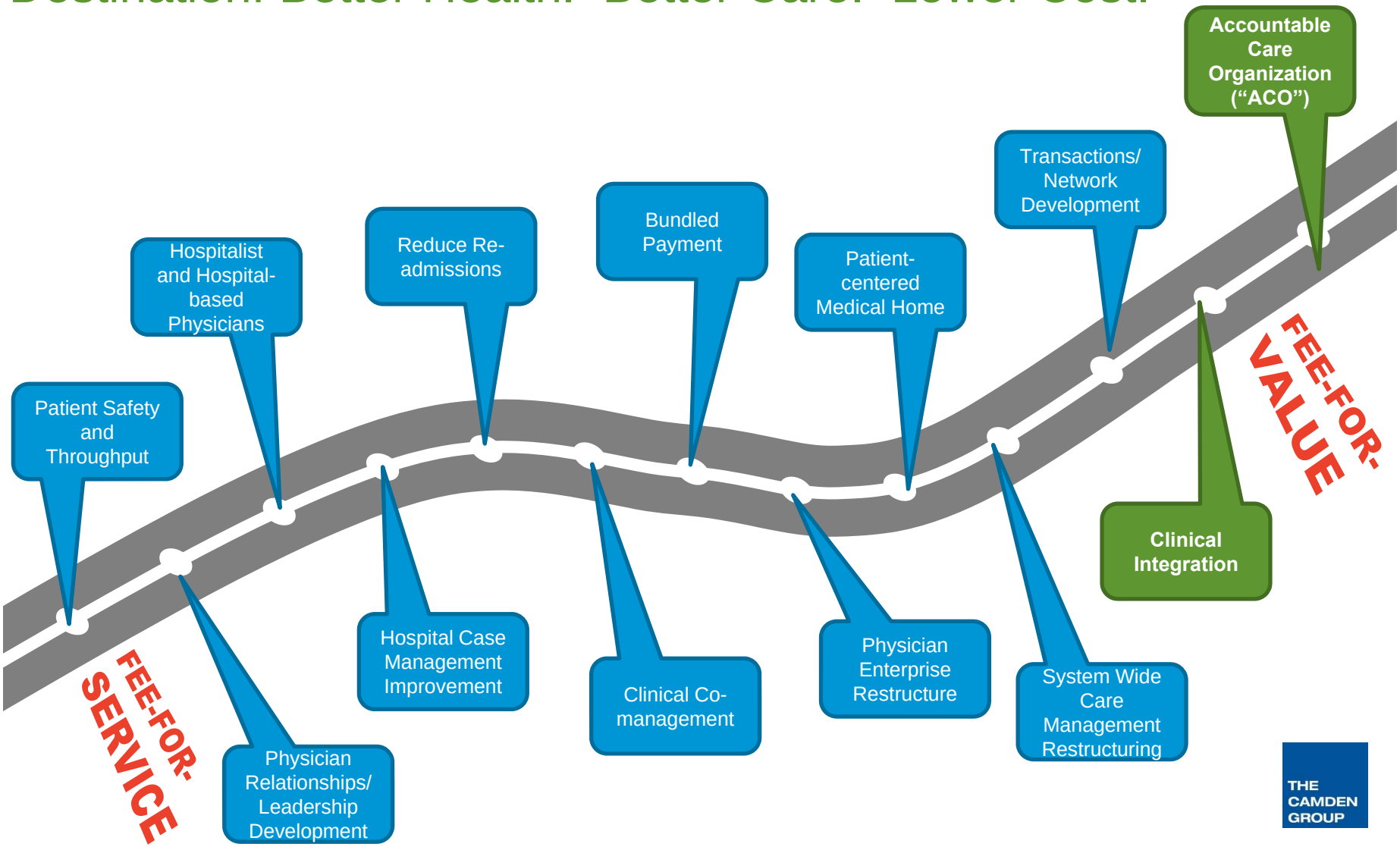
Pyramid of Success



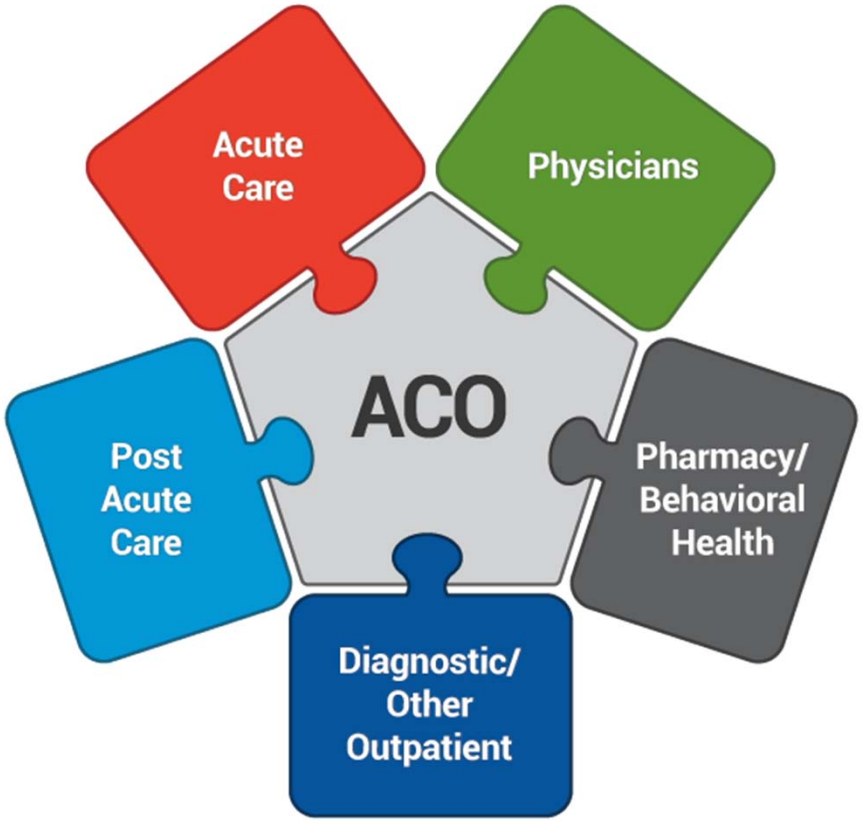
Commercial	CMS	Dual Eligibles	Medicaid
■ HMO ■ PPO ■ Direct to Employers ■ Insurance Exchange ■ Bundled Payment	■ ACO-MSSP ■ Pioneer ACO ■ Medicare Advantage ■ Bundled Payment	■ HMO	■ HMO ■ Fee-for-service

Destination: Start with the End in Mind

Destination: Better Health. Better Care. Lower Cost.



ACO Structure

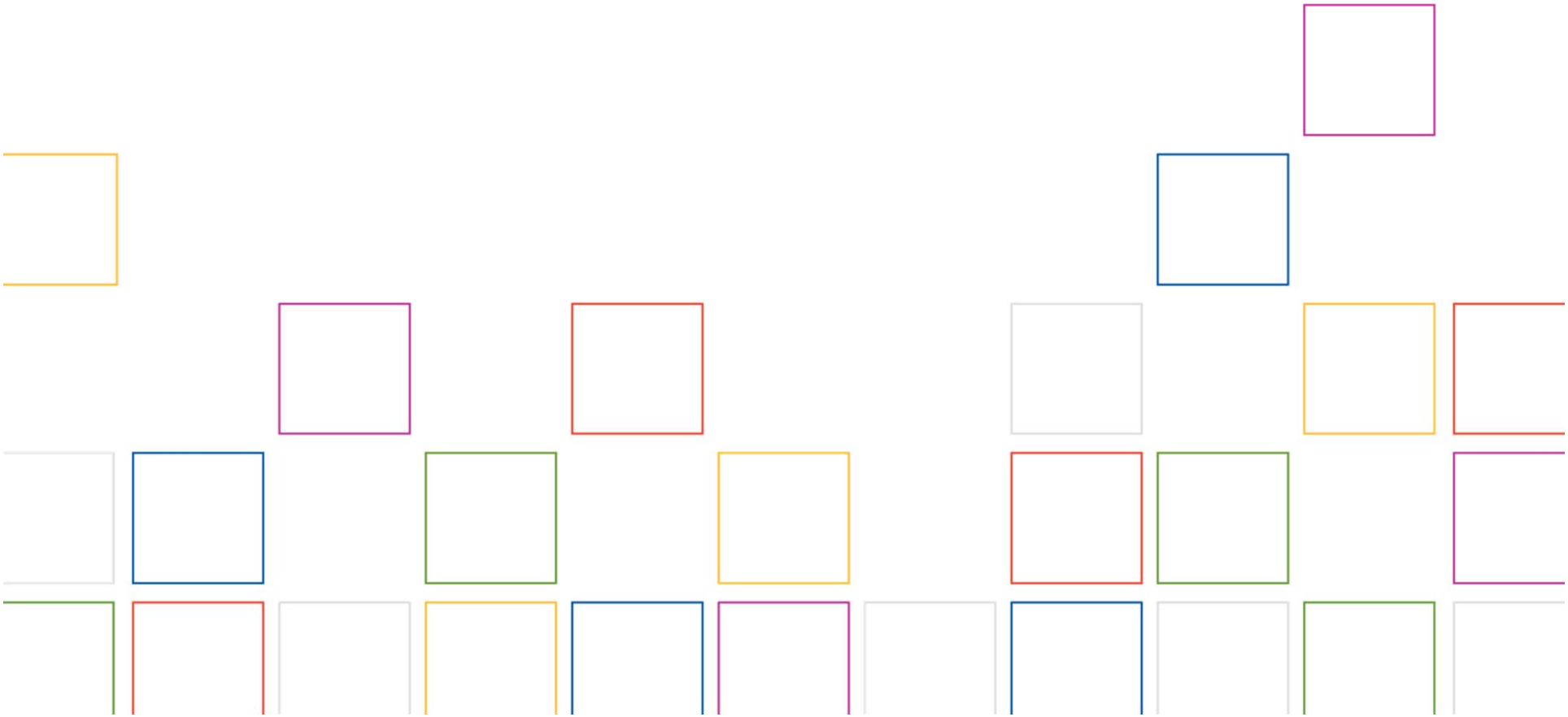


- ACO responsible for:
  - Clinical care management (clinical integration)
  - Capture data for continuum of care
  - Measure and monitor costs and quality

Infrastructure
(Provided or Contracted ACO Operations)

- Information Technology
  - EMR, CPOE, PACS
  - Data warehouse
  - Reporting
  - HIE
  - Patient portal
- Care Management
  - Hospitalists and Intensivists
  - CMO
  - Disease management
  - Clinical protocols
  - Advanced analytics and modeling
  - Call center
  - Utilization management
  - Knowledge management
- Health Network
  - Delivery network
- Financial/Payment Systems

Why Post Acute?

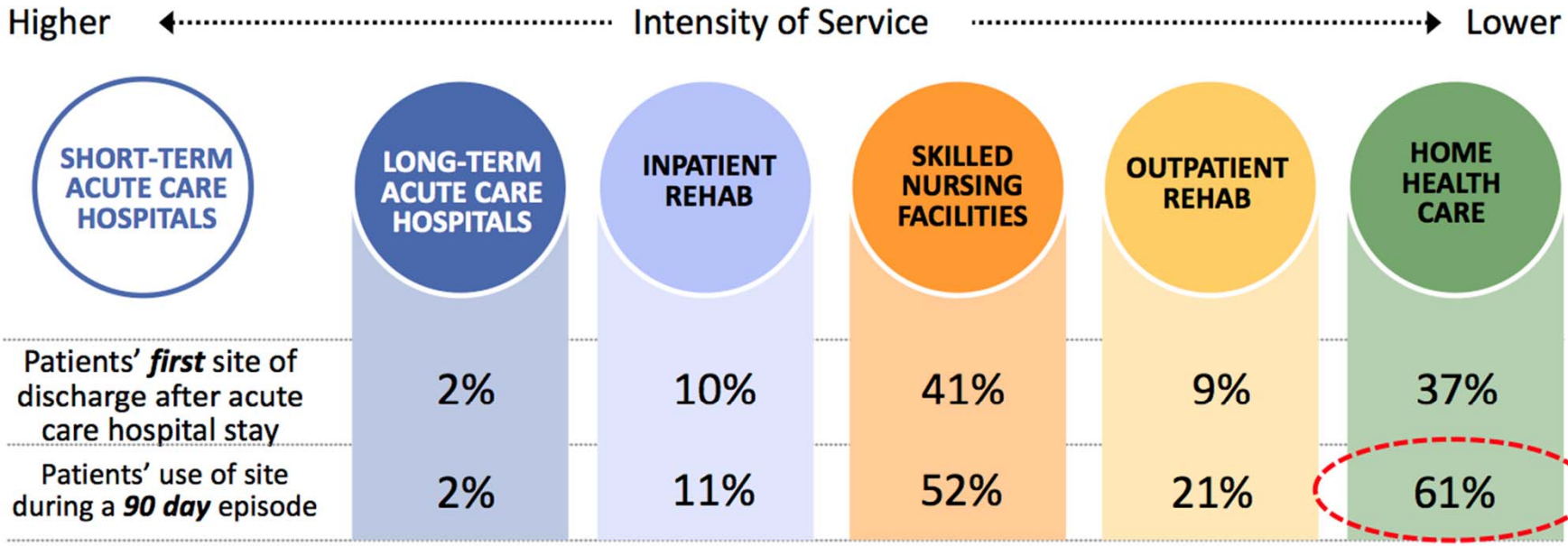


Medicare Patients Highest Volume Users of PAC

Currently there are 47.6 million Medicare beneficiaries with an estimated 9,100 individuals added to the program each day.[1]

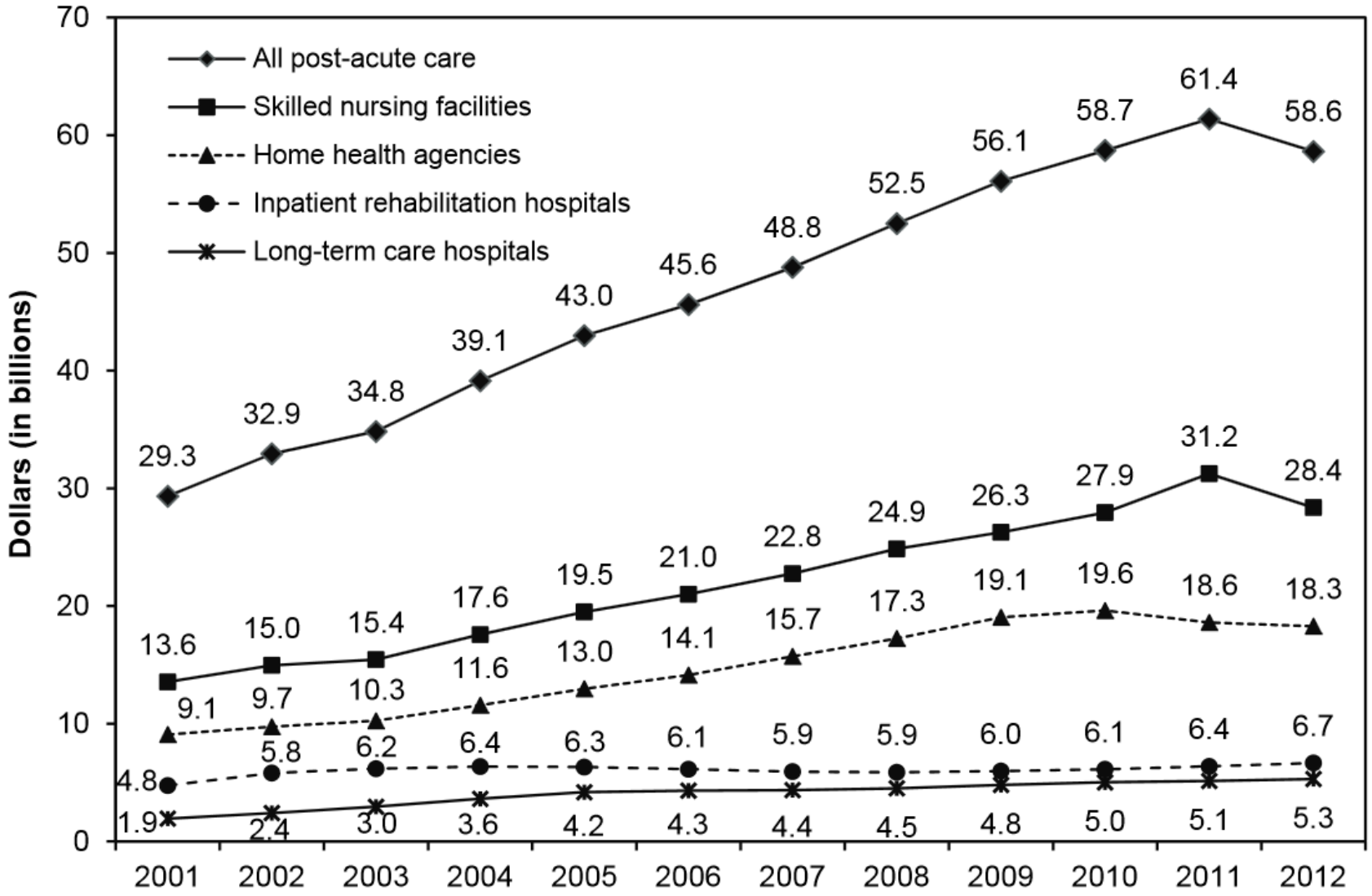
Medicare Patients' Use of Post-Acute Services Throughout an "Episode of Care" [2]

43% of Medicare Beneficiaries are Discharged from Acute Hospitals to Post-Acute Care



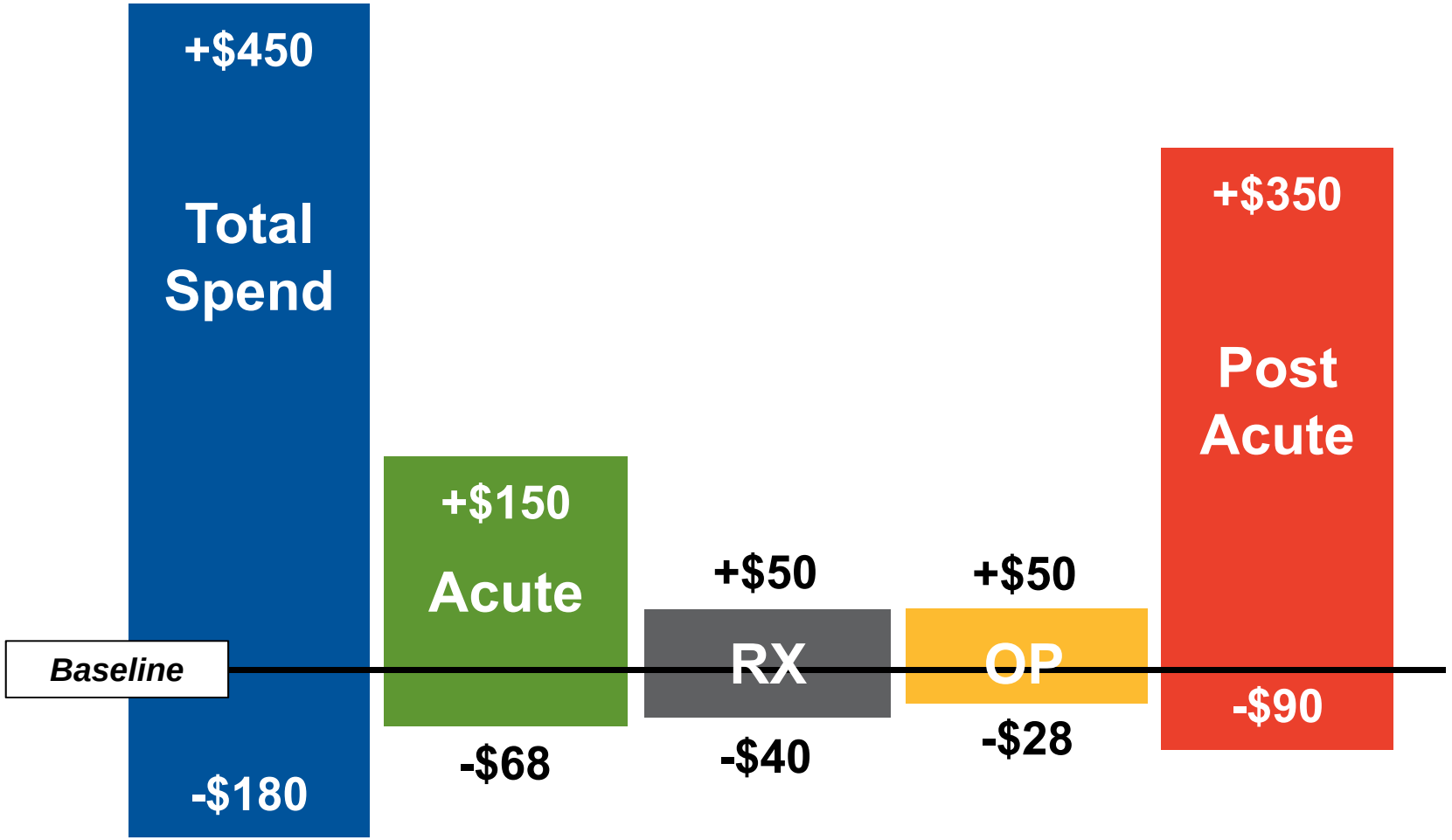
[1] Source: U.S. Census Projections

Post Acute Care Spending Is Significant



Source: *MedPAC, June 2014 Data Book*

Post-Acute Care Spending Variation Demands Control

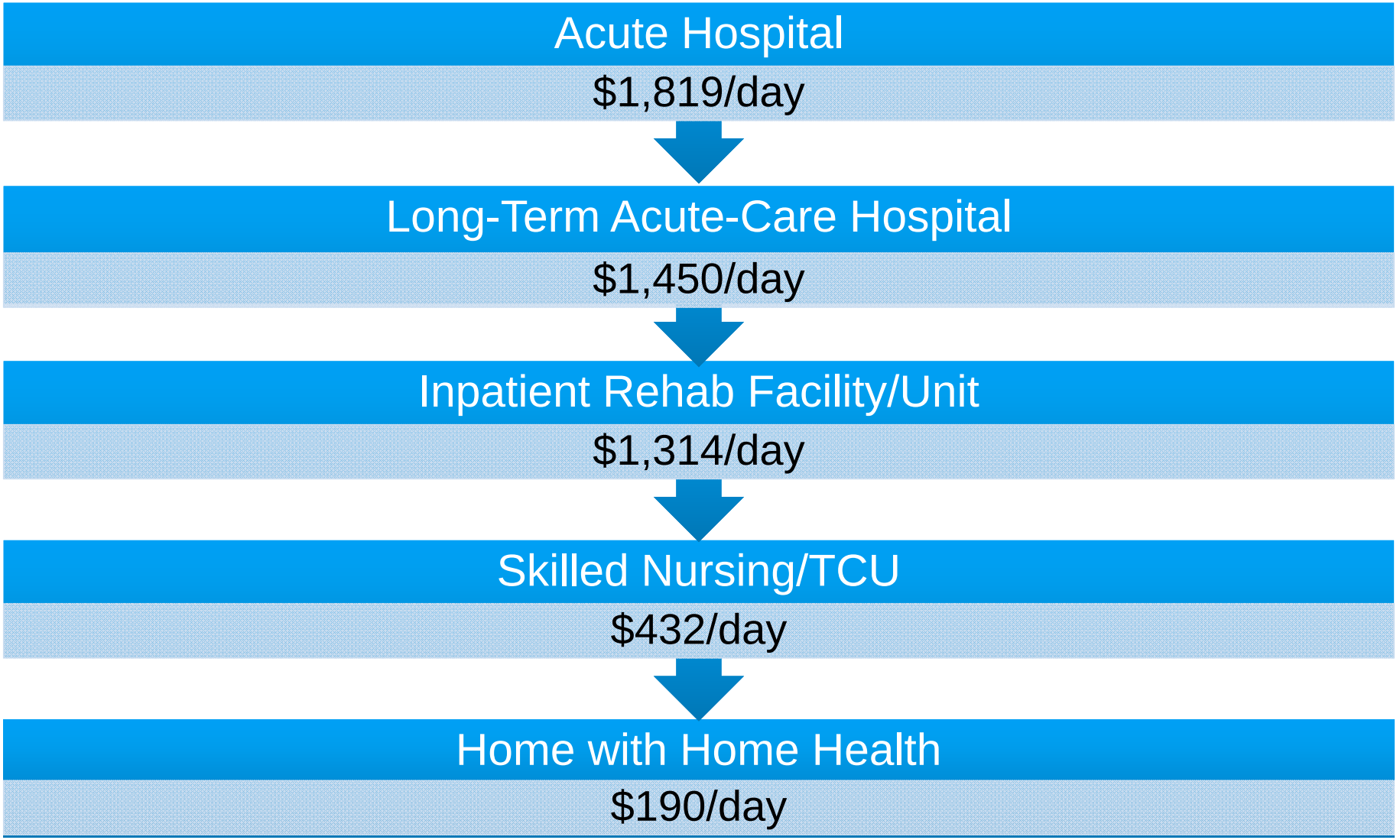


Source: Medicare Spend Variation PBPM. NEJM – 368;16 – 18 April 2013

Providers At Risk for Value-Based Payment

Seek to Reduce the Spend Across the Acute/PAC Continuum

Example: Daily Rates Across the Continuum for Medicare Fee-for-Service

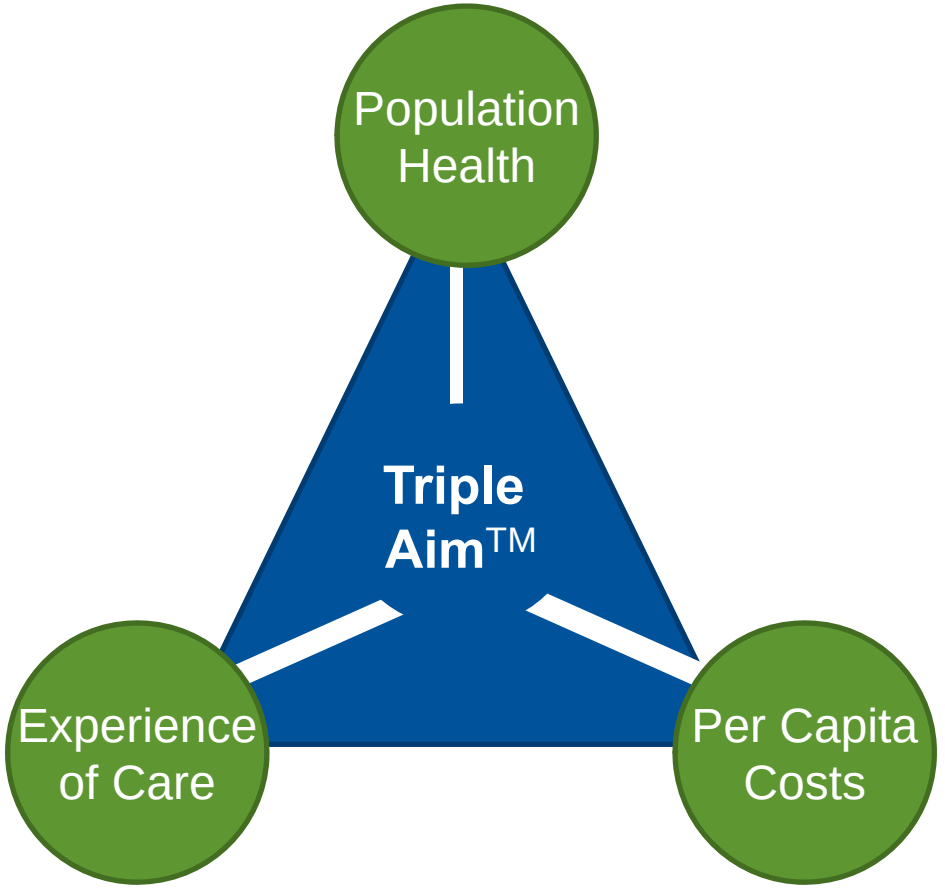


 Source: MedPAC 2013 Based on Fiscal Year 2011 Data

Institute for Healthcare Improvement: The Triple Aim™

The Triple Aim™ set forth by the Institute for Healthcare Improvement:

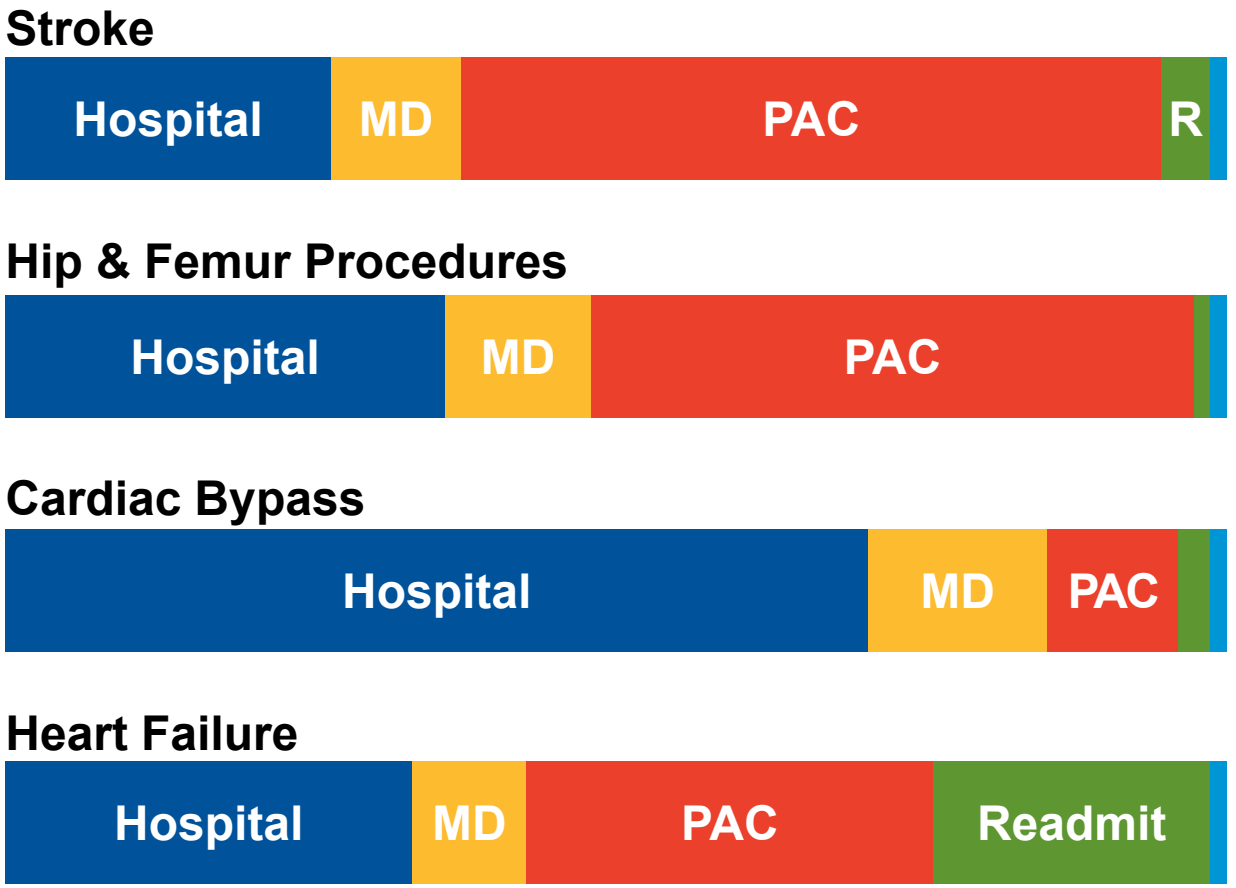
- Optimal care delivery within and across the continuum
- Focused on improving the health of the population and cost of care
- Right care, Right place, Right time



RIGHT PRICE!

Source: http://www.ihi.org/IHI/Programs/StrategicInitiatives/TripleAim.htm

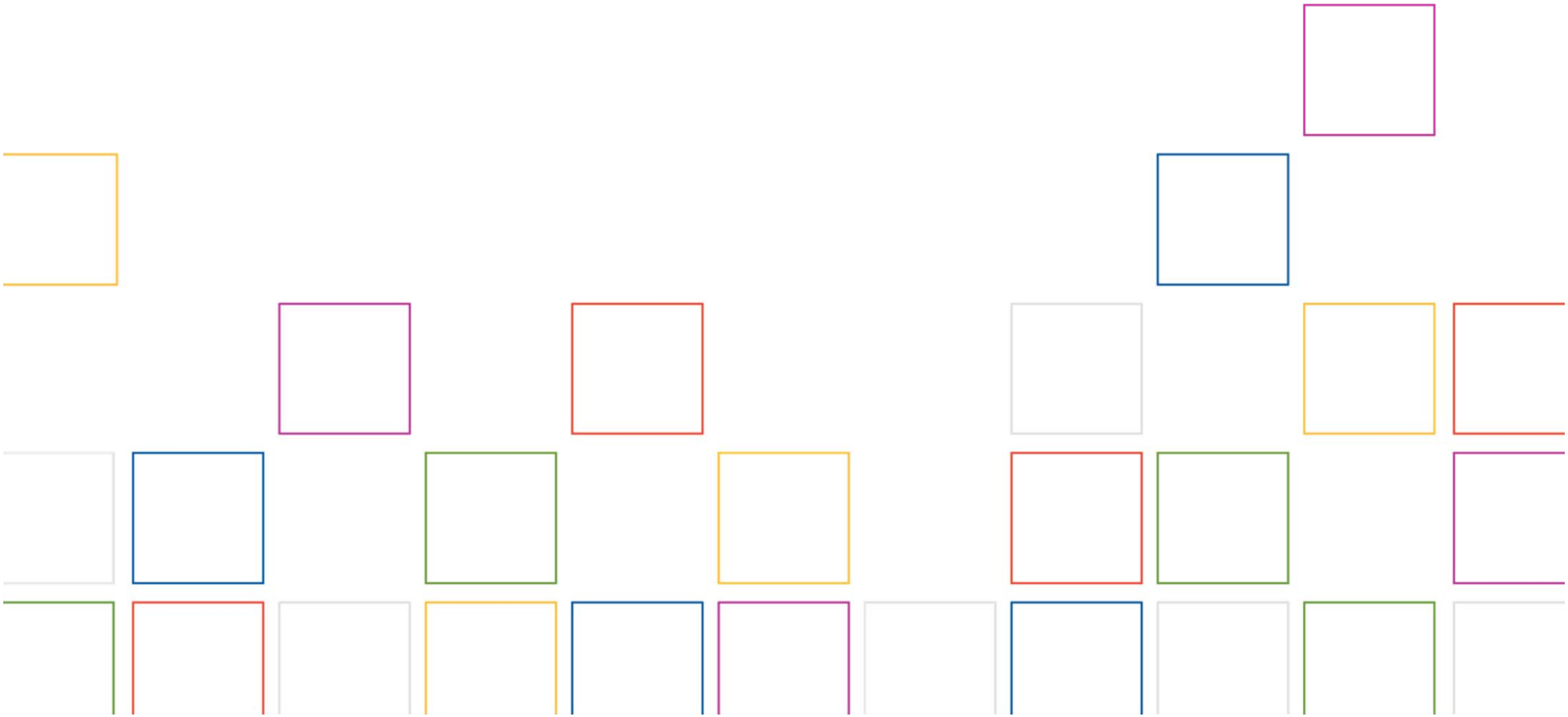
Post-Acute Accounts for a Big Chunk of Episodic Costs



And what is the typical hospital or MD relationship with PAC?

Source: MedPAC September 2012; MedPAC Analysis of 2004-2006 5% Medicare claims files

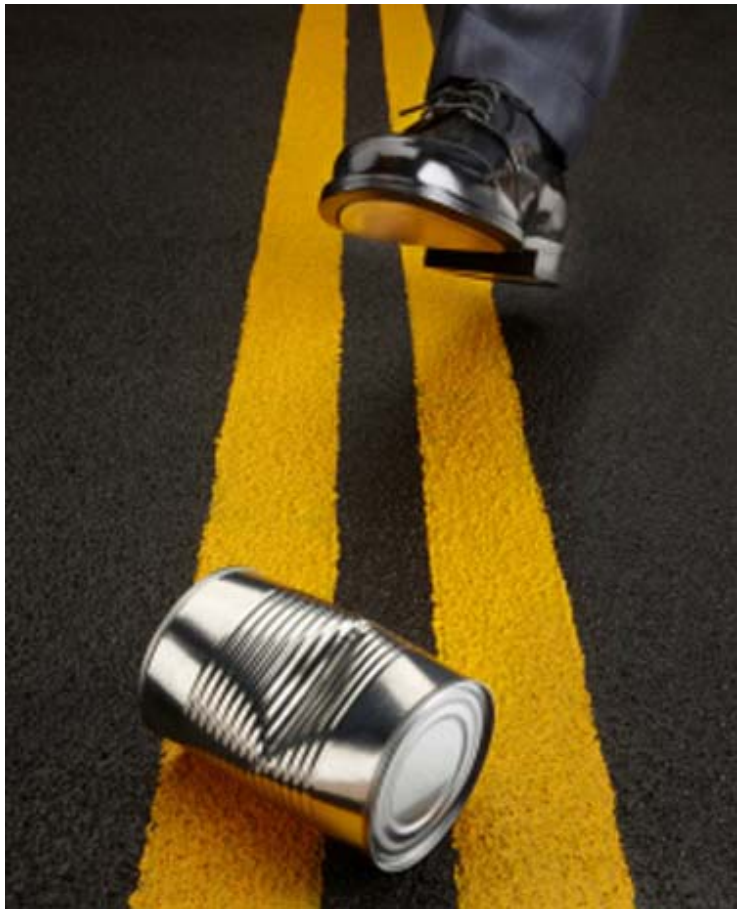
Forging Partnerships and Building Post Acute Networks



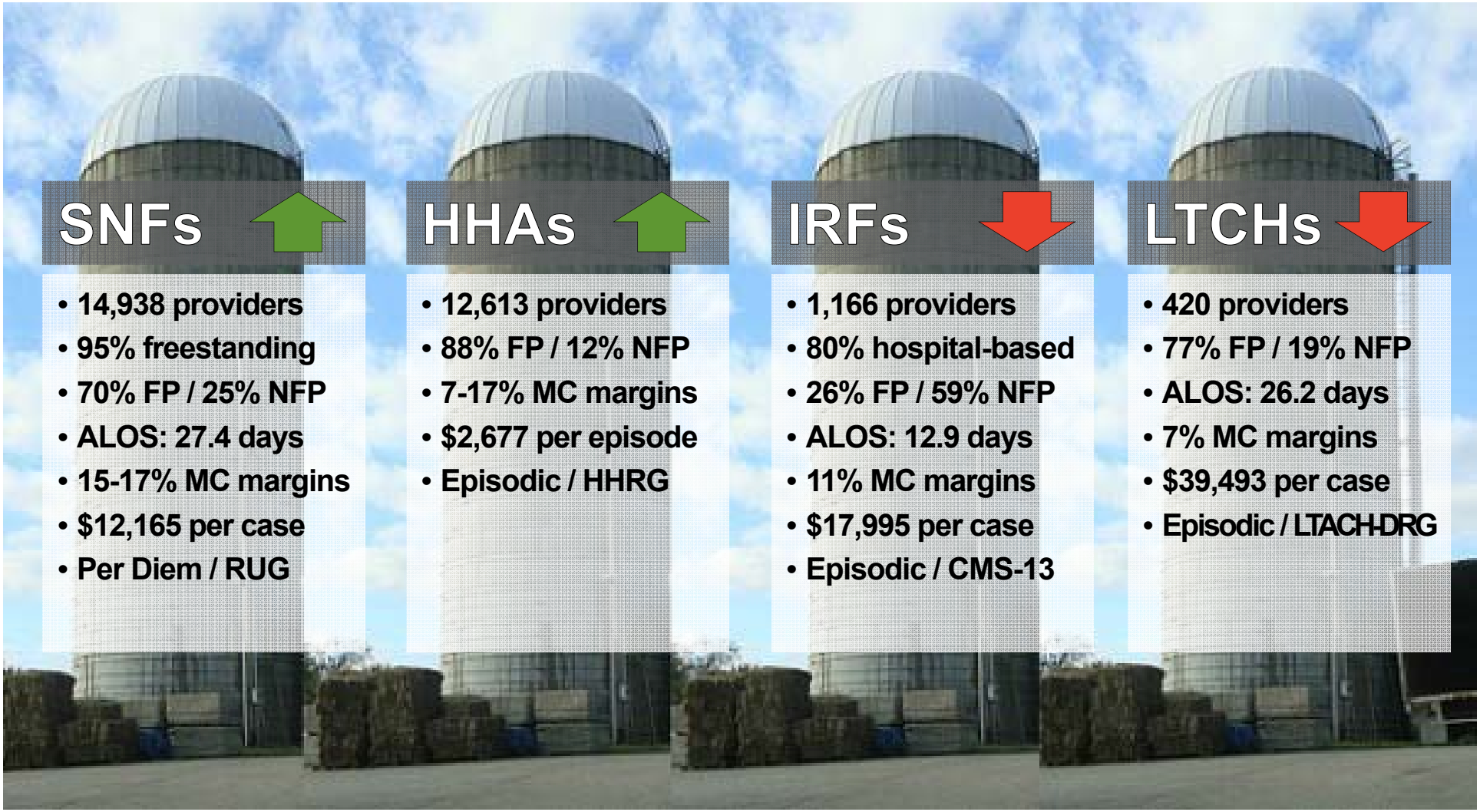
Looking Towards Networks…

The History of Acute & Post-Acute Relationships

- Historically challenged and tangled relationships – “kick the can down the road”
- Collective misunderstandings about payment, process and the definition of “success”
- Isolated points of pain
- Revolving door fundamental to a FFS business model
- No incentives (or punishments) to work together



Post Acute: A Vast Landscape of Silos



Looking Towards Networks…

Workgroups and Joint Committees

- Oftentimes an opening foray between two organizations – hospital and community-based provider; IRF and SNF, SNF and Home Health, etc.
- Usually focused on fixing a problem or improving a particular process, like care pathways, transfers or readmission management issues
- Good vehicle for overcoming historical disconnects and building a collaborative framework

Looking Towards Networks…

The Narrow or “Preferred Provider” Network

- The idea of networks is hardly new but has recently exploded for post acute services and SNFs in particular
- ACOs, IDNs, and regional health systems have taken several approaches in constructing and creating networks – some better than others
- Forward-looking organizations are emphasizing partnerships with post-acute providers, rather than just a credentialed or vetted list of facilities
- Integration and care redesign are fundamental

Building a Post-Acute Care Network

A Four-Part Process

1	2	3	4
Self Evaluation & Need	**Governance & Resources**	**Picking Your Partners**	**Integration & Redesign**
Why?	***What? When?***	***Who?***	***How?***
			

Building a Post-Acute Care Network

Part 1: Self Evaluation & Need

- Understanding internal PAC work to date and what you can build on
- Identifying the internal team and champion
- Evaluating historical use of PAC; access; challenges; opportunities.
  - Some assets owned? Others not?
  - Is there already some degree of integration?
- Determining the issues to be addressed (or solved) via a network development
- Characterizing specific need by service type, location, historical and expected future use

1

Self Evaluation & Need

Why?

Building a Post-Acute Care Network

Part 2: Governance & Resources

- Sorting out how you will manage, govern and monitor the network – roles, charters, reporting relationships
- Creating the internal infrastructure and resource teams to support both development and long-term management
- Identifying initial expectations of providers and potential challenges
- Determining primary care service and care management that may be needed
- Establishing process and players for provider selection

2

Governance & Resources

What? When?

Building a Post-Acute Care Network

Part 3: Picking Your Partners

- Winnowing the list of candidate provider organizations, based on deep data dives.
  - Reviewing public/private data resources
  - Surveying potential providers via an RFI or similar process; conducting on-site reviews to confirm data and expand understanding
  - Potentially revising expectations of providers, based on findings
- Creating a ranking system and sorting through selection
- Holding an initial meeting with the selection pool to discuss expectations and confirm interest

3

Picking Your Partners

Who?

It's Not What You Believe…

"All My Friends Are Getting a Car for their Birthday!"

Name Five.

"We Provide Great Quality Care!"

MAKE THEM PROVE IT.

Data, outcomes and on-site evaluation are the only means by which you should distinguish one organization from the next – especially when picking network providers.

Selection Criteria

What to Choose or Use?

Everyone is a little different, but here are some common criteria for SNF:

- Five-star rating
- Facility size, physical organization and capacity
- Private vs. semi-private room distribution
- Average LOS for Medicare FFS and managed care
- Short-stay to LTC transfer rate
- Program specialties and capacity
- Primary care coverage, medical director relationship
- Leadership tenure and turnover
- Staffing, especially RN coverage
- Therapy provision (5, 6, or 7 days)
- INTERACT deployment and use
- EHR deployment, use and integration
- FIM subscriber status
- Admission volume and “churn”
- Complex care delivery by volume
- 30 — 90-day readmission rates
- Survey history
- Monetary penalties
- Community discharge rates
- Number patients discharged to HHA

Selection Criteria

Where to Find the Data?

There are a range of resources:

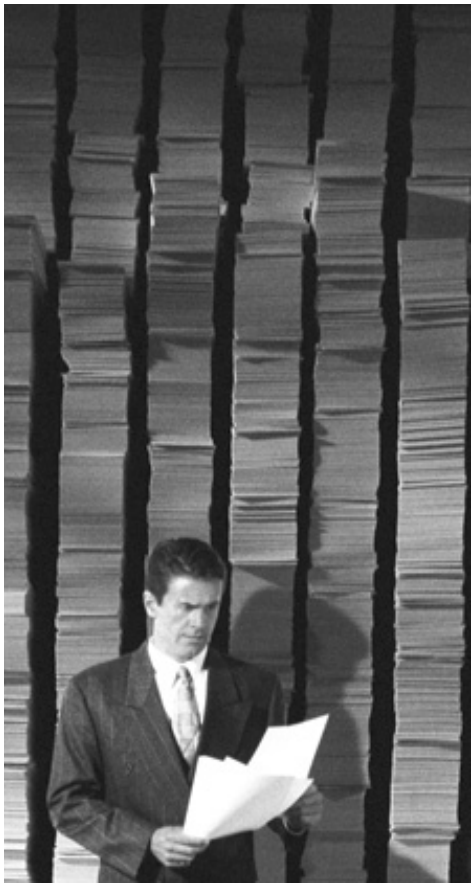
Medicare
- Nursing Home Compare / Home Health Compare

State Resources
- Quality Scorecards / Survey Results

Internal Organization
- Discharge Volumes / Readmissions by Venue
- Staff Anecdotal Input

Commercial Purchase
- Facility cost-report data
- Detailed Performance / Episodic Analysis

Requested
- Secured from providers via survey, interview or RFI



Building a Post-Acute Care Network

Part 4: Integration & Redesign

- Examining and improving the patient care and transition experience
- Addressing process re-design:
  - Transfers and “warm hand-offs”
  - Clinical skill improvement / education
  - IT interconnectivity and information transfer
  - Med reconciliation practices
  - Care management
  - Advance directives
  - Palliative care use
  - Risk stratification
  - Patient / caregiver education

4

Integration & Redesign

How?

Building a Post-Acute Care Network

Part 4: Integration & Redesign (continued)

- Establishing provider performance and quality metrics
  - Tied to issues and challenges that were identified early on
  - Establish reporting and submission methods
  - Utilize comparative reporting
  - Invite PAC providers to participate in the development process
  - Develop clear definitions of measures and related numerators/denominators
  - Determine how measures used to retain and revise the network participants

4

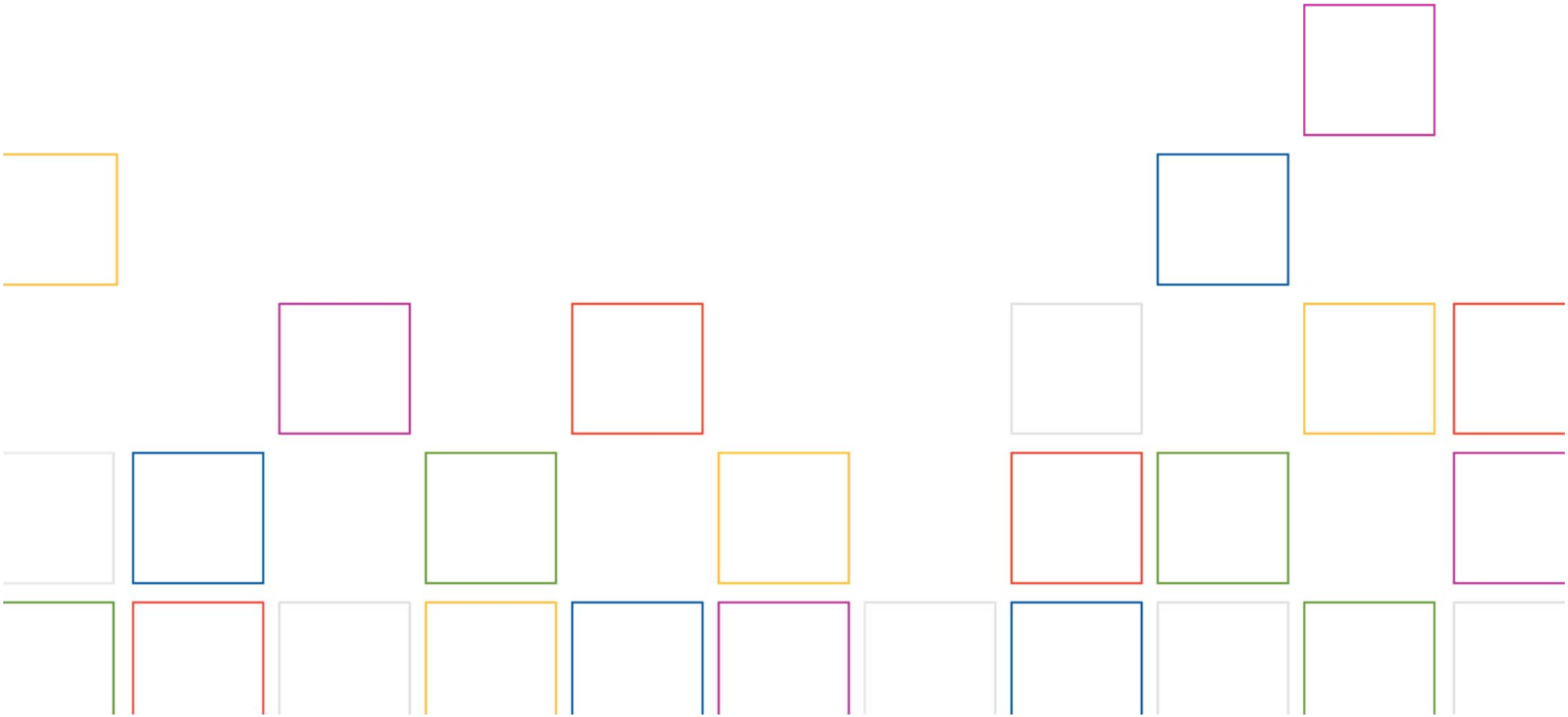
Integration & Redesign

How?

Some Advice…

- Communication is ESSENTIAL – have a plan and schedule
- Education will be required – most PAC providers don't have the skills (but the right providers will be eager to learn)
- Be transparent – with network members and patients
- Use data and results to improve, not punish
- Don't expect results overnight – a solid ramp-up will take four to six months

Looking Towards an Integrated Post-Acute Model



Integrated PAC Model Depends on Care Management

Bridging Across the Silos…

"A collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health needs through communication and available resources to promote quality cost-effective outcomes."

- The Case Management Society of America

Care Management Functions

- Education/Self-management
- Care coordination across networks
- Support to patient and caregivers
- Referral to community-based resources
- End-of-life support
  - Hospice referrals
  - Advanced directives

Care Management

Transitional Care Management

Inpatients at highest risk for readmissions, avoidable ED utilization and poor outcomes

Discharge and transitions plan. Clean hand off to next level. Close follow-up

Home Care Management

Chronically ill, highest risk, frail.

Care management team palliative care and end-of-life

Patients have mental, social, financial limitations to care

Complex Case Management

Multi-disciplinary team to address complex disease management

High-risk patients with barriers to compliance and gaps in care

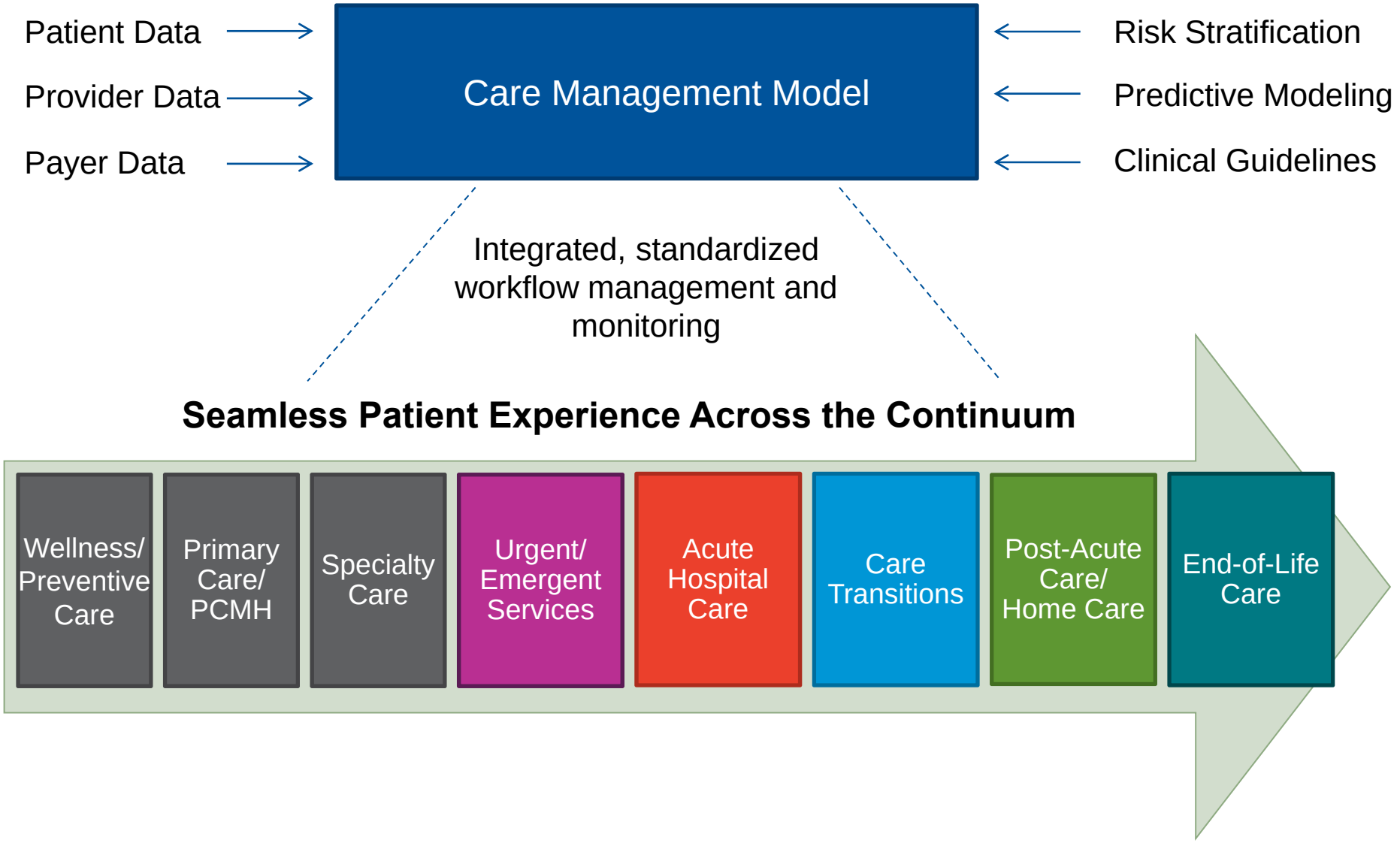
Plan of care including self care and patient engagement

Disease Management

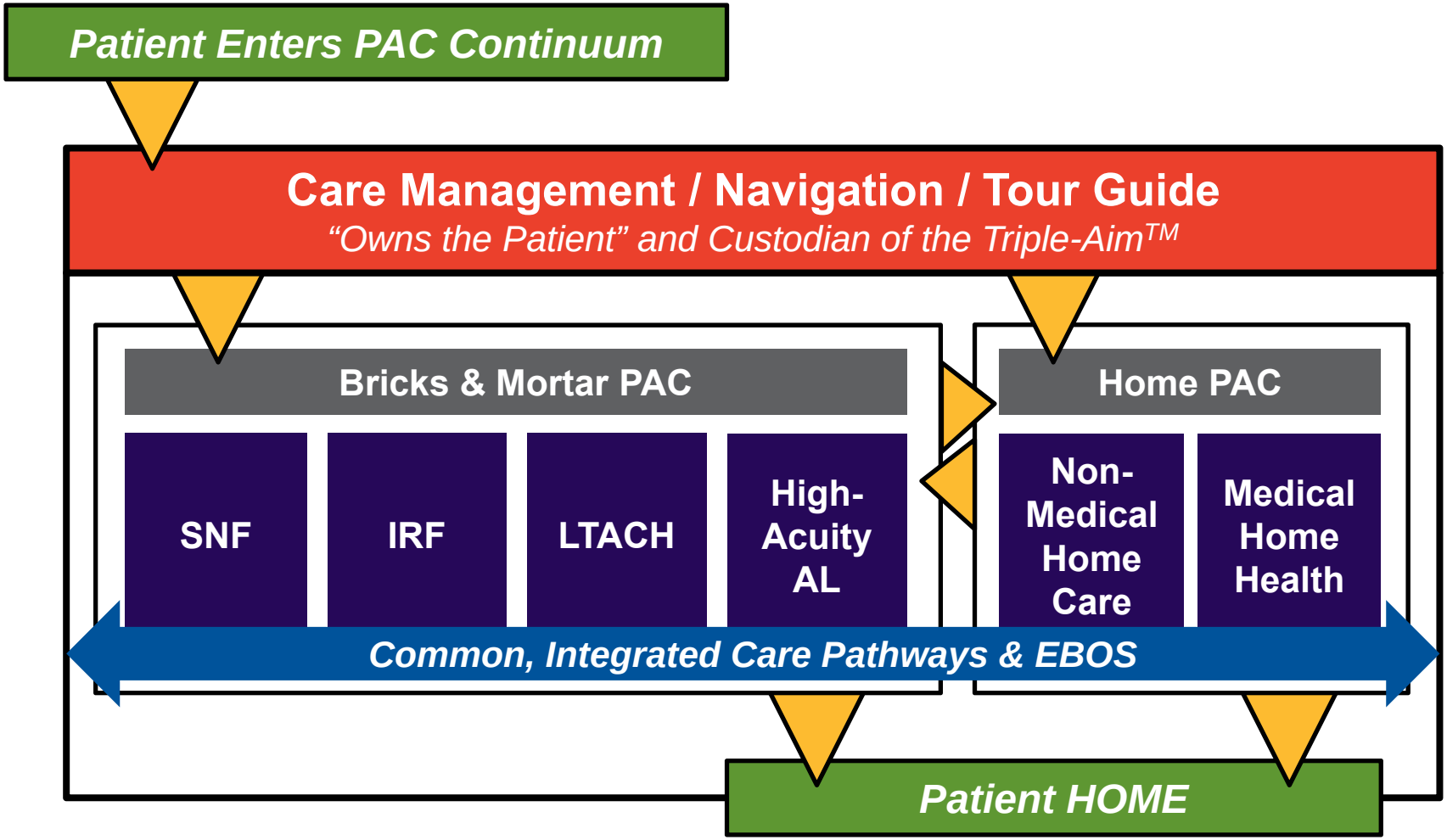
Patient-centered Medical Home ("PCMH") manages chronic disease with outreach, notifications, referrals and quality metrics

Wellness/Lifestyle Management
Accountable Communities

Population Health Management



An Integrated Model for Post Acute



Questions

Thank you

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