Value-Based Post-Acute Care Service for Hospice & Home: Key Strategic Considerations

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Today's Presenter: Kathy Ahearn, RN, BSN, PHN

Kathy Ahearn has a Bachelor's in both Nursing and Social Work, and owns Ahearn Advisement Partners. With over 30 years working and serving the healthcare community the combination of nursing and social work has served her well in obtaining her OCN. She has worked in a variety of post-acute care settings with an emphasis on home health and hospice, home infusion, and homecare and skilled nursing as a PICC and compliance expert.

Kathy helped develop pain scales to standardize assessment with the American Pain Society and the Joint Commission, which lead to identifying pain as the 5th vital sign. She was a trailblazer in the retail pharmacy world introducing the Joint Commission to the retail setting for disease state accreditation and reimbursement. In addition to developing manuals and policies, Kathy expanded into medical device as a Managed Care Director developing one of the first real-time cloud-based disease specific software programs to assist patients, clinicians, and managed care organizations improve outcomes and collect data.

Kathy began healthcare work due to a disabled parent and later a child with chronic disease state. She has experienced healthcare professionally and personally and has dedicated her life to it.

Goals & Objectives of Today's Webinar

Upon completion of today's webinar the participant will be able to:

- Define true post-acute "care coordination"
- Identify acute-care pain points that include alternate payment models
- Define the value-based payment landscape
- Identify critical data points for quality cross functional measures
- Define why value-based payments are likely to shift referral patterns
- Define what a Value-Based Post-Acute Care is

Today's Agenda

Value-Based Purchasing Landscape

Alternative Payment Models

How Markets Will Transform

Preferred Post-Acute Care Provider Networks (Care Coordination)

In Review – How Did We Get Here?

IMPACT Act of 2014

On September 18, 2014 Congress passed the Improving Medicare Post-Acute Care Transformation Act of 2014 (The IMPACT Act)

The IMPACT Act is considered a bipartisan bill signed in to law by President Obama on 10/6/2014.

The IMPACT Act requires standardized patient assessment data across Post-Acute Care Providers that will enable:

- Quality care and improved outcomes
- Data element uniformity
- Comparison of data and quality across PAC settings
- Improve person-centered, goals driven discharge planning
- Exchangeability of data
- Coordinated care

IMPACT Act of 2014

Purpose of the Impact Act:

- Improvement of the Medicare beneficiary outcomes
- Provider access to longitudinal information to facilitate coordinated care
- Enable comparable data and quality across PAC settings
- Improve Hospital discharge planning
- Provides research enabling payment models designed on patient characteristics derived from data

IMPACT Act of 2014

Mission of the IMPACT Act:

To transform and modernize the healthcare system, promoting effective, efficient, high quality care for beneficiaries through the use of standardized, reusable data.

- Facilitate rapid, accurate exchange of critical patient information to reduce errors, prevent adverse events and improve care.
- Allow for the measurement and reporting of comparable quality across providers and provider types.
- Enable person-centered decision making using comparable data.
- Inform payment models.

PAC Payment Reform Demo Care Tool Guiding Principles

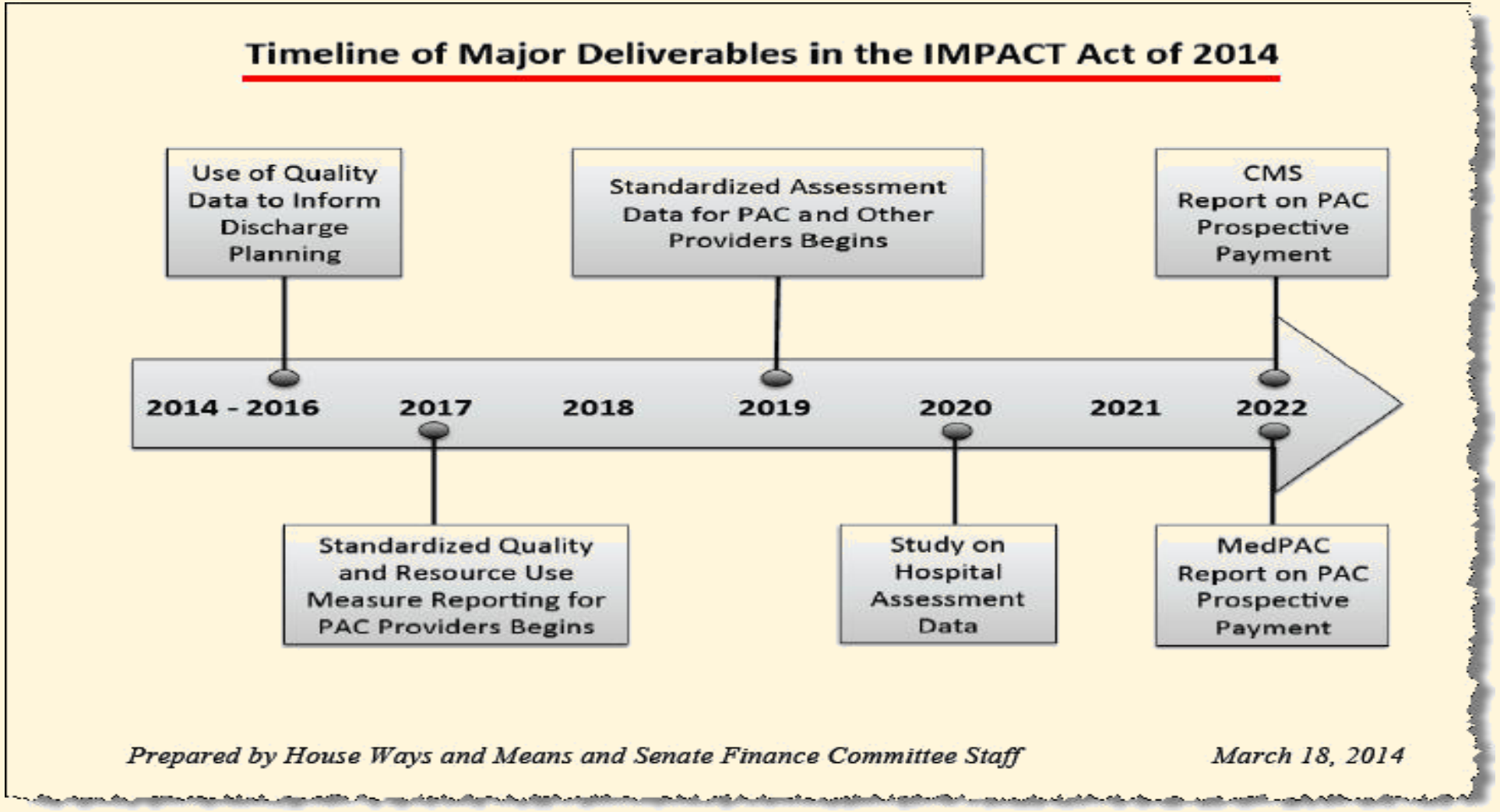
Data Uniformity

- ✓ Reusable
- ✓ Informative
- ✓ Increases reliability/validity
- ✓ Facilitates care coordination

Interoperability

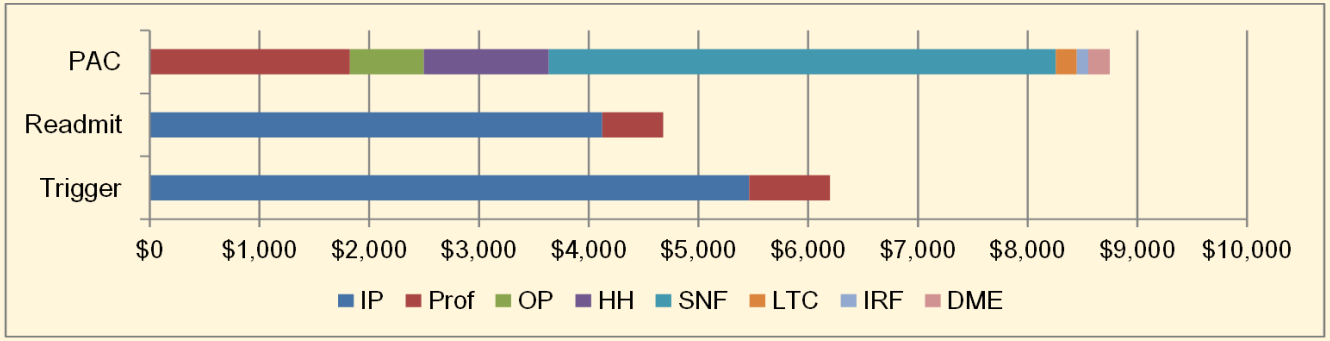
- ✓ Data that communicates in the same language across settings
- ✓ Data that can be transferred forward & backward to facilitate care coordination
- ✓ Follows the Individual - Most critical to note – the data can follow the person!

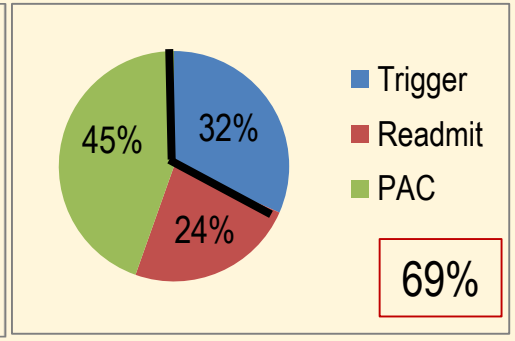
Deliverables Timeline



PAC & Readmissions: Accounts for 24-69% of the Spend in a 90-day Episode of Care

- CHF





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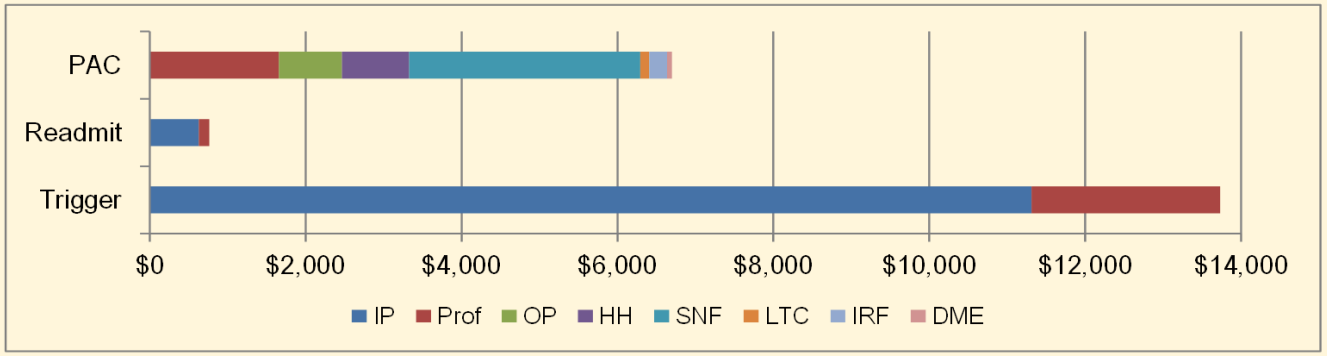

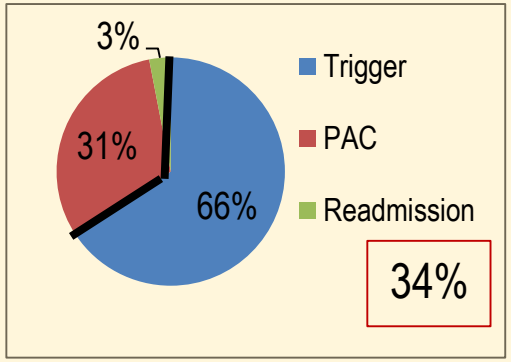

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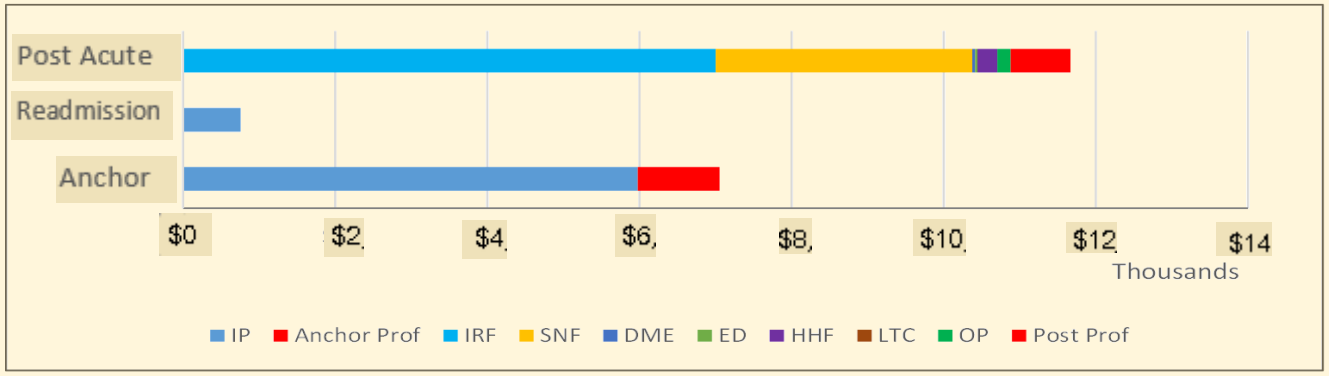
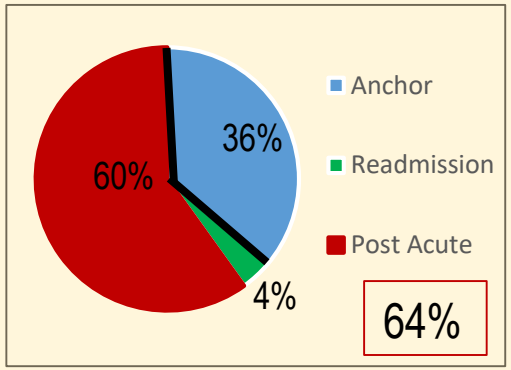




Forces Shaping Healthcare Today

3 Powerful Forces Shaping Healthcare Today

1. **The demand for cost control:**
    - Providers are under pressure to slow the overall rise of Healthcare spending.
    - This demand is coming from every direction:
        - the government, employers and patient's themselves.
    - C-Suite efforts must support reduction in:
        - costs, waste and utilization.

Forces Shaping Healthcare Today

2. The development of new payment models:

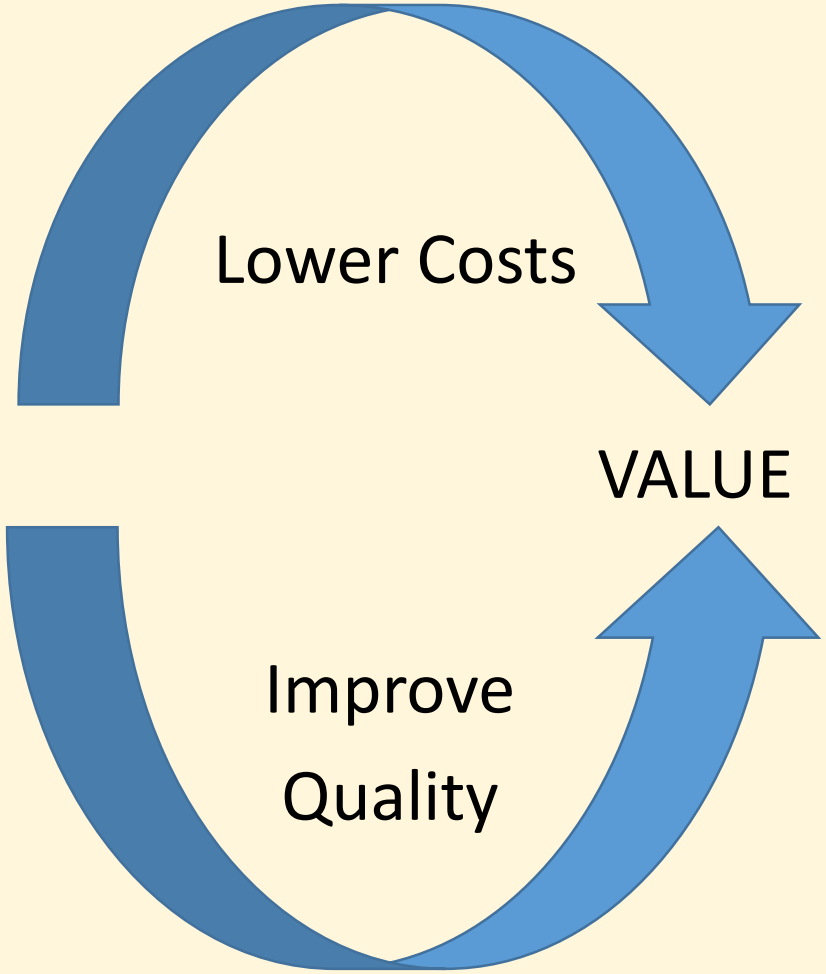
- Alternative payment and reimbursement models have been designed to control costs and incentivize higher quality.
- Payments are still triggered by a care event or encounter and providers have additional opportunities for reimbursement based on:
  - Reducing Cost of Care
  - Achieving Shared Savings
  - Expanding their Clinical Focus
  - Introducing New Care Delivery Models
    - 2016 – 30% of Medicare Reimbursement = APM
    - 2018 – 50% APM

Forces Shaping Healthcare Today

3. **The new paradigm of healthcare consumerism:**
   - Under Value-based care, Providers have a compelling need to proactively manage a patients health. This means connecting a consumer at every point in the healthcare continuum.
   - Not only during and after a healthcare episode but even before a consumer becomes a patient. (Marketing, branding, program differentiators).
   - Increasingly Provider organizations are competing based on:
   - Quality Performance, Experience Management and Expanded Access.

These forces can either limit the financial performance of Providers unprepared for change OR if understood, they can help Providers who strategically plan!!

What is Value-Based Purchasing?



Value-Based Purchasing refers to a broad set of performance-based payment strategies that link financial incentives to Provider's performance on a set of defined measures (value-based care).

Sometimes referred to as APM's (Alternate Payment Models) or VBP (Value-Based Purchasing).

Value-Based Care Key Components

Advanced Cost Management – High performing organizations are bringing down the cost of care by re-engineering clinical and business processes.

- ✓ Analytics
- ✓ Long LOS (acute)
- ✓ Miss-alignment of discharges to admissions,
- ✓ Inconsistent or misdirected patient placement practices.

How can your organization show efficiency improvements?

- ✓ Are you aware of local hospitals and health systems with high re-admission rates and extended length of stays?
- ✓ Misdirected patient placement?
- ✓ How can you be a solution, what is the opportunity for your organization?

Value-Based Care Key Components

Full Spectrum Care Coordination:

- Devoting significant resources to this across the entire healthcare spectrum and continuum.
- Enterprise wide care models (best practices), care protocols, disease management programs, longitudinal patient records.
- Care coordination utilizes proactive UM, minimizes redundant services.
- Services high-risk populations. **(Palliative Care, Hospice, Population Health Management)**
  - Frequent re-admits.
  - Right patient, right care, right setting.

Value-Based Care Key Components

Integrated Provider Network:

- Critical pre-requisite of Value-Based Care is a strong network of providers that are high performing and comprehensive that helps to minimize out mitigation of care from the network.

- Organized system of clinically integrated care that influences costs and clinical outcomes. The broader and stronger and health or hospital system has in place, the greater the outcomes.

- What value propositions does your organization offer?

  - ***Hospital readmission percentages low?***

  - ***Palliative Care Certified MD's? Inpatient Hospice Units?***

- Optimize patient experience?

  - ***Care coordination and transition with ease, technologic capabilities?***

Value-Based Care Key Components

Top to Bottom Incentive Alignment:

- Healthcare leaders (both Health Systems and PAC Leaders) must develop incentives that promote the cultural transformation to build a value-based system.
  - ***Evidence-based best practices across the care continuum.***
  - ***Telehealth/palliative care/home health to hospice bridge programs***
- Incentive distribution models can align incentives with goals.
  - ***Readmission decrease percentage goals, LOS goals, decreased acute mortality rates***
- Critical to incentive alignment/cultural transformation/goals is case management support with leading analytics!!
  - ***Technology, Analytics, Predictive Modeling Data Analytics***

Value-Based Care Key Components

Fully Leveraged Domestic Services:

- Service redundancy associated with Medical leakage (aka seeking services outside of the Network). This is also known as a significant contributor to medical spend waste.

- Referral tracking process – keeping patients/members in the Network.

- Analytics play a role here to determine if the "leakage" is related to a lack of services not offered within the Network and if the analytics show a large percentage of patients/members are utilizing a non-contracted service, it is critical the system develop a contract for the service!

Is this opportunity for: Palliative Care Teams/Programs and Palliative Care Certified Physicians from Hospice Organizations to affiliate and subcontract with Acute Care and Health Systems? To be available for Acute Clinical Rounds?

Value-Based Care Key Components

Modern Consumer Engagement:

Priority to keep the patient/member in the Network therefore Consumer Engagement concepts increasing as evidenced by:

- Patient portals and access via websites.
- Reaching out and engaging patients with chronic disease states.
- Social Media connections.
- Helping patients/members navigate the care system.

Big focus on the Consumer before they are a patient!

❖ In the future the focus will be consumer loyalty versus patient satisfaction!

Does your organization offer Care Transition Coordinators? Video's easily accessible on your website for patient/caregiver/family engagement in other words the "consumer"?

Value-Based Care Key Components

Comprehensive Data Aggregation:

- Capturing clinical and financial data has been a challenge but we are now beginning to leverage such data.
- Multi-disciplinary data governance allows:
  - Identifying information needs
  - It drives analytic initiatives
  - Ultimately care is improved by coordinating data and integrating it in to workflow and processes producing evidence-based best practices.
  - ***Data will ultimately help to support key decisions on Alternate Payment Models by CMS and standardize care more specific to Members versus payment variances across Regions.***

How can your organization support the capturing of both clinical and financial data?

New Payment Models Demand New Capabilities!

	Today	→	1-3 Years	→	3-5 Years
Delivery System Reform	Setting Specific Silos		Early attempts at Care Coordination		Population Health/Wellness
Payment System Reform	Volume-based Fee for Service FFS	→	P4P	→	Pay for Value Risk
Capabilities Required for Success	Ability to deliver highest Quality at Competitive Cost	→	Care Coordination/ Quality Outcomes across select metrics	→	Episodic Care Management on a Risk Basis

Challenge or Opportunity? – Hospice & Palliative Care*

Opportunity with improved Hospital Discharge Planning and Patient-Centered Care allowing for:

- ✓ More end-of-life discussions
- ✓ Improved - right patient, right care, right setting
- ✓ Palliative care partnerships with health systems (Physician)
- ✓ Partnership opportunities with health systems solving a challenge
  - Many re-admissions and ER visits are hospice appropriate patients.

Challenges?

- ✓ Data Requirements/Outcomes Reporting/Increased Oversight
- ✓ More Hospices/Competition/Health Systems/IDN's/Standardization
- ✓ Hospice Compare/Public Domain/Assessments changes the future?

Challenge or Opportunity? Home Health

Opportunity Lies Within:

- ✓ Specialized Services/Core Services – MSW, Therapy, Telehealth, Population Health
- ✓ Quality Patient Outcomes – Low readmission rates, infection rates
- ✓ Partnership Mentality – Meeting needs/providing solutions/care coordination
- ✓ Data Integrity – reports
- ✓ Star Ratings – 3.5 or >

Challenges:

- ✓ Best Practice Protocols – Health System Driven
- ✓ Data – Technology/Innovation- Costly

Value-Based Payment Landscape Summary

- Both challenging and an opportunity!!
- High performing providers will get in Preferred Networks based on quality and cost – others will be left out!!
- Providers must navigate “transition risk.”
- Avoiding hospitalizations and re-hospitalizations is a major area of opportunity!!
- Medicare has developed the know how, the infrastructure and will accelerate VBP implementation!! Other payers already following suit!
- Care re-design strategies!
- VBP most likely to shift referral behavior!
- Will increase the acuity of patients at all levels of care!

Alternate Payment Models

BPCI = Bundled Payments for Care Improvement

- ✓ "Clinical Episodes" are selected from 1 out of 48 possible diagnostic families that are triggered by an anchor hospitalization.
- ✓ Episodes can be 30 – 60 – 90 days in length and commence at episode initiating provider.
- ✓ Base target price (less 2-3% discount) is compared to performance period expenditures after the fact.
- ✓ Most frequently selected Clinical Episode Groups for BPCI are:
  - ✓CJR, CHF, Simple Pneumonia, Respiratory, COPD

Mandatory Bundling Programs/PAC Spending

Between 1994 and 2009 PAC spending compromised:

- 47% and 39% of growth expenditures for Heart Attack and CHF respectfully.

Mandatory proposed bundling program for July 1, 2017 – episode payment for: Heart Attacks and Bypass Surgery.

- Mandatory demonstration requiring participation from all inpatient PPS Hospitals in 98 randomly selected MSA's out of 291 eligible.
- Hospitals must bear financial risk for Hospital care and 90 days post-discharge for all related costs to heart attacks and bypass surgery.
- To qualify for realized savings, Hospitals must meet specific quality measure performance targets.

Opportunity or Challenge? Telehealth, Palliative care for Cardiac Conditions, Palliative Care Certified MD's on Staff, many Hospital Case Managers say Hospital re-admits are Heart failure frequent flyers – or Hospice appropriate patients.

Medicare Episodic Payment Timelines

Voluntary BPCI (Bundled Payment for Care Improvement)

- Initial sign-up 2012, subsequent sign-up 2014.

Mandatory Comprehensive CJR

- Proposed 7/2105, implemented 67 markets 4/2106.
- Proposed to add Surgical Hip/Femur Fracture treatment for 7/2017 implementation proposed.

Mandatory Advance Care Coordination Rule

- Proposed July 2016 for implementation in July 2017 for 98 markets.
- 2 new Cardiac bundles – Heart Attack/Bypass Surgery now called Episode Payment Models or RPM's
- Cardiac Rehab Incentive Payments

Voluntary BPCI 2.0 intended for CY 2018

- Greater linkage to quality and may use different episode triggering strategies.

Why Engage in Voluntary Bundling Partnerships?? What's to Gain??

Benefits to early partnership engagement in Voluntary Bundling:

- ✓ Learn by doing – forces a culture of change!! A culture of growth!!
- ✓ Learn true Post-Acute Care Coordination!
- ✓ Learn to understands markets through data!! Watch Market transformation through data, predictive modeling, predictive analytics!
- ✓ Improve quality through care re-design!
- ✓ Earn positive margins! Learn to align goals/performance metrics with incentives!

Post-Acute Care Provider Networks

ACO's

Currently a total of 434 MSSP (Medicare Shared Savings Program) ACO's!!

- CMS also proposed further adjustments to ACO benchmarking methods, designed to move away from historical data to regional benchmarks.
- This would reward Historically efficient regions.

Physician led ACO's appear to be more nimble.

Opportunity – has your organization contracted with both Health System, Hospital System and Physician lead ACO's? Alternate Payment Models that set up preferred or narrowed networks for care coordination often require "new contracts" with criteria for participation!

Potential ACO Arrangements for PAC Providers

1. Minimal Commitment – no formal arrangement.

2. Conditional Collaboration – PAC becomes the Preferred Provider by adhering to the ACO standards and protocols, shares data and both ACO and PAC Provider work together to prevent re-admissions, to decrease costs and improve outcomes.

3. Partnership – ACO partners with a network of select post-acute providers, the patient electronic health record is accessible by partners.

4. Financial and Data Integration – ACO – PAC Partnerships include quality measures and shared risk.

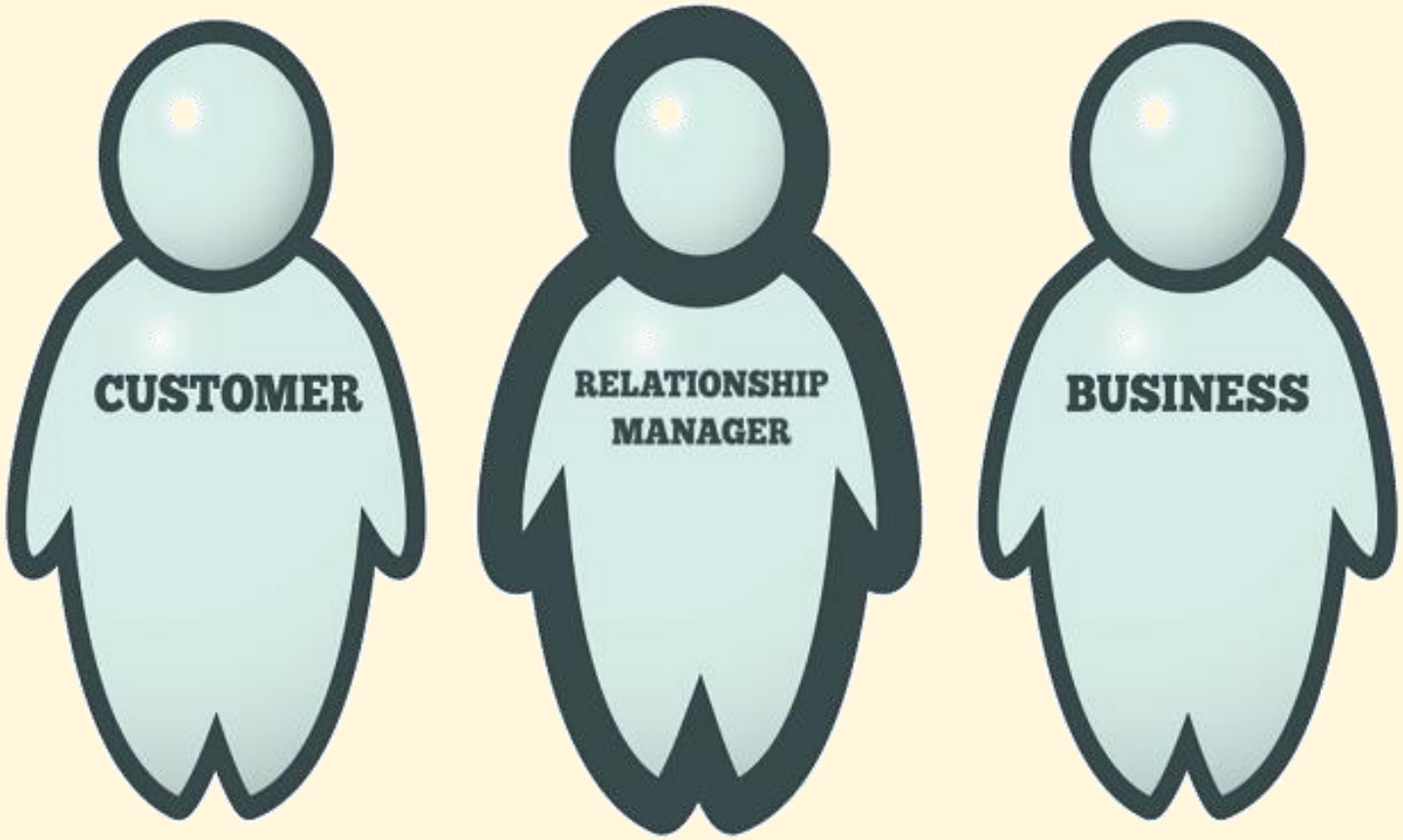
5. System Integration – ACO formally partners with PAC Providers sharing risk/reward; integration allows care management teams and transition coordinators to access all patient data.

Medicare Advantage Plans – Next VBP Frontier?

Value Based Insurance Design (VBID)

- Potentially the next frontier for Value-Based Purchasing!
- CMS announced that Medicare Advantage plans in 7 States will be offered flexibility in benefit design so beneficiaries with certain chronic conditions can be incentivized to pursue high-value treatments.
- Flexibility in benefit design could = reduce cost sharing or offer extra benefits.
- As Medicare Advantage penetration grows, plans will increasingly copy value-based payment initiatives.
- MA plans accorded significant payment flexibility under federal law.
- Special need plans likely to be early VBP adopters.
- Engaging MA Plans with APM approaches will become increasing common!
- Employer plans engaging VBID today!

VBP – New Contract Relationships



VBP – New Contract Relationships

A Value-Based Contractor is the entity that contracts the Value-Based Payer arrangement with the Managed Care Organization. This can include:

- ACO – Accountable Care Organization
- IPA – Independent Physician Association
- Individual Provider

STATE

MCO

VBP – ***Providers***

Value Based Payments – a whole new language!

Preferred/Narrow Networks will Continue to Form

This will occur due to Bundling, ACO's and VBP!!

Provider selection is critical!!

5 Star Rating

Re-admission rate

Medical Director – Active and Engaging

Palliative Care Certified Medical Director

Stability of Management and Leadership Team

Depth and Breath of Clinical Capabilities

Niche programs, services, best practices, transitional care support or coordination, bridge programs.

Patient Satisfaction!

Pillars of Value-Based Transformation

Whether Your Risk or Another's!!

Data	Quality	Process
LOS Cost	Safety/Falls Infection	Care Transition
Cost by Diagnosis	Star Rating	Care Pathways
Re-admission Rates	Patient Satisfaction	Interaction/ Engagement

To Prepare for Value-Based Care

Define your Value Proposition!!

- What is your ability to manage Re-admissions and LOS?
- What are your patient outcomes relative to your peers?
- Are you connected with any community service programs to support additional Social needs of the patient?
- What are you episodic management capabilities?
- Do you offer full service programs such as Hospice, Palliative Care, Home Health and Home Care?

This is your opportunity to shine for your organization, nothing says it better than knowing who your organization is and what value they bring! Brand that value, market that value everywhere! Be proactive in your marketing materials, on your web, in a video……every where you can.

Home Health/Hospice Partnership Selection Criteria

Quantitative

- Current referral pattern/volume
- Quality – Star ratings
- Geographical coverage
- Time between patient request and therapy/nurse visit
- Compliance with state and federal regulations
- Accreditation
- Ownership affiliation with a health system
- For-profit/Not-for-Profit
- Independent/part of a system
- Readmission rate (if available)

Home Health/Hospice Partnership Selection Criteria

Qualitative

- Willingness to partner
- Patient satisfaction
- Staffing
- Medical Director/physician alignment
- Patient/family/caregiver engagement
- Admission process
- Capacity for new volume
- Transition of care – processes and roles
- Chronic care management models (Palliative Care)
- Specialty services (Palliative Care Physician)
- Electronic Medical Record

Maximize Post-Acute Care Collaboration By:

Right patient, right care, right setting – Embedded “rounder's”: ***Palliative Care Certified Physicians, Transitional Care Coordinators, Hospice Liaisons.***

Work with evidence-based best practices and share amongst providers!

Provide support for the PAC Performance Improvement. This includes: ***Training, education, best practice policies and procedures, collaborate, data sharing, retrospective cross-continuum meetings!***

Must be open to “anchors” (Hospitals, Health Systems, Physician) best practices in order to “collaborate” – Real time communication.

Participate in pre-Partnership assessment planning!

- **State of the organization, capabilities assessment, close the gaps and how to get there, education and strategic alternatives.**
- **An “emergent” strategy and plan is fluid and developing – collaborative!**

Topics for Guiding Principles for Exploring Strategic Partnerships in Value-Based Care

1. Mission, Vision and Values – What are the critical elements and is the alignment between all partners?
2. Community Goals – How will a partnership assure:
   - Patient satisfaction
   - Assure service access and handle charity care
   - Promote and delivery health services to emerging populations
3. Strategic Plans for Value-based care? – What are the critical elements and do the initiatives mesh well together?
4. Clinical Programs and Services, Quality outcomes and costs. – What are the goals and how will the partners “collaborate” to achieve them? How will the partnership govern existing programs, develop new programs and service lines, increase the quality of care while improving efficiency?

Topics for Guiding Principles for Exploring Strategic Partnerships in Value-Based Care

5. Clinical arrangements, clinical integration, delivery network and IT.
   - What contracts and delivery networks/platforms will be supported and set-up?
6. Employees, how does a partnership handle workforce issues?
   - Retention, enough staffing, coverage, management and quality leadership.
7. Governance Considerations – How does a partnership involve trustees and setting up strategic direction and plans?
   - Create operational and capitol budgets?
   - Make decisions on range and scope of services?
8. Philanthropic and Foundation considerations.

Multiple Decisions in Partnership Care Collaboration & Narrow Network Participation

Post-Acute Care Collaborative - Incentives

PAC alignment for acute care systems have increased their importance due to 6 Incentives driving partnership.

Incentive #1: DRG – Based Hospital Payments

- Can your organization assist the Hospital with LOS?

Incentive #2: Readmission Penalties (Both CMS and Private Insurers)

- What are your readmission percentages? Are you a solution or part of the problem? (*)

Incentive #3: Mortality Rates

- CMS Value Based Purchasing program penalizes Hospitals systems with high Mortality rates.
- Partnerships with Hospice Providers accessing Hospice services in a timely manner can help with Mortality Rates (one of the most common causes of readmission – cardiac/mortality). (*)

Post-Acute Care Collaborative - Incentives

Incentive #4: Federal Meaningful Use Requirements

- Health Systems can receive Medicare Payment bonuses for select criteria related to their EHR.
- Select criteria requires stronger partnerships with PAC Providers.
- Stage 2 Meaningful Use requires Health Systems to send at least 10% of the "summary of care" documents electronically to the next level of care.
- PAC Provider must be technologically equipped to receive summary of care transfer document.

Are you technologically equipped, are you in alignment with your Hospitals and Health systems to support their incentives in order to collaborate and partner?

Post-Acute Care Collaborative - Incentives

Incentive #5: Patient Satisfaction

- Patient Experience = 25% of a Hospitals Value Based Purchasing performance with efficiency measures rising in performance.
- Post-acute care providers must contribute positively to patient satisfaction and the overall patient experience, you are now representing the health system.

Medicare Value Based Purchasing Domain Weights Are:

10% = Clinical Process

25% = Patient Experience

40% = Outcomes of Care

25% = Efficiency

Where do you fall with efficient processes and contributing positively? Do you have data to support the patient experience, your outcomes? Do you have marketing material, how are your Star Ratings?

Post-Acute Care Collaborative - Incentives

Incentive #6: Costly Accounting Programs

Both CMS and Private Payers have given Hospitals a stake in post-acute costs.

1. 30 day efficiency penalties – Hospitals with high Medicare spending 30 days after discharge receive a reimbursement penalty.
2. Bundled Payments – Hospitals participating in either public or private payment demonstration projects are at risk for post acute care costs often for up to 90 days (CJR).
3. ACO's/Hospital owned Medicare Advantage Plans – at risk for all post acute care spending.

Take note, alternate payment models are not just Medicare driven they are also occurring in the Private pay industry and moving in to the Medicaid Managed Market!!

Post-Acute Care Key Performance Metrics (KPI's)

Post-Acute Care Key Performance Indicators (KPIs) By Level of Care					
LTACH	**IRF**	**SNF**	**HHA**	**Hospice**	**OP Rehab**
Conversion Rate	Conversion Rate	Conversion Rate	Conversion Rate	Conversion Rate	Conversion Rate
Readmission Rate	Readmission Rate	Readmission Rate	Readmission Rate	Readmission Rate	Readmission Rate
Patient Satisfaction Rating	Patient Satisfaction Rating	Patient Satisfaction Rating	Patient Satisfaction Rating	Patient Satisfaction Rating	Patient Satisfaction Rating
Fall Rate	Fall Rate	Fall Rate	Fall Rate	Pain Management	Fall Rate
Infection Rate	Infection Rate	Infection Rate	Infection Rate	Infection Rate	Infection Rate
Discharge Disposition	Discharge Disposition	Discharge Disposition	Discharge Disposition	Self Determined Life Closure	Discharge Disposition
Average LOS	Average LOS	Average LOS	Average Visits/Episode	Average LOS	Average Visits/Episode
CMS Star Rating/Hospital Compare/Accreditation Status	Program Evaluation Model Score (PEM)	CMS Star Rating	Home Health Compare Star Rating/Accreditation Status	Hospice Compare Star Rating/Accreditation Status	Percentage of goals met
# of days on ventilator	FIM Gain	Admission to therapy eval time	Improvement in Daily Activities	Average Utilization of Services	Referral to Eval length of time
Cost per day/Payer rate per day/DRG payment per day	FIM Efficiency	RUG Scores	# of visits per service/DRG	Cost per day	
Percentage of patients evaluated within 24 hours of admission	Percentage of patients evaluated within 24 hours of admission	Percentage of patients evaluated within 24 hours of admission	Percentage of patients evaluated within 24 hours of admission	Inquiry to admission # of days	Referral to Eval length of time
Case Mix index	Case Mix Index	RUG utilization mix	Average Case Mix	Average Daily Census	

Questions Now or Later

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