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

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**Reality**
- Health Services 2.5% Margin

**Choice**
- Bigger

**Strategy**
- Integration
- Reduce Cost Profile (Units and Price)

**Goal**

**Hospital and Health System Major Pressures**
- Credit Rating Requirements
- Operating Costs
- Employment Physician Losses
- Capital Requirements
- SGR (Reimbursement Reduction)
- RAC Audits
- Throughput Volume Declines
- ICD-10
- Sequestration
- Price Transparency
- Health Insurance Exchange
- Payer Mix Change
Trends in Inpatient Utilization in Community Hospitals

An upturn in profitability in the face of declining admissions

Inpatient admissions

Total inpatient days in community hospitals

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

Pyramid of Success

Access Points
(UCF, FQHCs, ED, Health Plans, Physician Offices, Retail Clinics, etc.)

Defined Population

Commercial

CMS

Dual Eligibles

Medicaid

- HMO
- PPO
- Direct to Employers
- Insurance Exchange
- Bundled Payment

- ACO-MSSP
- Pioneer ACO
- Medicare Advantage
- Bundled Payment

- HMO
- Medicare

- HMO
- Fee-for-service
Destination: Start with the End in Mind

Patient Safety and Throughput
Hospitalist and Hospital-based Physicians
Reduce Re-admissions
Bundled Payment
Patient-centered Medical Home
Hospital Case Management Improvement
Clinical Co-management
Physician Enterprise Restructure
System Wide Care Management Restructures

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

ACO Structure

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 modelling
  - 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

Higher \……………………………………… Intensity of Service \……………………………………… Lower

<table>
<thead>
<tr>
<th></th>
<th>Short-Term Acute Care Hospitals</th>
<th>Long-Term Acute Care Hospitals</th>
<th>Inpatient Rehab</th>
<th>Skilled Nursing Facilities</th>
<th>Outpatient Rehab</th>
<th>Home HealthCare</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients’ first site of discharge after acute care hospital stay</td>
<td>2%</td>
<td>10%</td>
<td>41%</td>
<td>9%</td>
<td>37%</td>
<td></td>
</tr>
<tr>
<td>Patients’ use of site during a 90 day episode</td>
<td>2%</td>
<td>11%</td>
<td>52%</td>
<td>21%</td>
<td>61%</td>
<td></td>
</tr>
</tbody>
</table>

\(^1\) 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**

<table>
<thead>
<tr>
<th>Type of Care</th>
<th>Daily Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Hospital</td>
<td>$1,819/day</td>
</tr>
<tr>
<td>Long-Term Acute-Care Hospital</td>
<td>$1,450/day</td>
</tr>
<tr>
<td>Inpatient Rehab Facility/Unit</td>
<td>$1,314/day</td>
</tr>
<tr>
<td>Skilled Nursing/TCU</td>
<td>$432/day</td>
</tr>
<tr>
<td>Home with Home Health</td>
<td>$190/day</td>
</tr>
</tbody>
</table>

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](http://www.ihi.org/IHI/Programs/StrategicInitiatives/TripleAim.htm)
Post-Acute Accounts for a Big Chunk of Episodic Costs

Stroke

Hospital  MD  PAC  R

Hip & Femur Procedures

Hospital  MD  PAC

Cardiac Bypass

Hospital  MD  PAC

Heart Failure

Hospital  MD  PAC  Readmit

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
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

Looking Towards Networks…

Post Acute: A Vast Landscape of Silos

**SNFs**
- 14,938 providers
- 95% freestanding
- 70% FP / 25% NFP
- ALOS: 27.4 days
- 15-17% MC margins
- $12,165 per case
- Per Diem / RUG

**HHAs**
- 12,613 providers
- 88% FP / 12% NFP
- 7-17% MC margins
- $2,677 per episode
- Episodic / HHRG

**IRFs**
- 1,166 providers
- 80% hospital-based
- 26% FP / 59% NFP
- ALOS: 12.9 days
- 11% MC margins
- $17,995 per case
- Episodic / CMS-13

**LTCHs**
- 420 providers
- 77% FP / 19% NFP
- ALOS: 26.2 days
- 7% MC margins
- $39,493 per case
- Episodic / LTACHORG
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

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. 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

2. Governance & Resources
   - Why?
   - What? When?

3. Picking Your Partners
   - Who?

4. Integration & Redesign
   - How?
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

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
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

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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
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

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

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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

Care Management Model

- Patient Data
- Provider Data
- Payer Data

Risk Stratification
Predictive Modeling
Clinical Guidelines

Seamless Patient Experience Across the Continuum

- Wellness/Preventive Care
- Primary Care/PCMH
- Specialty Care
- Urgent/Emergent Services
- Acute Hospital Care
- Care Transitions
- Post-Acute Care/Home Care
- End-of-Life Care

An Integrated Model for Post Acute

Patient Enters PAC Continuum

Care Management / Navigation / Tour Guide
"Owns the Patient" and Custodian of the Triple-Aim™

- Bricks & Mortar PAC
  - SNF
  - IRF
  - LTACH
  - High-Acuity AL
- Home PAC
  - Non-Medical Home Care
  - Medical Home Health

Common, Integrated Care Pathways & EBOS

Patient HOME
Questions

Thank you

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