Post-Acute Opportunities in Population Health Management
Opening Questions

- Types of facilities
- Roles
- Parts of a Pioneer, Medicare Shared Savings Program (MSSP) or Commercial ACO network
- In a bundled payment contract
- How many have had conversations between PAC and acute care providers regarding:
  - Readmission penalties
  - ACOs or “population health management”
  - Bundled payments conversations with acute care providers
Objectives for Today’s Session

• Provide background on population health and the alignment necessary between PAC and acute care providers
• Discuss capabilities required/associated with acute, post-acute integration
• Share case studies and examples
PAC Costs and Utilization
Healthcare Spending Concentration

Approximately 50% of US health care spending is concentrated in just 5% of the population. A full 97% is concentrated in 50% of the population.

U.S. Population, 2007

Percent of Total Health Care Spending

- Top 1%: 22.9% (≥$44,482)
- Top 5%: 49.5% (≥$15,806)
- Top 10%: 65.2% (≥$8,716)
- Top 15%: 74.6% (≥$5,798)
- Top 20%: 81.2% (≥$4,064)
- Top 50%: 97.0% (≥$786)
- Bottom 50%: 3.0% (<$786)

Percent of Population, Ranked by Health Care Spending

Note: Dollar amounts in parentheses are the annual expenses per person in each percentile. Population is the civilian noninstitutionalized population, including those without any health care spending. Health care spending is total payments from all sources (including direct payments from individuals, private insurance, Medicare, Medicaid, and miscellaneous other sources) to hospitals, physicians, other providers (including dental care), and pharmacies; health insurance premiums are not included.

## Value-Based Purchasing Across Silos

### Payment Models

<table>
<thead>
<tr>
<th>Track 1</th>
<th>Physician</th>
<th>Outpatient Hospital and ASCs</th>
<th>Inpatient Acute Care</th>
<th>Long Term Acute Care</th>
<th>Inpatient Rehab</th>
<th>SNFs</th>
<th>Home Health Care</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>RBRVS</td>
<td>APC</td>
<td>MS-DRG</td>
<td>MS-DRG</td>
<td>RICs</td>
<td>RUGs</td>
<td>HHRGs</td>
</tr>
<tr>
<td></td>
<td>VBP modifier plan published on 11/1/11</td>
<td>P4R in FY2013; VBP implementation plan submitted to Congress on 4/18/11</td>
<td>VBP commenced 10/1/12</td>
<td>P4R in FY14: VBP test pilot by 1/1/16</td>
<td>VBP test pilot by 1/1/2016</td>
<td>VBP impl. plan sent to Congress 6/15/13</td>
<td>VBP impl. plan to Congress overdue (10/1/11 deadline)</td>
</tr>
</tbody>
</table>

### Accountable Care Organizations

- **Post-Acute Care Episode Bundling**
- **Acute and Post-Acute Care Episode Bundling**
- **Acute Care Bundling**
- **Medical Home**
Medicare Spending on Post-Acute Care

Medicare Spending on FFS Post-Acute Care 2001-2011

- All post-acute care
- Skilled nursing facilities
- Home health agencies
- Inpatient rehabilitation hospitals
- Long-term care hospitals

Source: CMS, Office of the Actuary (Healthcare Spending and the Medicare Program MEDPAC, June, 2012)

Managed care spending is not included in this chart.
Wide Variation in Spending Across the Country

Geographic Variation in Spending, MS-DRG 291
Heart Failure and Shock with Major Complications

<table>
<thead>
<tr>
<th>Location</th>
<th>Ratio to Nat’l Avg</th>
</tr>
</thead>
<tbody>
<tr>
<td>NJ - Ridgewood</td>
<td>1.49</td>
</tr>
<tr>
<td>FL - Hudson</td>
<td>1.15</td>
</tr>
<tr>
<td>PA - Lancaster</td>
<td>1.00</td>
</tr>
<tr>
<td>NC - Raleigh</td>
<td>0.85</td>
</tr>
<tr>
<td>KY - Owensboro</td>
<td>0.71</td>
</tr>
</tbody>
</table>

Source: CMS Office of Information Products and Data Analysis, Medicare Claims Analysis - 2010
### CMS MSSP Program Expenditures, Utilization 2012 Over 2011 – Average of Six Systems

<table>
<thead>
<tr>
<th>Total Expenditures per Assigned Beneficiary Medicare Enrollment Type</th>
<th>Average Year over Year Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>-4.1%</td>
</tr>
<tr>
<td>End Stage Renal Disease</td>
<td>-8.2%</td>
</tr>
<tr>
<td>Disabled</td>
<td>-1.3%</td>
</tr>
<tr>
<td>Aged/Dual</td>
<td>-3.7%</td>
</tr>
<tr>
<td>Aged/Non-Dual</td>
<td>-3.3%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Component Expenditures per Assigned Beneficiary</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient</td>
<td>-5.8%</td>
</tr>
<tr>
<td>Indirect Medical Education (IME)</td>
<td>-4.4%</td>
</tr>
<tr>
<td>Disproportionate Share Hospital (DSH)</td>
<td>-8.6%</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>-28.7%</td>
</tr>
<tr>
<td>Institutional (Hospital) Outpatient</td>
<td>0.0%</td>
</tr>
<tr>
<td>Part B Physician/Supplier</td>
<td>0.6%</td>
</tr>
<tr>
<td>Home Health</td>
<td>-2.4%</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>-0.3%</td>
</tr>
<tr>
<td>Hospice</td>
<td>-9.0%</td>
</tr>
</tbody>
</table>

### Transition of Care/Care Coordination Utilization

<table>
<thead>
<tr>
<th>Utilization</th>
<th>Average Year over Year Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>30-Day All-Cause Readmits Per 1,000 Discharges</td>
<td>-8.8%</td>
</tr>
<tr>
<td>30-Day Post-Dschg Provider Visits Per 1,000 Dschg</td>
<td>0.3%</td>
</tr>
</tbody>
</table>
For this health care system, 34 episodes were assessed and determined there was $8.8M in PAC savings opportunity compared to Milliman’s “well-managed” benchmark.
• Of the 34, nine episodes made up $4.5M, or 50% of the opportunity
• Within the nine, 50% of the opportunity in SNF, 40% in readmissions. Already better than benchmark in inpatient rehab and home health
Population Health
Background
Journey to Population Health Management

Changing reimbursement models:
• Reimbursement cuts
• Value-based reimbursement
• Pay-for-performance contracts
• Tiered networks/payments
• Bundled payments/gainsharing
• ACOs/shared savings
• PCMH/care management premiums
• Global or total cost of care payment

1. Preparatory
   • Manage costs to reimbursement
   • Maximize performance
   • Engage physicians
   • Develop network
   • Capitalize on payment incentives
   • Balance the service portfolio/growth strategies

2. Transformational
   • Manage episodes longitudinally
   • Address complex cases
   • Initiate care coordination
   • Employ data analytics
   • Utilize physician alignment models

3. Implementation
   • Establish insurance risk capability
   • Measure and monitor population health efforts
   • Narrow the network
   • Grow covered lives

4. Expansion

Necessary capabilities in each of the stages:

MOVEMENT TO INTEGRATED CARE, NEW PAYMENT MODELS & RISK
Care redesign should not outpace reimbursement changes
250 Medicare ACOs in 43 states

123 new MSSPs starting 1/1/14

Over 240 Commercial ACOs operating nationwide

CMS ESRD Seamless Care Organizations (ESCOs) application process underway

CMS Bundled Payment initiative has 500 participants and growing
Domains of Population Health Management

**High Value Network**
Provider networks that optimize care delivery within and across the continuum and ensure that care is coordinated.

**Patient Centered Medical Home**
PCP model that provides people centered care and care guidance to the practice population.

**People Centered Foundation**
Patient engagement that enables people to meet their needs and desires for good health.

**Leadership**
Strategy, governance, operational infrastructure supporting the network and Triple Aim goals.

**Population Health Data Management**
Clinical, financial, and patient related information across all components of the care delivery system.

**Payer Partnerships**
Mutually advantageous relationships with the government, commercial plans and employers.
High-Value Network

The HVN delivers a provider network that optimizes care delivery across the continuum and ensures care is coordinated.

**Key Attributes:**
- A wide range of clinical providers and facilities supporting primary care practices
- Care models across the system define how care is consistently delivered
- How and when patients move between sites of care is actively managed and supported
- The entire health system is focused on improving the health and costs of the population it serves

The Post Acute Spectrum serves as a step down from the intense acute hospital services and a partner in management of chronic conditions.

**Key Attributes:**
- Person-Centered Foundation
- High-Value PAC Network
- Payer Partnerships
- Leadership
- Post-Acute Care Coordination
- Population Health Data Management
Conclusions — Thus Far

• A perfect storm is brewing...reimbursement cuts/slowing AND lower utilization.
• ACOs, shared savings, clinical integration, bundled payment programs will continue to grow – dramatically
• PAC is a very, very big target for cost savings opportunities
• Concentrate on five percent
• Care coordination is paramount
• Market share is more paramount
• Significant clinical, strategic, operational, IT changes are going to be required to be successful
Moving Towards How & Implementation

- How do we initiate effective relationships and create the time required to maintain and improve upon them?

- How do we move beyond the assumptions that we hold and move towards understanding multiple perspectives?

- How do we design collaborations, models of delivery, etc. that align clinically and financially and produce the results we are seeking?
“We started by just meeting once a month”

-Steve Jakubcanin,
Vice President of Operations for Kindred’s Cleveland Integrated Care Market
What Hospitals are Doing

• Motivated to better understand what is happening after acute care (referral patterns, readmissions/PAC venue, root cause)

• Assessing potential provider partners (surface level and in-depth assessment around capabilities and operating activities)

• Identifying high performers (those willing and able to align clinically and financially, pro-active, solution-focused)

• Considering options (collaborate, preferred networks, own, J.V., shared resources, on-site presence, enhanced training)

• Implementing and monitoring performance
Baseline PAC Assessment

- Identify post-acute care (PAC) Providers comprising highest percentage referrals
- Readmission rates
- Surveys
- Medicare.gov compare ratings
- Location, bed, staffing, ownership
- Market reputation
- Strength/weakness from hospital case management perspective
- Clinical areas of focus
- Physician involvement
- Continuum strategies
Deeper Assessment

PAC Components

- **People-Centered Foundation**: Patient and caregivers at the center, honoring preferences, coordination, education, patient satisfaction scores, service, etc.
- **High Value PAC Network**: Source of full PAC continuum, access, coordination, transitions, and partnerships/affiliations
- **Payer Partnerships**: Focused on the framework necessary to develop and maintain mutually beneficial relationships with payers; ability and/or willingness to perform under a variety of reimbursement structures
- **Leadership**: Vision and strategy evident; corporate infrastructure, retention, alliances, and culture

- **Post-Acute Care Coordination**: Use of evidence-based medicine and clinical pathways, care transitions and coordination interventions, ability to accept medically complex patients, guaranteed access, medical champions, and in alignment with 33 quality indicators (Medicare Shared Savings Program)
- **Population Health Data Management (PHDM)**: Able to analyze clinical, financial and patient information; data exchange among providers
- **Capabilities**: Abilities needed to achieve the core PAC component
- **Operating Activity**: Process and infrastructure demonstrating that the capabilities are in place and functional.

Source: Premier, Inc.
## POST ACUTE CARE CAPABILITIES FRAMEWORK: Home Health

<table>
<thead>
<tr>
<th>PAC Component</th>
<th>Capability</th>
<th>Operating Activity</th>
<th>Description of Operating Activity to help score status</th>
</tr>
</thead>
<tbody>
<tr>
<td>High Value PAC Network</td>
<td>II.A. Provides full PAC continuum</td>
<td>II.A.1. System has full PAC continuum, from skilled care to palliative care</td>
<td>Baseline: Single Service Credentialed, Partnerships with other PAC providers. Partner: provides most services Driver: Source for full continuum</td>
</tr>
<tr>
<td>High Value PAC Network</td>
<td>II.B. Access</td>
<td>II.B.1. Admission Capabilities</td>
<td>The HHA has a written process for accepting patients that is based on its ability to provide the care, treatment or services required. Admission capabilities have been assessed, and the organization puts the necessary resources, oversight and staff development processes in place to enable them to receive and care for all levels of acuity appropriate for a home care setting.</td>
</tr>
<tr>
<td>High Value PAC Network</td>
<td></td>
<td>II.B.2. Within the hospital's service area</td>
<td>Locations close to ACO's population and/or related affiliated clinics and service providers. 24/7 coverage</td>
</tr>
<tr>
<td>High Value PAC Network</td>
<td>II.C. PAC collaborates to facilitate high-quality partnerships</td>
<td>II.C.1. Identifies and partners with ancillary care providers</td>
<td>Outsources/contracts for ancillary services such as lab; x-ray; podiatry; rehabilitative therapies. Selection standards for screening and performance of ancillary providers are identified and followed - including but not limited to their involvement in the IDT plan of care. Selection process includes an evaluation of willingness to share efforts and responsibility for reduction of readmissions and quality outcomes for patients.</td>
</tr>
<tr>
<td>High Value PAC Network</td>
<td></td>
<td>II.C.2. Identifies partners essential to success in reducing readmission rates/ER visits</td>
<td>HHA initiates/participates in a collaborative effort with hospitals and other PAC providers to reduce hospital readmission rates and ER visits. Metrics and best practices are studied. Shared processes and work flows are analyzed and improved (e.g., Method with which patient information is shared during transitions in care). The culture established is one of shared responsibility.</td>
</tr>
</tbody>
</table>
What Pro-Active PAC Providers Doing

- Tracking and Analyzing Data
  *Readmissions, ER visits, quality metrics*

- Doing something with the Information

- Engaging at the Hospital Leadership Level (CEO, CFO, CNO)

- Understanding the Hospital’s Data & Strategies
  *Readmissions, referral patterns, physician alignment, participation in ACOs, bundled payments, etc.*

- Presenting Solutions

- Implementing Transitional Care Interventions

- Considering PAC Continuum Strategies
  *Enhance ability to manage care over an episode, secure 1st & 2nd PAC referral, positioning to partner*

- Keeping informed on payment reform strategies
Transforming Ideas into ACTION
Fairview Health Services

- Not-for-profit
- 6 hospitals
- 44 PCP clinics
- 55 specialty clinics
- 65 senior-related facilities
- 31 retail pharmacies
Fairview Senior Services

Ebenezer — 5000 MN seniors daily
14 AL locations, 36 IL locations, 14 Memory Care, 7
Adult Day, 4 SNF, 3 TCUs

Home Care and Hospice
1800 patients/day, 50% referrals from FV hospitals

FV Partners
similar to PACE Model, serves 2,462, avg age 82
with 3+ chronic conditions
Continuum of Care Integration Aims

• Establish cost-effective care models (right time, place, provider)
• Deploy interventions to ensure safe transitions between care settings
• Reduce preventable ER visits, hospitalizations, and readmissions
• Offer lower-cost settings and methods for care delivery
• Link products/services to predict and minimize risk
• Utilize technology to predict health status change and enhance quality of care and customer experience
Initiatives to Achieve the Aims

- Fairview Partners
- Transitional Care Network (TCN)
- Use of INTERACT (SNF)
- Honoring Choices (advance care planning)
- Bluestone Vista (onsite AL PCP model)
- Remote Monitoring Technology
- Hub and Spoke Model (connecting community services)
SoCal Regional SNF Provider and Pioneer ACO

Strategic Thinking – 2010

- Change or be changed
- Affordable product
- Studied other models
- SNF to continuum provider
- Aligned with reform focus
- Leveraged reputation
- Leveraged relationships
- System approach to selling
Shift in Product

- Logistics model
- Single point of entry
- Customized product
- Private labeled
- Continuum of services (acquired)
- Transitions of care
- On site teams (ACO’s team)
- Investment in technology
- Diversify revenue
Guaranteed Outcomes

- Decrease in appeals
- Decrease in ALOS
- Decrease in readmissions
- Decrease in mortality rates
- Accept 98% of ACO’s referrals
Acute-Post-Acute Integration
Further Exploration

*LifeLong Health, Riverside Health System*

*Catholic Health Initiatives*

*Lehigh High Valley Network (LHVN) – Prioritizing Partners Across the Continuum*

*Kindred & Cleveland Clinic – Establishing a Joint Quality Committee*
Final Words

• Pace is accelerated and this work takes time
• Change is difficult and resistance makes it more so
• Balance between core business and innovation
• Talk is *not* cheap and can create the illusion of doing
• Internal culture can trump external initiatives
• Pre-work is critical and often jumping in creates the clarity needed
Contact Information

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