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

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Building an Integrated, Future-Focused Post Acute Care Model

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Evolving Healthcare Economics

### Reality
- Health Services 2.5% Margin

### Choice

### Strategy
- Integration
- Bigger
- Reduce Cost Profile (Units and Price)

Goal

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
An upturn in profitability in the face of declining admissions

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

- Quaternary
- Tertiary
- Community Hospital
- Surgical Specialists
- Medical Specialists
- Primary Care

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

Defined Population

<table>
<thead>
<tr>
<th>Commercial</th>
<th>CMS</th>
<th>Dual Eligibles</th>
<th>Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>HMO</td>
<td>ACO-MSSP</td>
<td>HMO</td>
<td>HMO</td>
</tr>
<tr>
<td>PPO</td>
<td>Pioneer ACO</td>
<td></td>
<td>Fee-for-service</td>
</tr>
<tr>
<td>Direct to Employers</td>
<td>Medicare Advantage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Insurance Exchange</td>
<td>Bundled Payment</td>
<td></td>
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<td>Bundled Payment</td>
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Destination: Start with the End in Mind


- Hospitalist and Hospital-based Physicians
- Reduce Readmissions
- Bundled Payment
- Patient-centered Medical Home
- Physician Enterprise Restructure
- System Wide Care Management Restructuring
- Clinical Integration
- Accountable Care Organization ("ACO")
- Transactions/Network Development
- Clinical Co-management
- Physician Relationships/Leadership Development
- Hospital Case Management Improvement
- Patient Safety and Throughput

Transactions/Network Development

Bundled Payment

Hospitalist and Hospital-based Physicians

Reduce Readmissions

Patient Safety and Throughput
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

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 Health Care</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

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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>Provider Type</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
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
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
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

No incentives (or punishments) to work together

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 / LTACH-DRG
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. Self Evaluation & Need
   Why?

2. Governance & Resources
   What? When?

3. Picking Your Partners
   Who?

4. Integration & Redesign
   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
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
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
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
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

- Patient Data
- Provider Data
- Payer Data

Care Management Model

- Risk Stratification
- Predictive Modeling
- Clinical Guidelines

Integrated, standardized workflow management and monitoring

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™

Common, Integrated Care Pathways & EBOS

Bricks & Mortar PAC
SNF IRF LTACH High-Acuity AL

Home PAC
Non-Medical Home Care Medical Home Health

Patient HOME
Questions
Thank you

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