Developing High-Performing Networks

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February 16, 2018
Agenda

- The Importance of Post-Acute Care
- Developing a High-Performing Network
  - High-level project plan
  - Data sources
- A Partnership for Success
5 “Must-Haves” for health systems to succeed in value-based care

1. Ability to identify and manage the **highest risk/need patients early** in the hospital stay

2. **Post-acute care (PAC) clinical decision support** that is integrated into discharge planning workflow
   - Evidence-based intelligence to place patients in the most clinically appropriate PAC settings with the right resources to maximize functional recovery
5 “Must-Haves” for health systems to succeed in value-based care (cont.)

3. Connected and engaged networks of PAC providers that have been formed based on data-driven insights regarding quality outcomes, efficiency, and operational effectiveness

4. Reporting and analytics to track performance, identify trends, and continuously drive operational improvements

5. Alignment among health system leadership, hospital-based physicians and case managers that value-based care is a priority
The Importance of Post-Acute Care
Post-acute care (PAC) by the numbers

There is an increasing focus on post-acute care to deliver value:

- **$59B** Spent by Medicare on post-acute care (PAC) services per year, more than doubling since 2001\(^1\)
- **73%** Variance in Medicare PAC spend regionally \(^2\)
- **43%** of Medicare patients utilize PAC after discharge \(^3\)
- **8%** – Rate at which Medicare spending on PAC grew annually from 2001-2012 \(^4\)

A value-based care opportunity in post-acute care

<table>
<thead>
<tr>
<th>BPCI – Episode Spend Breakdown¹</th>
<th>Medicare ACOs – Source of Savings²</th>
</tr>
</thead>
<tbody>
<tr>
<td>63% of episode costs are post-discharge</td>
<td>Hospice, 7.6%</td>
</tr>
<tr>
<td>15.0%</td>
<td>Other 8.4%</td>
</tr>
<tr>
<td>47.8%</td>
<td>Skilled Nursing, 36.1%</td>
</tr>
<tr>
<td>37.2%</td>
<td>Total Inpatient, 33.3%</td>
</tr>
</tbody>
</table>

- Reducing unnecessary utilization of post-acute care is the key to success in bundled payments, and has been the largest contributor to savings for Medicare ACOs.
- Given that post-acute care is 1) expensive, 2) historically unmanaged by hospitals, and 3) highly variable, this makes it the single biggest area of opportunity and risk for hospitals in value-based care.

The right PAC transitions strategy can be the differentiator that enables health systems to thrive in value-based care


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### Care Continuum

<table>
<thead>
<tr>
<th>Site of Care</th>
<th>Type of Service</th>
<th>Number of Sites Nationally</th>
<th>Medicare Spend</th>
<th># Beneficiaries</th>
<th>ALOS</th>
<th>Readmission Rate *</th>
</tr>
</thead>
<tbody>
<tr>
<td>LTCH</td>
<td>Long stay – Acute level of care for medically complex patients</td>
<td>420</td>
<td>$5.5 B</td>
<td>124K</td>
<td>27 days</td>
<td>29%</td>
</tr>
<tr>
<td>IRF</td>
<td>Intense rehabilitation services provided in Inpatient setting</td>
<td>1166</td>
<td>$6.7 B</td>
<td>373K</td>
<td>13 days</td>
<td>12.4%</td>
</tr>
<tr>
<td>SNF</td>
<td>Inpatient care consisting of skilled nursing and rehabilitative services</td>
<td>16,000</td>
<td>$28.7 B</td>
<td>1.7 M</td>
<td>29 days</td>
<td>26%</td>
</tr>
<tr>
<td>HHA</td>
<td>In-home treatment for medical conditions requiring intermittent skilled care</td>
<td>12,350</td>
<td>$18 B</td>
<td>3.5 M</td>
<td>NA</td>
<td>23%</td>
</tr>
</tbody>
</table>

* 30 day readmission rate - Manatt Health | Building Effective Post Acute Networks 7-17
A shift in how and where care is delivered

Source: SG2 Site of Care Forecast
Manatt Health | Building Effective Post Acute Networks 7-17

External Impact on Market

- Payment Reform – APMs
- Medicare Advantage funding cuts
- Readmission penalties
- More community-based services and programs
- Demand for more high-quality options
- Home Health, Physicians at Home, PCMH
- Technological Support – Smart support in home

Source: SG2 Site of Care Forecast
Manatt Health | Building Effective Post Acute Networks 7-17
3 factors that drive PAC optimization success

- Determining the appropriate PAC level of care is the first step of effective post-hospital care management
- Differences in costs between settings (avg. LTCH cost = $40k, avg. IRF cost = $18k, avg. SNF cost = $11k, avg. HH = $5k) drive significant variation in episodic expenditures

- Health systems must ensure that patients discharge to the highest quality providers
- Hospitals should use data driven insights to assess quality; CMS Star Ratings are a component
- Provider networks allow for tighter care coordination and collaboration across the continuum

- Significant variation in practice patterns and misalignment of incentives often leads to excess utilization, poor patient outcomes, and unnecessary expense
- Over 30% of Medicare eligible patients readmit to acute hospitals within 90 days

LTCH = Long Term Acute Care Hospital; IRF = Inpatient Rehabilitation Facility; SNF = Skilled Nursing Facility; HH = Home Health
Developing a High-Performing Network
Drive value with a high-performing SNF network

- Building a high-performing post-acute network requires a deep understanding of the providers that deliver the highest quality patient outcomes in the most efficient manner.

- There is wide variation in quality of PAC providers.

- A data-driven approach must be used to form networks based on quality, and common evaluation metrics must be articulated and established.

- Defining quality and ensuring cultural alignment in the PAC setting is a necessity.

RESULTS AND KEY FACTORS:

1. Elevates performance on key quality outcomes
2. Ensures patients are placed in right setting with right amount of services
3. Aligns expectations across the continuum
4. Creates healthy competition
Begin with a project plan to hit milestones

**Gather & Analyze Data**
- Measure current utilization
- Assess readiness
- ID key internal & external stakeholders
- Determine champions
- Leverage the talents of a change agent
- Determine bed need
- Determine data sources for measuring performance
- Determine qualitative measures
- Set utilization targets
- Convene work groups
- Create a communication strategy (internal & external)
- Review performance data
- Develop RFI
- Determine gating criteria
- Obtain organizational approval
- Notify providers
- Establish network review committee
- Create workflows to ensure compliance to network utilization

**Design & Develop**

**Execute Network**
- Review RFI submission
- Convene network review committee
- Determine network
- Obtain organizational approval
- Message internal and external
- Implement evidence-based technologies to monitor compliance and/or network performance
- Launch SNF network

**Manage & Maintain**
- Measure compliance with network utilization
- Develop transition and care management protocols based on mutually agreed upon goals
- Field questions to manage resistance
- Convene monthly PAC collaborative meetings
- Review performance data at regularly scheduled intervals

**Critical milestones for success**
Know your current practices

- Where are you referring patients today?
- What are your internal and external influences?
- What or who determines the next PAC site?
- How do your referral metrics compare to the region or nation?
Determine your opportunity

- SNF ALOS of ~29 days, slightly greater than the national average
- IRF admission rate ~2x greater than the national and census division average
- Client’s 90-day readmission rate is slightly greater than the national average

Source: 2013-2015 Medicare claims data; BPCI eligible episode groups
Performance across domains and categories

Quality
- Hospital readmission rates
- Star Ratings
- Discharge to community
- Functional status, cognitive function and improvement in functional status
- Medication reconciliation
- Patient survey/patient satisfaction
- Compliant and Quality of Care Investigations
- Physician/Extender assessment schedule

Efficiency
- LOS
- Medicare spend per beneficiary per diagnosis
- RUG utilization/distribution
- Other

Citizenship
- Willingness to take patients off hours
- Willingness to take patients with high cost medications/treatments
- Willingness to take patients with no payer source

Operations
- Staffing levels
- Ability to serve complex patients/specialty programing
- Utilization of EMR
- Utilization of patient management tools/interactions
Which data source to use?

<table>
<thead>
<tr>
<th>General Information</th>
<th>Health Inspections</th>
<th>Fire Safety Inspections</th>
<th>Staffing</th>
<th>Quality of resident care</th>
<th>Penalties</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>OSS FELLOWS HOME OF MASSACHUSETTS</strong></td>
<td><strong>HOLY TRINITY EASTERN ORTHODOX N &amp; R CENTER</strong></td>
<td><strong>KNOLLWOOD NURSING CENTER</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overall rating: Above Average</td>
<td>Overall rating: Below Average</td>
<td>Overall rating: Much Above Average</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Distance: 1.3 miles</td>
<td>Distance: 1.6 miles</td>
<td>Distance: 1.6 miles</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Learn more about the overall star ratings</td>
<td>Learn why these characteristics and services are important</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health inspection rating: Above Average</td>
<td>Staffing rating: Above Average</td>
<td>Quality measures rating: Above Average</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of certified beds: 100</td>
<td>Participation: Medicare and Medicaid</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Assess and track PAC network performance

Assessing performance and identifying high-performing providers will drive efficiencies that enable providers to work with a smaller number of providers on targeted clinical and performance improvement initiatives.

- Percentile rank across 3 domains:
  - Quality
  - Efficiency
  - Operations

- Results can be viewed relative to CMS Five Star Quality Rating System

  - CMS should not be the only determinant
Drill down on the data to manage PAC network performance.

PAC provider scorecards enable a data-driven approach.
Compare detailed provider information to other facilities

<table>
<thead>
<tr>
<th>Domains</th>
<th>National median</th>
<th>Score trended over last 3 quarters</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality Measures</td>
<td>[2016 Q2]</td>
<td>National Median</td>
</tr>
<tr>
<td>Short Stay Antipsychotic Meds</td>
<td>1.30</td>
<td>0.602</td>
</tr>
<tr>
<td>Short Stay Pressure Ulcer</td>
<td>0.000</td>
<td>0.000</td>
</tr>
<tr>
<td>Short Stay Reporting Pain</td>
<td>13.00</td>
<td>2.000</td>
</tr>
<tr>
<td>Readmit Rate</td>
<td>14.3%</td>
<td>15.4%</td>
</tr>
<tr>
<td>Efficacy Measures</td>
<td>[2016 Q2]</td>
<td>National Median</td>
</tr>
<tr>
<td>Adjusted RN Hours per Day</td>
<td>0.7887</td>
<td>0.515</td>
</tr>
<tr>
<td>Complaints</td>
<td>0.0000</td>
<td>1.000</td>
</tr>
<tr>
<td>PT Hours per Resident Day</td>
<td>0.1750</td>
<td>0.071</td>
</tr>
<tr>
<td>Incidents</td>
<td>0.0000</td>
<td>0.000</td>
</tr>
<tr>
<td>Operations Measures</td>
<td>[2016 Q2]</td>
<td>National Median</td>
</tr>
<tr>
<td>Deficiency Score</td>
<td>22.67</td>
<td>24.67</td>
</tr>
<tr>
<td>Discharge to Community</td>
<td>0.73</td>
<td>0.71</td>
</tr>
<tr>
<td>Length of Stay</td>
<td>21.40</td>
<td>22.40</td>
</tr>
</tbody>
</table>
A Partnership for Success
Formation of high-performing SNF networks leads to significant cost savings per episode while also driving better clinical outcomes and enhanced experience for patients.

- Using quality, efficiency, and operational data, a BPCI participating provider network was formed in each market for this partner.

- For patients that admit to in-network SNFs, the average decrease in total episode cost is ~$7,000 in comparison to patients that go to out-of-network SNFs.

- Continued SNF improvement is dependent on hospital case management adherence to network utilization, as there is significant correlation between preferred network utilization and attributable savings.

- These networks are continually refined based on interactions with SNFs, tracking the functional recovery of patients, and looking at the variance between actual and expected utilization.

- Providers aligned due to transparency, communication, education and support initiatives in a shared mission to reduce costs and improve outcomes and experiences for patients.
Aligning incentives and goals

Hospitals/Health Systems Want:
- Optimized hospital performance
- Reduced LOS
- Integrated service offerings
- Enhanced throughput
- Comprehensive management and quality outcomes for high cost patients
- Improved patient experience
- A cultural fit

Post-Acute Care Providers Want:
- Volume/Scale
- High level of communication/engagement
- Stable patients on admission
- Clinical Challenge – Advanced training
- Clinical Protocols – Care maps
- Gainshare – Partnership in savings
- A cultural fit
Benefits of a high-performing network

**HOSPITAL**
- Ability to move stable patients quicker
- Increased efficiency in discharge planning
- Reduced ER visits
- A coordinated & well-informed patient progression plan

**PAC**
- Improved occupancy rates
- More coordinated admissions
- Hospital support in proactively preventing readmissions
- Competitive advantage in the market
- Experience for future payment reform

**HOSPITAL + PAC**
- Data sharing and other integrated functions to increase patient engagement time
- Coordinated partnership to maximize quality of care
- Patient centered pro-active approach to manage complex cases
- Brand Recognition; patient loyalty
- Additional payer contracts
- Improved patient experience and outcomes
**Legal and compliance considerations**

- Unified Payment System
- Uniform Assessment Instrument
- Consistent Publicly Available Quality Reporting
- Incentives to serve higher need populations

**IMPACT Act of 2014**

**Triple Aim**

- Transfer agreements, collaboration agreements, contracts?
- Consistent gating criteria
- Federal regulations
  - Hospital disclosure requirements*
  - Patient choice
  - Any willing agency*
  - OIG monitoring relationships between DC planners and PAC* (AKS)

Reduce spend by $5-10B in 5 years

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Pitfalls

- A one-size-fits-all approach
- Setting expectations too high
- Underestimating the influence at the bedside
- Lack of communication
- Expecting change to come easy
- Missing key stakeholders in process
- Failure to document
- Defaulting to blame or penalty
- Turnover of key leadership – especially PAC liaison
- Lack of due diligence in determining cultural alignment

Opportunities

- Overcommunicate
- Presume best intent
- Nurture the program and the relationships
- Set attainable goals and expectations
- Follow through on commitments
- Shared savings
- Celebrate small successes
- There are always 3 winners
- Keep the well-being of the patient at the forefront
Keys to sustained success
Managing the relationship

- Once the HPN is developed, monitoring compliance to utilization is critical; review utilization targets/metrics regularly
- Ensure messaging around informed patient choice is clear; monitor risk for legal/compliance issues; anti-kickback
- Establish a culture of continuous quality improvement
- Develop appropriate care transition plans for optimal outcomes
- Employ monthly or quarterly engagement meetings with the PAC community; ensure key leadership continues to champion the program
- Consider the use or optimization of technology to support decision-making and to seamlessly integrate assessments into workflow
- Discuss ALL outcomes in a judgment-free manner; use data to drive change
Questions?

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