Rehabilitation in the Era of Population Health Management: Why We Must Change

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California Hospital Association
Post-Acute Care Conference
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What we will cover

Reform
Redesign & Role
Trust & Talking
Recommendations

My goals for today

- Recognize population health conversation is already occurring
  - In the meeting rooms and hallways of your institutions
  - In this meeting
- Provide fuel for the conversation
  - The stakes for our field and you are high
  - The time is urgent – MedPAC ready now
    (Medicare Payment Advisory Commission)
- Provide additional clarity
- I am a fellow journeyer
The upheaval of reform

• Most tumultuous time in modern health care
• Looking back: growth & reimbursement…

1965 - Medicare & Medicaid
   – Cost plus 2%
   – Growth of 13% per year

1983 – DRGs – retrospective to prospective
   – Growth slows from 9.9% to 5% per year

2010 – PPACA and (Patient Protection and Affordable Care Act - Obamacare)
2015 – MACRA (Medicare Access and CHIP Reauthorization Act)
   – Payment for volume to payment for value
   – No longer the more we do the more we get paid
   – ACO, VBP, BPCI, APM, MIPS, and coming …
   – Unified PAC PPS (Post-Acute Care Prospective Payment System)

providers scrambling to …
   – Realign
   – Cut cost without diminishing quality

  If it doesn’t add value…
  redesign it or stop doing it!

My perspective

Rehabilitation experience
   – Leader and provider
   • IRF: free-standing and hospital-based within an IDN system
   • Subacute rehabilitation
   • Private practice single specialty PM&R group
   – Four acute hospitals and 10 subacute facilities

Hospital and health system experience
   – Care redesign: acute & post-acute
   – Home health
Advocate Health Care

Advocate Health Care
12 Hospitals
• 11 acute care hospitals
• 1 children's hospital
Post-Acute Care
• Post acute network > 40 SNF affiliates
• Home health care
6,300 affiliated physicians
Over 400 sites of care
35,000 employees

Advocate Physician Partners
• 11 PHOs
• Over 4,900 participating physicians
• Nationally recognized CI program
• Leader in population health management
• Largest ACO in US - 769,900 covered lives
• Saved CMS $29 million (for 2016)

Advocate continuum of care

<table>
<thead>
<tr>
<th>Provider</th>
<th>ADC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advocate Hospitals</td>
<td>2,126</td>
</tr>
<tr>
<td>Advocate at Home (Home Health, Hospice, RT/DME, Home Infusion)</td>
<td>9,925</td>
</tr>
<tr>
<td>Advocate Post Acute Network</td>
<td>1,245</td>
</tr>
<tr>
<td>Advocate Rehab Network</td>
<td>93</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>13,389</strong></td>
</tr>
</tbody>
</table>

Advocate Post Acute represents an ADC of 11,254 or 84% of Total ADC

Commitment and caution

Pursuing the Triple Aim
• Better care
• Better outcome
• Less cost

Caution re: minimizing cost
• Unanticipated, untoward impacts
• Medical complications
• Unachieved function
• Additional costs
Sutton’s Law

Famous bank robber Willie Sutton was asked by a reporter why he robbed banks.

According to the reporter, he replied,

"Because that's where the money is."

Sutton’s Law & Medicare spending per beneficiary (MSPB)

<table>
<thead>
<tr>
<th>MSPB (2016)</th>
<th>Highest (NV)</th>
<th>Lowest (IA)</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>5–3 Days Before Admission</td>
<td>$886</td>
<td>$754</td>
<td>$132</td>
</tr>
<tr>
<td>During Index Hospitalization</td>
<td>$11,667</td>
<td>$11,049</td>
<td>$618</td>
</tr>
<tr>
<td>90–30 Days After Discharge</td>
<td>$9,344</td>
<td>$7,223</td>
<td>$2,121</td>
</tr>
<tr>
<td>Complete Episode</td>
<td>$21,897</td>
<td>$19,026</td>
<td>$2,871</td>
</tr>
</tbody>
</table>

Post-acute care accounts for 73.9% of the variation in Medicare spending per beneficiary.


The Triple Aim & health care value

The Triple Aim
– Improving care
– Improving health
– Reducing cost

Health care value = \( \frac{\text{outcome} + \text{experience}}{\text{cost}} \)

Population health management
Population health changes

CMS and other payers shifting
- From - fee-for-volume
- To - fee-for-value

Utilizing risk shifting (and potential benefit) to provider
- MSSP (Medicare Shared Savings Program)
- ACO (Accountable Care Organization)
- BPCI (Bundled Payment for Care Improvement Initiative)
  - Mandated CJR (Comprehensive Care for Joint Replacement)

Population health changes

CMS Slows Expansion of Mandated Bundling
- Final rule December 2017
- Cancels both
  • Episode Payment Models (EPMs) and
  • Cardiac Rehabilitation Incentive Payment Model
- Scales back CJR
  • Makes 33/67 Metropolitan Statistical Areas (MSAs) voluntary
  • 34/67 MSAs remain mandatory

Nevertheless, the shift to fee-for-value is inexorable

Sutton's Law & population health

Sutton's Law applied to the care continuum
+ population health management =

Post-acute care is in the cross-hairs!
Re redesigning post-acute care

• What will redesigned post-acute look like?
• Who is – and will be – redesigning post-acute care?
• Where does inpatient rehabilitation fit in?
• How do we individually and collectively think and feel about these changes?

TODAY
Rehabilitation across the care continuum

FUTURE
Rehabilitation across the care continuum
Who will lead the SNF/SAR team?

SNFist role emerging
– Growing need
– Varied specialties

Number of SNFs: 15,600 (CMS, 2015)

Hospitalists (Society of Hospital Medicine survey)
– 52,000 estimate
– 30% some post-acute care now
– 58% say hospitalists should be in post-acute

Potential hospitalist/SNFist supply
≈31,000
Physiatrist supply
≈ 10,000 (AAPM&R)

Need
≈ 15,000

Non-physiatrists will necessarily provide clinical care and team leadership within SNF/SAR setting

Shifting point of control

• Probable effects on post-acute care of moving to population health management
  – Less IRF utilization
  – More SNF/SAR utilization
• Point of control shifting from referring physician to post-acute policy makers
  – Criteria for whether or not to involve physiatrist
    Note: initial CJR bundle impact
• Guiding forces
  – Cost containment
  – Evidence?
Where’s the evidence? IRF vs SNF

- Lower extremity joint replacement studies
  - Equivocal
  - No significant difference or
  - Inconsistently in favor of IRF

- Stroke and hip fracture studies
  - In favor of IRF
  - Better functional outcome
  - Higher discharge to home
  - Lesser mortality

Where’s the evidence? IRF vs SNF

Potential explanations for observations
- Differences in patient characteristics
- Differences in provision of care
  - Amount of therapy
  - Physician-led care

Where’s the evidence? IRF vs SNF

Dobson | DaVanzo, 2014
Comprehensive, cross-sectional, longitudinal, and claims based study

Rehabilitation in IRFs leads to:
- Lower
  - Mortality
  - Readmissions
  - ER visits
- More
  - Days at home
  - Cost

Caution: pre-ACA, 2005 – 2009
Where's the evidence? SNFist

- Few studies: varied models and mixed results

Two studies...
- Large academic system
generically/NP model vs standard care
  - Decreased LOS
  - Trend toward lesser readmissions
- Nursing home:
  post-acute hospitalist vs community-based
  - Increased laboratory costs
  - No reduction in falls
  - No report on length of stay

Where's the evidence?
Physiatrist vs Non-physiatrist

Important implicit elements in these prior studies
- IRF care
  - Includes physiatrist: clinical care and team leadership
- SNF care
  - Physician required
  - Physician (SNFist) specialty variable
- Pre ACA impact care models

No studies differentiating physiatrist vs non-physiatrist physician role or impact within the SNF setting

Shifting our identity – portrayed in stark contrast

- What is our role?
  - For individual patients
  - For society
- How does population health affect our role?
- How do we balance the tension of individual benefit and societal cost?
- This tension touches our values and may threaten our perceived role and identity

So … how do we see ourselves and how do we look to others?
### How We See Ourselves vs. How Population Health Leaders See Us

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<th>How Population Health Leaders See Us</th>
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<tbody>
<tr>
<td>Advocate for the individual patient</td>
<td>Advocate for the individual patient not health care value-oriented</td>
</tr>
<tr>
<td>Advocate for inpatient rehabilitation (IRF) over subacute (SNF) rehabilitation</td>
<td>Requestor of more intense care without attention to cost</td>
</tr>
<tr>
<td>Protector against the system who will seek to deny access to care</td>
<td></td>
</tr>
<tr>
<td>Appropriate determiner of level of care for patients with disability</td>
<td>Advisor (at times) regarding appropriate level of care</td>
</tr>
<tr>
<td>Appropriate clinician and leader for interdisciplinary care team for patients with disability</td>
<td>Too willing to see patients “too often” without adequate consideration of value added</td>
</tr>
</tbody>
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### Building trust – starting with ourselves

- Must address our mutual distrust
- Accept the reality of population health and payment-for-value
- Face our stories about the “big bad system” – true and untrue
- Reframe our perspective on population health management
  - Partner not adversary
  - Jointly redesign post-acute care
- To meet our patients’ needs
  - Not discarding our commitment to advocacy
  - Willing to be a part of the “mess”

### Having Crucial Conversations

- New skills and knowledge needed for…
  - “Crucial Conversations”
    - High stakes
    - Varied opinions
    - Strong emotions
- Think outside our normal comfort zone
- Be willing to innovate how to be a meaningful partner at all post-acute levels
Building trust – shared meaning

- Creating larger pool of shared meaning
- All participants feel safe enough to share their perspective or meaning

"The more we add of each person's meaning, the more information is available to everyone involved and the better the decisions made."

Building trust – shared meaning

- Triple Aim
- Evidence
- Experience
- Lead to increased Trust

Physiatrist Population Health Leader

Being a part of the conversation – demonstrating our value

- Enter with commitment to Triple Aim
- Be willing to be honest, have constructive conflict and build trust
- Look for and define common ground
- Explain value-based physiatrist capability
  - Highest functional outcome
  - Least financial cost
  - Managing resource utilization of costly therapy
- Manage ourselves with value in mind
Framework for value conversation

Co-create care path
- Patients appropriate for evaluation for inpatient rehabilitation
- Determining next care level
- Coordinating the interdisciplinary care team
- Appropriate therapies
  - Intensity and frequency to achieve functional goals
  - Especially in the SNF setting
- Responsibilities in handover to next level of care

Where do we go from here?

Our choices are clear
- Stick with what we are doing … or
- Accept emerging reality and change ourselves
  - Beliefs
  - Attitudes
  - Knowledge
  - Practice
  - Even personal and professional identity

So that …

Where do we go from here?

We can thrive as partnered clinicians and leaders in the ongoing care of our patients
Recommendations

To our rehabilitation leaders in health care

• Know your local hospital and post-acute care environment
• Intentionally develop positive working relationships with decision makers about physiatrist involvement
  – ACO
  – PHO
  – Physician groups: larger employed or private especially those taking risk
• Prepare for and engage in the rehabilitation value conversation

Recommendations

“Don’t lose heart!”

You can choose to see all of this as malevolent and resist changing or chose to be a flexible learner, advocating for your patients while being an active participant in the change.

The words of Victor Frankel

“Everything can be taken from a man or a woman, but one thing: the last of human freedoms — to choose one’s attitude in any given set of circumstances, to choose one’s own way.”

THE CHOICE IS OURS
Questions?

Thank You!

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