Health Care Reform for Post-Acute Providers

Arnie Cisneros

Arnie Cisneros, P.T. HHSM
- 30 years Medicare Care Continuum
- 30 year Home Health clinician/contractor
- Home Health consultant & speaker
- Progressive clinical delivery/management
- ACO Post-Acute Bundling Consultant – Vanguard Health Systems – DMC Pioneer ACO Grant Awardee
- Model 2 Bundling Awardee – DMC 10/9/12

Thoughts on the Future
“Ten years from now, homecare will still be around but it will be different; it will not be what we see today, it will be a much, much bigger realm of homecare services; it may not even be called Home Health anymore.”

Thoughts on the Future
“It’s not just price per visit, it’s outcomes. If I’m an ACO, I don’t want you because you’re cheaper, I want you because you cost less in a dynamic way: less re-hospitalizations, better management of patients, better integration, etc. We have the skill set and the infrastructure, we just have to adapt.”

Thoughts on the Future
“Budget some of your energy and resources towards keeping the ship afloat, dealing with current care, the proposed cuts, etc., while devoting energies as well to those new opportunities that are out there. If you don’t, somebody else is, and they will be the one who succeeds.”

Care Continuum – Silo History
- Hospital as Primary Provider
- Care Site Based Coverage
- Separate Insurance
- Episode-based Approach
- Wellness-Based Healthcare
- Acute vs. Post-Acute
- Fails to Promote Episode Care Efficiency
Healthcare Reform – 2010

- Patient Protection/Affordable Care Act (PPACA)
- Accountable Care Organizations (ACOs)
- Care Transitions Management
- Population Health – Chronic Care
- Triple-Aim Philosophy
- Value-Based Purchasing (VBP)
- Single-Bundled Payment (SBP)

ACCOUNTABLE CARE ORGANIZATIONS

Accountable Care Organizations

An ACO is a healthcare organization characterized by a payment and care delivery model that seeks to tie provider reimbursements to quality metrics and reductions in the total cost of care for an assigned population of patients.

Integrated Health Care System

Managed care system that includes a hospital organization that provides acute patient care, a multispecialty medical care delivery system, the capability of contracting for any other needed services, and a payer (CMS).

Integrated Health Systems

- Accountable Care Organization Format
- Episode-based Care Approach
- Acuity-based Programming
- Care Site Selection
- Prompts Value-Based Purchasing
- Prompts Single-Bundled Payment
PPACA “en” Action

<table>
<thead>
<tr>
<th>Patient Protection and Affordable Care Act</th>
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<tbody>
<tr>
<td><strong>Full title</strong></td>
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<tr>
<td><strong>Acronym</strong></td>
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<tr>
<td><strong>Colloquial name(s)</strong></td>
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<td><strong>Enacted by the</strong></td>
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<td><strong>Effective</strong></td>
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<tr>
<td><strong>Specific provisions phased in</strong> through</td>
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**PPACA defined by Healthcare.gov**

- The law is the principal health care reform legislative action of the 111th United States Congress.
- PPACA reforms certain aspects of the private health insurance industry and public health insurance programs, including increasing insurance coverage of pre-existing conditions, expanding access to insurance to over 30 million Americans that, financially, is achieved through subsidies by the federal government and increased enrollment in federal health care programs (increasing total national medical expenditures in the short term), and additional policy changes to reduce the long-term cost of health care.

**Triple Aim Philosophy**

PPACA was created with a “triple aim” in mind:
1. Improve the health of patient populations
2. Improve patients’ experience of healthcare
3. Reduce per capita costs of healthcare

“The components of the Triple Aim are not independent of each other. Changes pursuing any one goal can affect the other two sometimes negatively, sometimes positively”

Donald Berwick, Triple Aim: Care, Health and Cost, Health Affairs, 27, no. 3 (2008)

**POST-ACUTE BUNDLING**

**Post-Acute Bundling**

Post-Acute Bundling is a single bundled payment for all treatment and expenses required for completing a patient’s acute episode of care.

**VALUE BASED PURCHASING (VBP)**
Value Based Purchasing

Value Based Purchasing is a common strategy to reform the health care system by rewarding excellence in health care delivery.

ACO/Bundled Payment Linkage

- The ACO is viewed by hospitals & physicians as a key strategy to adapting to changes under healthcare reform.
- Many healthcare executives & thought leaders view ACO's + Value-based payments as a precursor to bundled payments for episodic care.
- Post-acute entities account for 25-30% of healthcare costs and must be prepared to deliver a "value-based" service that aligns with referring source priorities, as part of the episode of care.

ACO + VBP = SBP

SINGLE BUNDLED PAYMENT (SBP)

Single Bundled Payment

Single Bundled Payment is defined as the reimbursement of health care providers on the basis of expected costs for clinically-defined episodes of care.

Net Results of ACO Modeling on Current & Future Post-Acute Care
Net Effects on Post-Acute Care

- Decreased Utilization per Episode
- Decreased Payments for Rehab
- Increased Scrutiny
- Integration into the Team
- Clinical Content replaces LOS-Based Care

ACO Metrics

- Primary Care (wellness & prevention)
- Physician/hospital alignment
- Quality outcomes
- Community stakeholder collaboration
- Data sharing/integration
- Improved care transitions and efficiency
- Capitated payments

Why Post-Acute is Key

<table>
<thead>
<tr>
<th>PAC Setting</th>
<th>% D/C from Hospital to PAC Setting</th>
<th>% Readmitted after PAC Setting</th>
<th>% D/C to 2nd PAC Setting</th>
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<tr>
<td>SNF</td>
<td>17.3</td>
<td>22.0</td>
<td>29.3</td>
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<tr>
<td>HHC</td>
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<tr>
<td>Psych</td>
<td>0.5</td>
<td>8.7</td>
<td>25.4</td>
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<tr>
<td>Total</td>
<td>40.0</td>
<td>18.0</td>
<td>19.8</td>
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Post-Acute Benefits to Accountable Care

- **Pre-PPACA:**
  - Reduce LOS
  - Follow hospital/physician treatment plan
  - Volume-based payments
  - Minimal transparency
- **Post-PPACA:**
  - Improve continuity of care and quality
  - Improve patient experience
  - Decrease post-acute care costs
  - Decrease avoidable readmissions
  - Value-based payments (bundling and quality)
  - Increase transparency

Care Transition Model

- Post-Acute Bundling
- Re-invent Acute Discharges
- Decreased Re-hospitalizations
- Find Savings/efficiencies
- Re-examines Acute Episode

Opportunity Knocks: Shifting from Volume to Value

- Assess current program delivery system
- **KNOW YOUR NUMBERS**
  - Determine opportunities for optimizing value – Set the Vision
  - Operationalize at the granular level
- Evaluate and Communicate
Hardwiring Value

- Start of Care within 24 hours or less
- Shift care focus from care dependence to self-care determination
- Proven ability to manage high acuity patients
  - Clearly define clinical vulnerabilities and strengthen them
  - Telehealth
  - Mid-level providers
- Better communication and coordination
- Data integration
- Outcomes measurement/reporting - transparency
- Provide expertise in Accountable Care strategy
  - ED to home care
  - Home care to SNF

HEALTHCARE OF THE FUTURE

Healthcare of the Future

- Evidence-based, Best Practice
- Wellness-based, Episodic Care
- Value-based Delivery
- Hospital Redefinition
- Acute Admissions for Critical Care
- Affordable Care Approach to Episodes
- Value Based Care Delivery

MODEL 2 BUNDLING PILOT (MSDRG – 469/470)

Model 2 Bundling Pilot

- Detroit Medical Center – Pioneer ACO
- Bundle Payment Care Improvement
- MS DRG 469/470
- Joint Utilization Management Program
- J.U.M.P.
- UR-based Care Episode

HOSPITAL READMISSION STRATEGIES
Hospital Readmissions
- Symptom of expensive/uncoordinated system
- Hospitals benefit fiscally from readmits
- 2 million-30 day readmits - $17.5 billion
- 71% of hospitals penalized 2012 - $280 mil
- Penalties double 10/13 increase again 10/14
- Make admissions less toxic
- Promote safe patient passage from acute care

Post – Hospital Syndrome
An acquired, transient period of vulnerability and risk in the critical first 30 days after DC. This period of clinical risk is connected as much to the stresses of the inpatient admission as it is connected to lingering effects of the original illness. Patients are not only recovering from their illness, but they are also in a phase of generalized risk for a series of adverse events.

CAN YOUR CARE DELIVERY SYSTEM SELF-MONITOR OR SELF-MAINTAIN?

Hospital Readmissions
- Assess current delivery system
- Focus on CHF, AMI, and Pneumonia
- Identify Opportunities to create/modify
- Retrain workforce to strategic focus
- Retrain for improvement and communication
- Evaluate performance for opportunities
- Track outcomes for reinforcement

Hospital Readmissions
- How do we affect change in this area?
- Replicating the programs of the past?
- Evidence-based, best practice focus
- Accurate assessment of condition
- OASIS/Care Tool?
- Focus on illness/Post-Hospital Syndrome
- Residential vs Care Acuity Programming

Conditions at Initial Discharge
- Heart Failure 63%
- Pneumonia 71%
- COPD 64%
- GI 79%
- Readmissions for other causes
- Readmission for same cause

CAN YOUR CARE DELIVERY SYSTEM SELF-MONITOR OR SELF-MAINTAIN?

EVIDENCE-BASED, BEST PRACTICE FOCUS
- Accurate assessment of condition
- OASIS/Care Tool?
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CAN YOUR CARE DELIVERY SYSTEM SELF-MONITOR OR SELF-MAINTAIN?
ACOs – Provider Involvement
- Potential for Participation
- Philosophical Requirements
- Part A Clinical Management Requirements
- Nursing Philosophies required
- Therapy Philosophies - Concerns
- How will (can) you contribute?
- Programs – problem solving, etc.

ACOs – Provider Requirements
- Reporting Requirements
- Financial Disclosures
- Clinical Parameters – Protocols
- Utilization Review Required
- Savings Approach
- Innovative care management and delivery
- Therapy Philosophies - Concerns

ACOs – Provider Requirements
- Adverse Events – Legacy - Management
- Med Management Errors
- Falls – Occur – Response - Prevention
- Readmissions – Diagnosis-based
- Survey Results – Accreditation?
- Clinical Programs – Volume-based?
- Ancillary Providers – DME, Lab, ER, Etc

ACOs – Where to Start?
- Post-Acute Caseload
- MD groups - Hospitals – Systems - SNF
- Look Inward – Care Mgmt & Delivery
- Nursing/Therapy Communication
- Clinical Assessment/Analysis/Performance
- Readmission Focus – 30 days

ACOs – How to Start?
- Utilization Review – When and How?
- Clinical Staff – Can you control your staff?
- Timely documentation – Productivity
- Fresh Staffing – Clean Care Programs
- Weekly Rounds vs Case Conference
- Identify Keepers in the New Care Model
- Make it Work – Make it Happen!

ACOs – Miscellaneous
- Post-Acute Providers – Multiple ACOs
- CMS Direct Billing
- Confidentiality Agreements
- The Opposite of What We Do Today
- Un-Managed Therapy Breaks Bundles
- Clinical Content/Control Philosophies
- Don’t let Patient Choice Fool You
Post-Acute Bundling
- Model 2 Bundling Award – DMC
- Payment for Care Improvement
- Post-Acute – Today’s Role
- Choose care model/per patient basis
- Readmissions – meds, falls
- Lead your Care, patients, MDs

Post-Acute Bundling
- Therapy Concerns – Contract/Employ
- SOC, Eval, POC, Documentation
- Connection to Acuity-Based Care
- In-episode Rehab Management
- Questions regarding Provider Control
- Same Page w Rehab – Start Now!!

S.U.R.C.H.©
SERVICE UTILIZATION REVIEW for CARE in the HOME

S.U.R.C.H.©
Create episode expectations and specific care plans for programming based on QA identified clinical concerns or deficits, and share those expectations with front line clinical staff prior to care initiation.
The Functional “F”
Efficiency will be based on objective assessment of the Functional questions, followed by best practice-focused care delivered by managed clinical rehab staff.

Functional “F” versus M1900
- Self Care – PLOF Dressing/Bathing
- Ambulation – Mobility
- Transfers
- Household Tasks - Meal Prep, Laundry
- Independent – NSH – Dependent

THERAPY PAYMENT REGRESSION

Non-Visit Therapy Payments
- Clinical / Functional Analysis
- C1 – C2 Progression $21.00
- F1 – F2 Progression $449.00
- Functional/Clinical Ratio = > 20/1
Home Health Strategies
● Intake
● Start of Care
● Care Plan Production
● In-episode Interventions

Intake Strategies
● How do we affect change in this area?
● Referral Content
● Previous History
● Admission Strategies
● Residential vs Skilled

Start of Care Strategies
● OASIS Accuracy
● Care Tool Use
● Case-mix Focus
● Co-morbidities

Care Plan Production
● Utilization Review
● Identify Clinical Concerns
● Acuity-based Volumes
● Evidence-based, Best Practice Care
● Complete, & Fresh Staffing

In-Episode Interventions
● Visit Content – consistent care
● Vitals, Common Care Plan mgmt
● Home Programs
● Caregiver, Compliance
● Skilled Progression
● Real-time Communication
● Telehealth, Phone Checks

Sub-Acute Strategies
● Admission
● Therapy
● PPS Utilization
● ACO Philosophy
● ACO Patient Management
Admission
- Reason for Sub-Acute
- Discharge Plan
- Community Environment
- Standard SNF Programming
- ACO Philosophy

Therapy
- PPS RUG Fee Structure
- High – Very High – Ultra High
- Group Therapy
- Skilled Progression
- ACO Philosophy

PPS Utilization
- Gross vs Net RUG Realities
- Patient Contribution
- Historical vs PAC-Bundling
- ACO Philosophy

ACO Philosophy
- PPACA Mandate
- Triple Aim/VBP
- Wellness Based/Prevention
- DRG Based Payments
- Capitation Effects

New Care Practices for the ACO era

ACO Deficit Based Care
- Safety is Therapy Baseline
- Deficit-Proportional Care Volumes
- Safety Concerns Prompt Urgency
- Altering Safety Prompts POC Change
- Resolving Deficits for Discharge
Skilled Episode Delivery
- Baseline Relevant HP First Visit
- Full Performance HP Each Visit
- Capture Progression Each Visit
- Seek/Reinforce Progress
- Move Program Forward Each Visit

Goal Production/Management
- Safety/Function is the ONLY Focus
- Distance as Gait Goal Prompts Denials
- Possess Skilled Rehab Visit Approach
- Utilize a Sense of Urgency
- Focus on BPCI Clinical Parameters
- Follow BPCI Protocol Pathway

HEALTHCARE EVOLUTION

Hospital - Centric
- Medicare History – 1965
- Healthcare Reform History
- PPS – DRGs, RUGs, HHRGs
- Subsequent Reforms/Utilization Effects
- Hospital Role in ACO

Post-Acute – IRF/SNF/HH
- Silo Care Continuum
- Qualification Requirements
- History of Reforms
- ACO Philosophy towards Post-Acute
- Care Site Competition

Healthcare Evolution
- Hospital – centric
- Post-Acute – IRF vs. SNF vs. HH
- Patient Fiscal Contribution
- IL/AL/Community
- IT/Telehealth/ACO
Patient Fiscal Contribution
- History across Care Continuum
- Home Health obvious in exclusion
- Non Post-Acute patient contribution
- $150/cert period for Home Health
- Acute vs. Chronic – Assisted Living Hx

IL/AL/Community
- History of Assisted Living
- Community Care Evolution
- ACO Effects on chronic care
- Population Health
- Affordability of Patient Management

IT/Telehealth/ACO
- Assessment Standardization - CARE
- Telehealth
- TeleMonitoring
- Costs of Care in community
- Progressive Programming

Future Opportunities
- DRG-based
- Site-neutral payments
- Fluency of Care
- Patient Participation
- Redefined Care Landscape in Community

10 Ways to Start Today
1. Analyze/Assess your Agency (Volume/Patients)
2. Identify Silo Activities – Care Production/Delivery
3. Utilization Review – ???????
4. In – Episode Clinical Management
5. Therapy – Connection to Functional Acuity

10 Ways to Start Today
6. Know your Numbers – Volumes, Readmissions
7. Evidence Based, Best Practice Content?
8. Ability to Manage Patients/Caregivers?
9. Diagnosis Specialty Programs
10. Future Care Philosophy
CAN YOU MANAGE TO IMPROVE YOUR CARE?

IT’S THE OPPOSITE OF BUSINESS AS USUAL

WHAT IF THE PATIENT WAS YOUR AUNT?

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