Florida Health Care Association
2013 Annual Conference

The Westin Diplomat Resort & Spa

Session #4 – What Makes an Attractive Post-Acute Partner for ACOs

Monday, August 5 – 8:30 to 10:30 a.m.

Regency 1

Upon completion of this presentation, the learner will be able to:

- identify appropriate reporting features to monitor and track quality measures and outcomes;
- describe strategies for developing positive relationships with the healthcare community; and
- prepare a facility report card in order to attract partnerships.

Seminar Description:

Payment reform will focus on increasing value and reducing costs. How will this affect skilled nursing facilities? Does your facility have the reporting features in place to monitor and track quality measures, patient outcomes and hospital readmissions? This session will help identify how your therapy department can enhance or distract you from becoming that ideal partner, including how improving quality will require valid metrics, good data and proactive systematic approaches. Rehabilitation can contribute in connecting patient progress, patient engagement and quality to a facility's value within the health care community. This session will provide strategies to help facilities prepare systems that will make them attractive to building new relationships within the health care community.

Presenter Bio(s):

Holli Benthusen, Regional Director of Business Development for Select Medical Rehabilitation, is an experienced Occupational Therapist practicing in the long term care industry in operations, compliance and education. She is a member of POE Boards for First Coast and Novitas. Holli has extensive public speaking experience, including rehabilitation, MDS 3.0/RUGS IV, documentation and compliance. She has comprehensive knowledge in developing denial management systems including software development and participation in hearings.

Margaret Kopp is Vice President of Clinical Services for Select Medical Rehabilitation Services. She has over 20 years of experience in positions of leadership and management in the long term care rehabilitation industry. She has expertise in employee development, customer relations, organizational change, clinical operations, budgetary compliance, strategic planning, program development and quality clinical service delivery. She received a Master of Science in Speech Pathology from Rutgers University. She is a member of various state and national organizations and received the Chairman’s Award from Novacare, Inc.
What Makes An Attractive Post-Acute Partner for ACO’s

Holli Benthusen, OTR/L
Regional Director of Business Development & Client Relations

Margaret Kopp, SLP M.S. CCC SLP
Vice President of Clinical Services and Quality Management

August 5, 2013

Learner Objectives

• Identify appropriate reporting features to monitor and track quality measures and outcomes
• Describe strategies for developing positive relationships with the healthcare community
• Prepare a facility report card to be able to attract partnerships

Healthcare Reform

Theme of the Affordable Care Act
• Increasing value and reducing costs
  – ACO’s
  – Bundling
Overview

Kaiser Health News
Early Signs That ACOs Are Boosting Care, Saving Money - June 2013

Bloomberg reports that hospitals across the U.S. are improving care and saving millions by creating ACOs

Less than five months before the Affordable Care Act fully kicks in, hospitals are improving care and saving millions of dollars with one of the least touted but potentially most effective provisions of the law

While much of the focus on Obamacare has been on the government rush to open insurance exchanges by Oct. 1, 252 hospitals and physician groups across the U.S. have signed up to join the administration's ACO program (Wayne, 6/12).

The government expects the savings may be as much as $1.9 billion from 2012 to 2015.

Opportunities Created by Healthcare Reform

"Push is on to reduce the 4.4 million hospital stays that are a result of potentially preventable re-admissions, which add more than $30 billion a year to the nation's health-care tab, or 1 of every $10 spent on hospital care, according to the federal Agency for Healthcare Research and Quality."


Significant opportunity exists to better manage patients discharged from acute care hospitals.
Accountable Care Organizations-ACOs

- CMS develops final rule on October 20, 2011
- Under the Patient Protection and Affordable Care Act (Affordable Care Act)
- Improve care coordination to Medicare patients across care settings including doctor’s offices, hospitals, and long-term care facilities.
- The Medicare Shared Savings Program (Shared Savings Program) will reward ACOs that lower their growth in health care costs while meeting performance standards on quality of care and putting patients first.

How does CMS describe an ACO?

- Accountable Care Organizations (ACOs) are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to their Medicare patients.
- The goal of coordinated care is to ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors.
- When an ACO succeeds both in delivering high-quality care and spending health care dollars more wisely, it will share in the savings it achieves for the Medicare program.

Key Principles of Accountable Care

The Brookings Institution
**Types of Medicare ACO programs:**

- **Medicare Shared Savings Program** — program that helps a Medicare fee-for-service program providers become an ACO.
  - bringing the total number of Medicare ACOs to 220*
- **Advance Payment ACO Model** — supplementary incentive program for selected participants in the Shared Savings Program.
  - There are currently 35 ACOs participating in the Advance Payment Model
- **Pioneer ACO Model** — program designed for early adopters of coordinated care. No longer accepting applications.
  - There are 32 ACOs participating in the Pioneer ACO Model

* As of 6/14/2013 http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/index.html?redirect=/aco/
How else is Medicare encouraging coordinated care?

- The CMS Innovation Center offers a menu of alternative options, including:
  - Comprehensive Primary Care initiative
  - Bundled Payments for Care Improvement initiative
  - Community Based care Transition Program
- We want to try to meet you where you are. Our hope is to show you models of participation that will encourage you to join in and begin this work, no matter your organization's stage.

Bundled Payments for Care Improvement initiative (BPCI).

- August 23, 2011, CMS invited providers to apply to help test and develop 4 different models of bundling payments with different phases of risk.
- Under the Bundled Payments for Care Improvement initiative, organizations will enter into payment arrangements that include financial and performance accountability for episodes of care.
- These models may lead to higher quality, more coordinated care at a lower cost to Medicare.
- Participants in Phase 1 of Models 2, 3, and 4, that are ultimately approved by CMS and decide to move forward with implementation and assume financial risk, may enter into a Bundled Payments for Care Improvement Model agreement with CMS and begin Phase 2 of the Model.

The 4 Models

**BPCI Model 1: Retrospective Acute Care Hospital Stay Only**

- Episode of care is defined as the inpatient stay in the acute care hospital.
- Medicare will pay the hospital a discounted amount based on the Inpatient PPS
  - Medicare will continue to pay physicians separately for their services under the Medicare Physician Fee Schedule.
- Participation will begin as early as April, 2013 and no later than January, 2014.
BPCI Model 2: Retrospective Acute & Post Acute Care Episode

• The episode of care will include the inpatient stay in the acute care hospital and all related services during the episode.
  – The episode will end either 30, 60, or 90 days after hospital discharge.
  – Participants can select up to 48 different clinical condition episodes.
  – On January 31, 2013, Phase 1 participants were announced.
• Phase 1 (January-July 2013), also referred to as the “no risk preparation” period, is the initial period of the initiative
• The “risk-bearing implementation” period, Phase 2, is expected to begin in July 2013. The beginning of Phase 2 would mark the beginning of the performance period, or risk-bearing period.

BPCI Model 3: Retrospective Post Acute Care Only

• For Model 3, the episode of care will be triggered by an acute care hospital stay and will begin at initiation of post-acute care services with a participating
  – skilled nursing facility,
  – inpatient rehabilitation facility,
  – long-term care hospital
  – or home health agency.
• The post-acute care services included in the episode must begin within 30 days of discharge from the inpatient stay and will end either a minimum of 30, 60, or 90 days after the initiation of the episode.
• Participants can select up to 48 different clinical condition episodes.

BPCI Model 4: Prospective Acute Care Hospital Stay Only

• CMS will make a single, prospectively determined bundled payment to the hospital that would encompass all services furnished during the inpatient stay by the hospital, physicians, and other practitioners.
• Physicians and other practitioners will submit “no-pay” claims to Medicare and will be paid by the hospital out of the bundled payment.
• Related readmissions for 30 days after hospital discharge will be included in the bundled payment amount.
• Participants can select up to 48 different clinical condition episodes.
Strategies - What Makes an Attractive Post Acute Partner

Episode of Care

Medicare Patients’ Use of Post-Acute Services Throughout an “Episode of Care” (1)

35% of Medicare Beneficiaries are Discharged from Acute Hospitals to Post-Acute Care

• SNFs are in a powerful position to use data to their competitive advantage
• Data is essential in creating a competitive advantage.

How Are Hospitals Measuring SNF Performance?

On October 1st, hospitals in the bottom quartile will face cuts from Medicare.

- SNFs are in a powerful position to use data to their competitive advantage
- Data is essential in creating a competitive advantage.
How Are Hospitals Measuring SNF Performance?

John DiCola, SVP, Strategy & Business Development, Catholic Health Initiatives, shared that his company is "assessing post-acute care capacity & creating a credentialing system"...this is how a partner will be evaluated:

- Beds, census, discharge status, LOS
- 7 and 30 day readmissions
- FIM Scores
- Patient & family satisfaction
- Emergency department visit rates
- Infection rates

Top Outcomes against which providers will be measured by hospitals include:

- **Perceived quality of care and outcomes.**
- **Readmissions** - Incidents of hospital readmissions
  - FY 2013 and 2014 - Adopted readmission measures for the applicable conditions of Acute Myocardial Infarction (AMI), Heart Failure (HF) and Pneumonia (PN)
  - In the FY 2014 IPPS proposed rule, CMS proposes to expand the applicable conditions for FY 2015 to include: (1) patients admitted for an acute exacerbation of chronic obstructive pulmonary disease (COPD); and (2) patients admitted for elective total hip arthroplasty (THA) and total knee arthroplasty (TKA).
- **Communication and coordination of care.**
- **Lowest cost**, as measured by length of stay (LOS)

How to become the Preferred Discharge Destination?

Quality measures - Does your facility have these measures?

- Patient/family satisfaction reports
- Statistical reporting including:
  - Patient functional independence measure outcome scores
  - LOS by diagnosis
  - Discharge destination
  - Staffing
  - Therapy Expertise
**Quality Measures- Rehabilitation Outcomes Implementation**

1. Establish a means of collecting rehabilitation data in a consistent manner to allow clinicians:
   - To follow changes in functional status
   - Measure the effectiveness of treatment
   - Tracking and reporting to assess quality and cost effectiveness of program

2. Determine method for obtaining Outcome tool
   - Software/Services
   - Partnering with Contracted Therapy
     - Established Outcome tool
     - Report Capability
     - 3rd Party Surveys

**Outcome Measures-Report Card of Performance**

• Pull together a profile of the building to help “sell value” to ACO’s
• Establish method of pulling metrics together to be able to highlight strengths of facility and program
  – Use data to address concerned areas
• Patient Surveys
• Annual Surveys
• 5 Star Rating
Facility Outcome Report

Facility Facts

- **Age Range accepted**: Under 60 case by case
- **Average Age**: 74 years old
- **Bariatrics**: Case by case
- **Smoking/ Non-smoking**: Non smoking campus

Intensity of Therapy/Sub-acute Rehab

- **Average Length of Stay**: 24 days
- **Therapy Availability**: 7 days/week
- **Therapy Intensity**: 72% receive 2.5 hrs/day
- **Specialty Programs**: Memory Care

Discharge Destination

- **Home**: 89%
- **ALF**: 3%
- **SNF**: 8%
Facility Outcome Report

Return Home

- Mng A: 81%
- Med A: 94%
- Total: 89%

Facility Outcome Report

Patient Satisfaction

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<thead>
<tr>
<th>Measure</th>
<th>Scoring</th>
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<tbody>
<tr>
<td>Physical Therapy: PT explained treatment &amp; program</td>
<td>4.55</td>
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<tr>
<td>Physical Therapy: Involved in setting PT goals</td>
<td>4.50</td>
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<tr>
<td>Physical Therapy: PT helped meet goals</td>
<td>4.50</td>
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<tr>
<td>Occupational Therapy: OT explained treatment &amp; program</td>
<td>4.70</td>
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<tr>
<td>Occupational Therapy: Involved in setting OT goals</td>
<td>4.63</td>
</tr>
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<td>Occupational Therapy: OT helped meet goals</td>
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Facility Outcome Report

Clinical Outcomes

- Admission
- Discharge

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### Diagnosis groups/data on point gain and LOS

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### Patient Specific Reports

![Graph](image)

### Facility Outcome Report

Support to the Hospital/Continuum

- ER/hospital
- Lab
- Radiology
- Wound Center
- Home Care
- Hospice

Our facility makes referrals to SSM:
Facility Outcome Report

Return to Hospital within 30 days 11%

Readmission Rates

- Investigate how Acute Care Hospitals in region are monitoring and tracking readmissions
  - Do you want to be the first to report?
- Gather information on readmissions- who will be tagged?
  - Directly to hospital
  - From Home to hospital?
  - Home health to hospital?
- Establishing effective communication between physician and nursing to address care issues proactively

Readmission Rates

- Ensure that discharges are appropriate and that all safety and education are completed prior to D/C
  - Utilize methods to get patient and family buy-in
- LOS- weighing effective care and costs to prevent early discharges and subsequent readmissions back to acute care
Facility Outcome Report

Communication and Coordination of Care
- Patient Health Records - how are they shared?
- Established Nursing Home liaison
  - Who is primary contact
  - Who is back up contacts
  - What happens on weekends
- What types of patients does SNF accept
  - Niche marketing
  - Nursing and therapy strengths

Communication and Coordination of Care
- What is the turn around time for admissions?
- What typically is the discharge planners’ customer service experience?
- How is the family introduced to the building?
- How is the family introduced to therapy?
Reasons for Hospital CEOs to consider regarding referrals

- Return to Hospital rate
- Use of continuum services/referrals to hospital
- Use of ancillary services, i.e. lab, radiology

Five Questions for Case Managers/Social Workers

1. What are the top 3-4 issues that influence a referral?
2. What most often influences the patient/family decision?
3. How often do families request to tour a facility prior to making a decision?
4. Do specialty services, i.e. respiratory therapy, massage therapy, specialists, make a difference?
5. What percent of referrals have insurance other than Medicare?

Reasons for Case Management or Social Worker referrals to a SNF

1. Location of patient’s home or family members’ home
2. Insurance
3. PCP/physician referral
4. Speed of response once referral is made
5. Relationship with facility marketer/admissions staff
6. Patient/family previous experience at facility
7. Dialysis availability
Reasons for Case Management or Social Worker referrals to a SNF

8. Reputation of facility/referral from someone patient/family knows
9. Medicare.gov website reviews (Star rating)
10. Age of patient
11. Diagnosis
12. Smoking
13. Return to hospital rate

Post-acute providers will be asked by hospitals-

“What value do you bring to the table as a partner?”

The goal is person-centered care:

What is the best setting for the patient, at the lowest cost, with the highest quality, safety, & outcomes.
Preferred Discharge Destination

- Quality measures.
  - Patient/family satisfaction reports.
  - Therapy/softwar statistical reports including:
    - Patient functional independence measure outcome scores
    - LOS by diagnosis
    - Discharge destination
    - Staffing/productivity levels, etc.
- Electronic medical records.
- Clinical pathways and precautions related to the rehab needs associated with the top 5 diagnosis
- Use of therapeutic modalities as a means to measure patient status (BP cuff, pulse oximeter, stethoscope).
- Staffing levels to support patient census and needs, including weekends.
- Screens following all patient incidents.
- Nursing education and training related to top 3 diagnosis that would penalize acute care referral source.
- Participation in patient care meetings.
- Patient transition policy.
- Participation in facility task force to address hospital readmission.

Marketing

Get your data house in order!
- EMRs with complete, accurate, & solid data you can trust
- Specialization programs that give you the edge in reducing LOS and quality care
- Outcomes Reports showing your positive trends for lowering costs, boosting quality, and reducing return to hospital

Questions?
Thank You