Objectives

• Identify the importance of developing a strategic framework to provide a unique discharge option for post-acute care providers.
• Identify quality care and outcomes measures that impact success and sustainability; use of care capabilities form, care coordination meetings, scorecards and IT solutions to survive and thrive in the midst of reform.
• Identify quality partners among network of care providers, how to coordinate successful care transitions between hospitals, assisted living, home health and skilled nursing (implementing CARE Tool and other resources).
• Identify opportunities for specialized program implementation as a niche to differentiate your community from competitors, while meeting an unmet care need identified by referring hospital(s).

Assisted Living

• Defined: Assisted Living is a program that promotes resident self-direction and participation in decisions that emphasize choice, dignity, privacy, individuality, independence and homelike surroundings.
The Evolution of Assisted Living

- 1986-24 Hour Staffing Model
  - Personal & health related services
- 1995-Founding of Person Centered Living Approach
- 2000
  - Shift from Assisted Living to Senior Living
  - Increase in staff levels
  - Increased presence of Memory Care product
  - Expanded Level of Services
- 2010
  - Shift from Assisted Living to Senior Living
  - Increase in staff levels
  - Increased presence of Memory Care product
  - Expanded Level of Services
  - Rehabilitation Services provided as standard
  - LTC Plans: Long Term Care insurance
  - PAC Discharge
  - PAC Discharge

Out with the old...

- Acute Care (Hospital)
- Short Term Rehab
- Home Health
- Outpatient Rehab

CMS’ Triple Aim
In with the new…
(Healthcare Reform)

Acute Care (Hospital)  Short Term Rehab  Home Health  Outpatient Rehab  Assisted Living Community

Opportunities...

• Discharge destination no longer a given;
• Payer no longer precludes AL as an option, ACO/Bundles etc. want least expensive option with best clinical capabilities and outcomes
• Demonstrate quality and outcomes; can get a seat at the table to be a preferred provider
• PAC discharge option
• CJR and Bundled Payment Comprehensive Care Initiatives
• Industry knowledge
• Thinking outside the BOX!
  – examples

Developing a Strategic Framework
What are you trying to accomplish?

• Provide a new post acute care discharge option for hospitals
• Improve census
• Increase clinical capabilities
• Develop or strengthen collaborative partnerships
• Offer niche programs
• Develop a new revenue stream

Framework Development

• Find a differentiator
• Build a network of collaborative partners
• Know your referral sources
• Identify a strong Home Health partner
• Identify a strong Rehab partner
• Know and understand your outcomes
• What are you marketing?

Thoughts to Consider

• What are your competitors selling?
• What do your referral sources need?
• What can you feasibly provide within regulatory requirements?
• Where do you have strong relationships you can leverage?
Developing and Expanding Collaborative Partnerships

Understanding Clinical Capabilities

• What can you do?
• What do you do well?
• What could you expand or improve?
• What could you eliminate?

Hospital Partnerships

• Seat at the table
  – C-level if possible
• Need analysis; solution oriented
• Clinical capabilities
• Rehab solution
Short Term Rehab Partnerships

- Seat at the table
- C-level if possible
- Need analysis; solution oriented
- Clinical capabilities
- Rehab solution

Home Health Partnerships

- Continuity of care
- Communicate understanding of serving resident first; Part A vs. Part B benefits
- Environmental focus

Hospice Partnerships

- Distinct group of individuals
- May still have rehab needs
- Quality of life
- Unrelated dx/condition
- Communication and assessment is critical
Outcomes: Measuring your Success

What are outcomes?

Outcomes Categories

- Financial
- Clinical
- Demographic
- Quality Assurance
Who wants/needs outcomes?

- Patients
- Doctors
- Family members
- Administrators
- Executive Directors
- Corporate
- Hospitals/referral sources
- CMS
- Clinicians
- Congress
- Payers
- Marketing department

Improving Medicare Post-Acute Care Transformation Act (IMPACT Act)

- This is being compared to OBRA '87 and the BBA '97 as far as significance in the PAC marketplace.
- It was introduced June 26, 2014 and signed by President Obama on October 6, 2014...in Congressional time that is FAST!
- Three components:
  - Reporting of standardized patient assessments (data)
  - Reporting of additional Quality Measures
  - Report Resource Use Measures

Standardized Data

Why standardize data across PAC settings?
- Enable Congress and CMS to compare services across PAC settings
  - Complexity
  - Outcomes
  - Costs
- As a predicate for PAC payment reform.
  - CMS concern: the different types of PAC providers frequently provide similar services to similar patients, but payment can vary significantly.
  - Each silo’s patient assessment tool uses different definitions, scales, time periods, and method of assessment.
- Standardization may enable policymakers to develop a payment system that cuts across all PAC settings.
Quality Measures

- SNFs, IRFs, LTCHs must begin reporting on quality measures by October 1, 2016, and by January 2017 for HHAs.
- At a minimum, must contain the following quality domains:
  - Functional status and changes in function
  - Skin integrity and changes in skin integrity
  - Medication reconciliation
  - Incidence of major falls
  - Patient preferences

Resource Use Measures

- By October 1, 2016, Secretary shall specify “resource use” reporting requirements.
  - Medicare spending per beneficiary
  - Discharge to community/LOS
  - Hospitalization rates of potentially preventable readmissions

Using your data effectively: Score Cards
Outcomes: More than Re-hospitalization Rate

- The set expectations are re-hospitalization rates by diagnosis, quality measure based scorecards and a 24 hour a day intake.

The new areas to focus

- Percent of patients discharging home
  - Percentage home care referrals
- Average length of stay by diagnosis for all settings
- Therapy intensity (minutes/week) and cost
- Functional Changes
- Control group/peer benchmarking/national standards
- Cost/episode by diagnostic group
- Use of evidenced based guidelines and protocols

Case Studies

Florida Assisted Living Community

- 100 Bed AL in desirable market
- 5 New AL constructions within 3 miles of community
- Census Challenged (74% occupancy)
- Recommendations:
  - Developed Clinical Care Capabilities List
  - Completed Market Analysis of Acute Care Opportunities
  - Scheduled Meeting with hospitals
- Upstream partnerships with hospitals:
  - Leverage specialty program as a model for clinical excellence and efficiency
  - Provide assistance in clinical programming and care transitions to assist with decreasing hospital LOS and re-hospitalization penalties
- Downstream partnership with home health and community groups to excel in care transitions considering up to 90 day episode
Proven Success

South Carolina Assisted Living Community

- 120 Bed AL in desirable market
- Strong reputation in the community
- Consistently 100% occupied
- Recommendation:
  - Develop an Niche Program to market for outpatient services
- Must have “Brand Recognition” within the facility, community and among referral sources.
- Requires dedicated Resources
- Dedicated staff, training, technology
- Proven Clinical Competence/Excellent Outcomes
- Data and outcomes prove the program is success (clinical, QA and financial)

Proven Success

- Year over year increase
  - Rehab Patients: Baseline 0 patients
    - Year 1: 10 patients
    - Year 2: 27 patients
    - Year 3: 69 patients
  - Transitioned to full time residents
    - Year 1: 1 resident (10% transition)
    - Year 2: 5 residents (19% transition)
    - Year 3: 14 residents (20% transition)
- ALF noted a 6% increase in referrals from physician groups to community
Summary and Next Steps

- Understand the Opportunities
- Develop a Strategic Framework
- Develop and Expand Partnerships
- Track Outcomes to Measure Success
- Understand your Outcomes

Q&A...

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