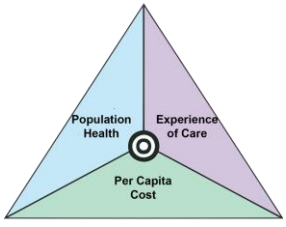
Penn Medicine
Lancaster General Health

Clinical and Business Strategies to Survive in an ACO world.

Leon Kraybill M.D., CMD, Division Chief Geriatrics Penn Medicine Lancaster General Health
Phyllis Wojtusik R.N. Director Post Acute Care Penn Medicine Lancaster General Health
September 28, 2016

1

The Search is on…..



IHI Triple Aim

2

U.S. Department of Health and Human Services (HHS) goals

- For the ***first time*** since the establishment of Medicare, HHS has set explicit goals for **alternative payment models (APMs)** and value-based payments.
- By **12/2016**, **30%** of traditional fee-for-service Medicare payments will be **tied to quality or value** through **APMs**, such as accountable care organizations or bundled payment arrangements.
- By **12/2018**, **50%** of payments will be **tied to APMs.**
- HHS has also set a goal of linking ***85%*** of all traditional Medicare payments to **quality or value by 2016**, and ***90%* by 2018**, through the Hospital Value-Based Purchasing Program and the Hospital Readmissions Reduction Program.

3

HVBP HRR HAC -- What does it all Mean?

The **Affordable Care Act (ACA)** established three new hospital pay-for-performance programs: **HVBP HRR HAC**

- **H**ospital **V**alue-**B**ased **P**urchasing (HVBP), pays hospitals for inpatient acute care services based on the ***quality of care***
- **H**ospital **R**eadmissions **R**eduction (HRR), reduces payments to hospitals with ***excess readmissions***
- **H**ospital-**A**cquired **C**onditions (HAC) Reduction program encourages hospitals to ***reduce HACs***, which are a group of reasonably preventable conditions (Falls, CLABSI, CLASSI, CDIFF) that patients can develop during a hospital stay.

4

MACRA MIPS APMs -- What does it all mean?

Medicare Access & CHIP Reauthorization (MACRA)

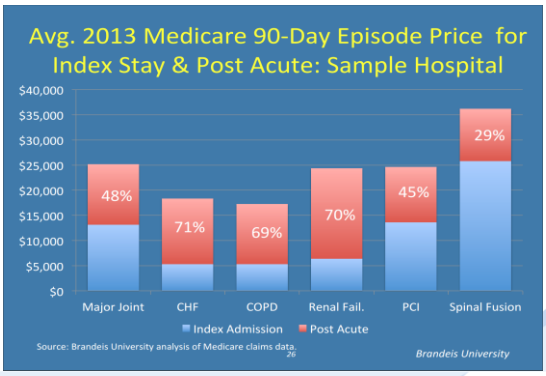
- **Repeals** the Sustainable Growth Rate (SGR) Formula
- Changes the way that **Medicare** rewards clinicians for **value** over **volume**
- **Streamlines** multiple quality programs under the new **Merit-Based Incentive Payments System (MIPS) –** specifically Physician/Provider payments
- Provides **bonus payments** for participation in eligible **alternative payment models (APMs) –ex. ACOs (Track II and III) and PCMH models**

5

If acute care focused, why should post acute providers care?

- ***How*** you get ***paid*** and ***who pays*** you is changing
  - By end of 2016, 30% of all Medicare FFS will be in an APM
  - By end of 2018, 50% of all Medicare FFS will be in an APM
- **Value focus** on **re-admissions and quality** will be tied to Medicare dollars no matter who is paying them
- Hospitals have been under cost reduction efforts for a long time…..There is still wide variability on the Post Acute side
  -- Acute care consolidation
- Better to be in a qualified APM for potential bonus opportunities
  -- Learning opportunities for PAC providers

6



7

Act of 2014 – The IMPACT ACT
Improving Medicare Post-Acute Care Transformation

- Submission of standardized data by Long-Term Care Hospitals (LTCHs), Skilled Nursing Facilities (SNFs), Home Health Agencies (HHAs) and Inpatient Rehabilitation Facilities (IRFs). Interoperability -common standards and definitions in order to provide access to longitudinal information for providers to facilitate coordinated care

Measure Domains to be standardized:

- Skin integrity;
- Functional status, cognitive function;
- Medication reconciliation;
- Incidence of major falls;
- Transfer of health information and care preferences when an individual transitions;
- Resource use measures, including total estimated Medicare spending per beneficiary;
- Discharge to community; and All-condition risk-adjusted potentially preventable hospital readmissions rates

8

How IMPACT works

IMPACT Act has five parts:

1. **Incorporate standardized assessment**, including components of the CARE tool, into existing assessment tools across PAC providers: This tool will measure quality based on a variety of metrics: pressure ulcers, functional status, cognitive status, and special services.
2. Development and **public reporting of quality measures across settings**, including hospitalizations, rehospitalizations, rehospitalizations after discharge from PAC provider, discharge to community, pressure ulcers, medication reconciliation, incidence of major falls, patient preferences, and average total Medicare cost per beneficiary.

9

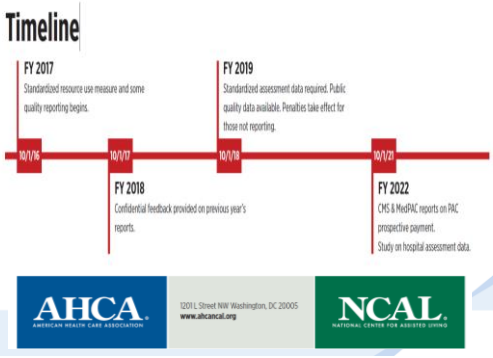
How IMPACT Works

3. Hospitals and PAC providers are required to **provide quality measures to consumers** when transitioning to a PAC provider. Conditions of participation are modified to incorporate Quality Measures (QMs) into the discharge planning process.
   * There is a market basket payment penalty of 2% for failure to effectively collect and report data.
4. Requires HHS and MedPAC to **conduct studies and reports to link payment to quality**. HHS and MedPAC must develop a plan to link Medicare
5. **PAC payment to quality of care**, review current risk adjustment methodologies, and study the effect of beneficiaries' socioeconomic status on quality, resource use, and other measures.

Adds $11M in funding for CMS to use payroll data to measure staffing in SNF setting.

10

IMPACT ACT



AHCA AMERICAN HEALTH CARE ASSOCIATION | 1201 L Street NW Washington, DC 20005 www.ahcancal.org | NCAL NATIONAL CENTER FOR ASSISTED LIVING

11

What does all this mean to Post Acute Providers?

Places we are all going

- Data Driven world
- Reproducible Quality over Volume
- One Episode of Care – acute and post acute tied together
- Patient Engagement / Satisfaction
- Least restrictive / Lowest cost environment

What should Skilled Providers Do?

- Develop a relationship with local ACO
- Ask for and understand ACO goals
- Be able to talk numbers
  - Quality ratings
  - LOS
  - Numbers of admissions by case-types
  - Re-admissions per 1000 resident days
  - Staffing ratio's
- Ask your local ACO what clinical needs they have on the Post Acute side and try to meet them
- Ask for EMR or HIE access
- Work on transitions between Acute and Post Acute

14

What should Personal Care Providers Do?

- Develop relationship with Hospital and or ACO
- Develop ability for ***short term*** personal care
- Have resources at your facility to handle higher acuity patients
  - Skilled Home Health
  - Hospice Services
  - Transportation services to outpatient therapies
  - RN/LPN in the facility at all times

15

How Should Post Acute Care Providers Prepare?

- Know your business – costs per case, LOS, case types, keep a close eye on these metrics
- Understand the fundamental changes that will happen
  - Therapy ***is not*** the LOS driver anymore
  - ***Transitions*** are ***key*** to outcomes – ensure robust discharge and follow-up process
  - ***Medicare days*** will go ***down***, however CMI will go up
- Prepare your staff
  - Improve skill sets, invest in education
  - Talk about Health Care Transformation

16

How Should Post Acute Care Providers Prepare?

- Align your care with the discharging facility – clinical pathways or clinical protocols
- ***Engage*** your ***Medical Director*** in ***quality*** improvement using national benchmarks
- Concentrate your short term "rehab like" cases
- Utilize your industry resources – reach out to facilities in more emerged markets
- Be ready to ***change***….frequently. ***Agility*** in this market is key

17

Seven Strategies to Flourish in the ACO World

- Care Management
- Transitions of Care
- Clinical Plans
- Discharge Planning
- Quality Metrics
- Patient Engagement
- Advanced Care Planning

18

Care Management

- Basis for other strategies
- ***Not just*** for utilization management any more
- Robust – utilize systematic electronic approach
- Invest in proven Case Managers
- Link to Acute Care Strategy and Payor Strategy
- Set targets for Length of Stay based off of national standards (Milliman, Intermountain) and local practice. Manage care to those targets.
- Link closely to RNAC
- Set Standards for Practice
  - What is their role? – Manage individual cases, link to home services, deal with variances, intervene with providers, prior authorization
  - Who do they report to? – DON, Social Work, VP of Health Care Services
  - How many do you need? Case Load for Skilled vs PC vs Community

Transitions of Care

- Link Closely with Acute Care: feedback is good for all of us
- Push ⇨ your EMR for **C**ontinuity of **C**are **D**ocuments CCD's
- Medication Reconciliation critical to success
- Staff for admissions on evenings
- Consider early patient onboarding process (48 hours)
  - Level set patient and family expectations
  - Agree to goals of care

Clinical Plans

- Predictable care in a repeatable manner
- Standardization leads to quality results
- Work with Acute Care to determine case type need
- Work with Medical director to determine medical progression
- Start discharge planning on day of admission
- Planned education for patient and family during stay
  - Pass Ports
- Concentrate case types so staff become excellent

Discharge Planning

- Start on Day of admission
- Home needs assessment – physical, environmental, emotional and financial
- Early identification of care giver at home
- Ensure PCP follow-up in 7 days post discharge
- Identify home health partner for follow up in 24-48 hours of discharge

Quality Metrics

- Track outcomes
  - LOS by case type
  - Costs- equipment/resource utilization – ADL levels A, B & C
  - Readmissions
  - Ed / Obs visits
  - Patient Satisfaction
  - Staff and provider satisfaction
- Short Term and Long Term SNF Quality Measures
- Ingrain metrics into your culture, share with staff on regular basis, track by unit – team approach
- ***QUALITY*** will be your differentiator

Patient Engagement

- Engaged staff –
  - Education – specialty certifications
  - Clinical ladders, clinical advancement
- 48 hour onboarding process
- Regular administrative check-ins
- Sell your outcomes
- Education – patients and families/significant others
- Satisfaction surveys - utilize a service
  - Identify areas of discontent
  - Develop/implement improvement plans

Advanced Care Planning

- Coordinated effort across your facility – Independent, Personal Care and Skilled
- Utilize a standard approach, Work with acute care in your area
  - Gunderson Model
  - 5 Wishes
  - Compassion and Support -End of Life Planning
- POLST on all Skilled patients
- Reduces hospitalizations and costs of care when we respect patients wishes

Your Vision

Moving Forward

- Not all changes are bad…. Opportunity to show the quality of care delivered at your facility
- Coordination of care and transitions are the guardrails of the road
- Use your relationship with your ACO as the roadmap to developing clinical programming and improving outcomes

and remember ….

If you are not moving forward you will be left behind

QUESTIONS ?