Remodeling Healthcare for Better Patient Programming through Care Redesign

2016 NICHE CONFERENCE

Arnie Cisneros President HHSM

- 30+ year Post-Acute Provider (Hosp, SNF, HH)
- 30+ year Home Health rehab clinician
- Home Health Strategic Management (2004)
- Hospital-2-Home Strategic Management (2014)
- Pioneer ACO (x3) – Post – Acute Strategist
- Model 2 BPCI Award – DMC – DRG 469/470
- JUMP = Joint Utilization Management Program

How do we improve on the care delivery model we’ve had for more than a quarter century?

Where do we currently use methods that cost more than required to provide care?

How do we eliminate waste, improve communication, focus on outcomes and prevention?
Can we reinvent acute episodes to be more seamless and efficient given the progress of society as a whole?

How do we eliminate waste, improve communication, focus on outcomes and prevention?

How can we change care focus from a volume-based platform to a value-centric model?

PATIENT PROTECTION & AFFORDABLE CARE ACT

Patient Protection and Affordable Care Act

The most significant regulatory overhaul of US healthcare since Medicare was introduced in 1965. Under the Affordable Care Act, Hospitals and MDs transform care practices financially, technologically, and clinically for better outcomes, lower costs, and improved distribution and accessibility through a wellness-based focus.
Patient Protection and Affordable Care Act

- Redesign elements of the Affordable Care Act
- Universal Coverage
- Healthcare Funding
- Care Redesign
- Alternative Payment Models
- Episodic Bundling
- Cost Savings across Healthcare

ACCOUNTABLE CARE ORGANIZATIONS

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

- Coordinated Healthcare Providers
- Care Coverage for a group of Patients
- May use a range of payment models
- Capitation, Fee-for-Service, Savings-based model
- ACO becomes PAYER and PROVIDER
- Clinical focus is on Quality and Efficiency
- ACO Care Model – proposed/refined over decades

Making Sense of CMS Alternative Payment Models
(Volume to Value)

Alternative Payment Models (APM)

Alternative Payment Models (APM) are the basis of the ACA – mandated shift from the fee-for-service programming of the PPS era. By tying programs and payment to quality and value, ACA goals are achieved and the shift from volume to value begins, and will mature and refine over time. CMS APM projection – 90% by 2018.
Alternative Payment Models (APM)
Alternative Payment Models represent a new set of incentives that build on the progress of healthcare over recent years. They are slated to improve the efficiency and personalization of care programming by emphasizing care coordination and outcomes by controlling costs. Early returns from APM trials or pilot programs demo improved quality/cost results.

Examples of Alternative Payment Models
- Gain-sharing Clinical Program model
- Shared – Savings Program model
- Value – Based Purchasing (VBP)
- Episodic Bundling – Acute care programs
- CCJR – Total Joint Replacement 90-day Bundling
- Population Health - Chronic Care Coverage
- Accountable Care Communities OR Medical Homes

ACO Episodic Acute Care Delivery via Bundling
Episodic Care Delivery

The re-engineering of the acute episode derived from \textit{acuity-based expectations} of patient care requirements, devoid of Provider preference, and driven by the \textit{least restrictive/costly} care environment.

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CARE TRANSITIONS MANAGEMENT

Care Transitions Management

Care Transition refers to the movement patients make between health care settings \textit{as their condition and care needs change} during the course of a chronic or acute illness; each shift from care providers and settings is defined as a care transition.
The Effect Of Silo Behaviors On The Care Continuum

The Silo Effect

The Silo effect refers to the lack of communication and support often found in acute care episodes. Provider types focus primarily on their own goals, often ignoring the needs of others.

Sub-Acute (SNF) Silo Effect Concerns

- 3-day Hospital Stay required for Certification
- Elevated Re-Infection and Re-admission Rates
- Inpatient Costs exceed In-Home Service Delivery
- Legacy of Volume Based Care - 21 day standard
- RUG tradition maximizes billing/costs – H, VH, UH
- Clinical Content/Approach – not prepared for APM
- Care programs must be sub-divided for acuity
Home Health Silo Effect Concerns
- Intake Accuracy/Integrity
- Inadequate SOC Response times – 24 hours?
- SOC/OASIS Accuracy – Incomplete Programming
- 60 Day Certification (versus Post-Acute)
- Efficiency/Productivity/Lacks In-Episode Control
- Lack of Safety-Based Frequencies?
- Disconnected Rehab Services
- In – Episode Clinical Conferences for skill/value

Lessons of a BPCI Episodic Bundling Pilot

J.U.M.P.
Joint Utilization Management Program
Detroit Medical Center/HHSM
J.U.M.P. - Joint Utilization Management Program
- The Centers for Medicare and Medicaid Innovation’s (CMMI) Bundled Payment for Care Improvement (BPCI) initiative
- Detroit Medical Center (DMC) was awarded BPCI Model 2
  - MS DRG 468/470 – Lower Extremity Joint Replacements
  - includes acute and post-acute claims
- Three-year project that will involve pre-operative care transition planning; ends December 2016
- Straight Medicare cases (no Medicare Advantage included)
- ACA CMS MANDATE - All acute care DCs Bundled 1/1/18
- Effect on Care expected to mimic DRG Evolution
- Basis of CMS Comprehensive Care for Joint Replacements (CCJR)

Vetting Post – Acute Vendors to Create a PAC Vendor Network

JUMP Post – Acute Vendor – Analysis/Chronology
- Quality Ratings, Meds, Falls, Re-admits, Stats,
- On – site Inspection and Analysis
- Orientation re ACA, Episodic Bundling, Develop Protocol
- On – Site PAC Vendor Clinical Staff Orientation
- Establishment of Contractual ACA agreement
- Establishment/Orientation of Connecting Software
- PAC Ongoing Education, Webinars, Onsite In-services
- Therex Demo, Quality Metric Clinical Management
- Dismissal or Addition of Post – Acute Vendors
Services and Costs included in an Episodic Bundle

Episodic Bundle Services and Costs
• Inpatient Hospital & MD Services
• LTCH, IRF, SNF, Home Health
• Outpatient Part B Services
• Laboratory, DME Costs, X-Ray, ER charges
• Part B Drugs
• Hospice Care
• Inpatient Psych Services

Reducing Post-Acute Utilization through use of Clinical Indicators
Skilled Nursing Facility (SNF) Bundle Utilization

Using Clinical Indicators to Reduce Post-Acute Utilization

<table>
<thead>
<tr>
<th></th>
<th>Prior to BUNDLE Program</th>
<th>Initial BUNDLE Program</th>
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<tbody>
<tr>
<td>LOS</td>
<td>Average 21 days</td>
<td>Average 11 days</td>
</tr>
<tr>
<td>Average Therapy Utilization</td>
<td>900 mins/week</td>
<td>325 mins/week</td>
</tr>
<tr>
<td>Cost/episode</td>
<td>$15,000 - $14,000</td>
<td>$4,000</td>
</tr>
<tr>
<td>RUGs</td>
<td>Very High/Ultra High</td>
<td>High</td>
</tr>
<tr>
<td>DC Focus</td>
<td>Patient managed at Day 20</td>
<td>Reduces LOS/Cost</td>
</tr>
<tr>
<td>DC Focus</td>
<td>able to safely DC to HH</td>
<td></td>
</tr>
</tbody>
</table>

Home Health (HH) Bundle Utilization

Using Clinical Indicators to Reduce Post-Acute Utilization

<table>
<thead>
<tr>
<th></th>
<th>Prior to JUMP Program</th>
<th>Initial JUMP Program</th>
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</thead>
<tbody>
<tr>
<td>Standard total joint protocol</td>
<td>average 11-15 therapy visits</td>
<td>Acuity based on total joint protocol</td>
</tr>
<tr>
<td>Average HRRG Total</td>
<td>$3,300 episode</td>
<td>Average HRRG Total</td>
</tr>
<tr>
<td></td>
<td>$1,950 episode</td>
<td></td>
</tr>
<tr>
<td>DC Focus</td>
<td>Ortho revisit protocol</td>
<td>Reduction in Cost</td>
</tr>
<tr>
<td>DC Focus</td>
<td>able to safely DC to OPT</td>
<td></td>
</tr>
</tbody>
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What is the most appropriate level of Care for a patient upon acute discharge?
Post-Acute Placement – Clinical/Support Parameters
• Pre-Surg Disposition and Functional Performance
• Living situation, caregivers in-home or nearby
• Post-Surg Disposition, Function, Orientation
• Level of Skilled services required at discharge
• DC Concerns – IV antibiotics, Wound, CGVR
• Home Layout, Equipment, Co-morbidities, OPT
• Promote Cost/Risk/Opportunity of PAC sites
• DC analysis Work from bottom up – HH,SNF,IRF
• Safety is bottom line for post-DC placement

Post-Acute Placement – Care Site Specifics
• HH – Ind Safety ? – CGVR available? – DME?
• Avoid Reinfection/Readmission risk – Value ID
• Assertive HH management works – LUPA?
• 24 hr admit – Daily Rounds – Compliance/MV?
• SNF – Unsafe patient w no CGVR available
• Wound issues, IV antibiotic, Clinical Deficit Issues
• Manage RUG volume/DC Plan - for CCJR value
• IRF – Significant/Functional Co-morbidities
• Lack of post-surg Safety, Strength, Mobility

Population Health
(Chronic Care)
Physician Extender
- Support for ongoing patient management outside the physician office.
- Focus on care coordination and advocacy

Wellness Program
- Total Population Management

Closing Summary for ACA Success
Closing Summary for ACA Success

• Embrace the Affordable Care Act for Success
• Seek efficiencies in standard care procedure
• Seek areas for collaboration, communication
• Eliminate wasteful practices
• Understand wellness vs. deficits
• Create Volume to Value dynamic in workplace
• Outcomes – FASTER MAY BE BETTER!!!
• Create IT pathways to support care redesign
• Lead your Staff – your Patients – your Care

Get started Today on this exciting Care Model that streamlines care through Home Health value opportunities

CAN YOU MANAGE TO IMPROVE YOUR CARE?