Disclosure of Commercial Interests

Irving Stackpole is the President of Stackpole & Associates, which consults for a wide array of healthcare providers, corporations, agencies, associations and governmental organizations.

John Sheridan is an employee of ABILITY Network, and has no commercial interests to disclose.

Post-Acute Care

Good-bye Volume; Hello Value

presented by
Irving L. Stackpole
John Sheridan

Volume to Value

- Volume - Fee for Service
- Value

$$\text{Value} = \frac{\text{Quality}^{*}}{\text{Payment}^{\dagger}}$$

* A composite of patient outcomes, safety, and experiences
† The cost to all purchasers of purchasing care

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The Challenges

- *Volume – Value Shift will survive*
- *Changing demands*
  - *Consumers*
  - *Intermediaries*
- *Poor occupancy*
- *Declining payments*
  - *What should be done?*

Short Cut – New Rules

- *Defend, protect & fortify*
- *Increase Productivity / Efficiency*
- *Innovate*
- *Differentiate*
- ***Engage v. Bunker***
- ***COLLABORATION***

"Take your partner by the hand…"

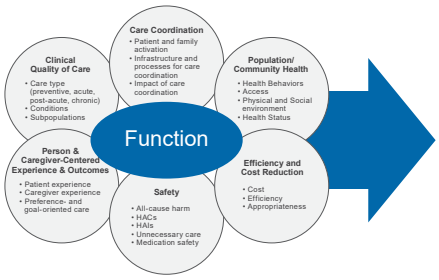
- ***Steps to the dance…***
- *Leadership*
- *Trust*
- *Shared experiences*
- *Early wins*
- *Inclusive*
- *Data, data, data*

What we measure depends on what we do and why

Operating a space shuttle

Scoring a baseball game

CMS Framework for Measurement



IMPACT Act – not PPACA adds Measure Domains

A. Functional status, cognitive function and changes in function and cognitive function
B. Skin integrity and changes in skin integrity
C. Medication reconciliation
D. Incidence of major falls
E. Transfer of health information and care preferences when an individual transitions
F. Resource use measures including estimated Medicare spending per beneficiary
G. Discharge to community
H. All condition risk-adjusted potentially preventable hospital readmission rates

IMPACT Act: Key Dates for SNFs

- ✓ 10/1/16: SNF providers begin reporting quality measure data specified by the Secretary (domains A,B,D,F,G,H)
- ✓ 10/1/17:
  - Begin 2% reduction for SNF failure to report quality and resource use measure data
  - Confidential feedback reports to SNF providers (A,B,D,F,G,H)
- ✓ 7/1/18: Preview reports – SNF provider opportunity to review (A,B,D,F,G,H)

IMPACT Act: Key Dates for SNFs

- ✓ 10/1/18:
  - SNF providers begin reporting quality measure data specified by the Secretary (domains C,E)
  - Public reporting of provider-previewed individual performance (A,B,D,F,G,H)
  - Assessment domains standardized
- ✓ 10/1/19: Confidential feedback reports to SNF providers (A,B,C,D,E,F,G,H)

And we face The New SNF Requirements for Participation

- Person-Centered Care
- Facility-Based Responsibility
  - Assessment/Staffing, Competency-Based Approach
    - Assess Your Center, Your Patients, Your Staff and Know your Care!
- Quality of Care & Quality of life
  - New/changed evidence-based practice
  - Care Planning
    - Patient goals
    - Patient as the center of control
- Changing Patient Population
  - Higher Acuity
  - New Behavioral Health Management challenges!
- "New Rule" responsive to culture and technology of now

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Requirements Align with HHS Triple Aim Priorities

Advancing cross-continuum priorities:

- Reducing unnecessary hospitalizations & the incidences of healthcare acquired infections and costly adverse events
- Improving behavioral healthcare
- Safeguarding nursing home residents from the use of unnecessary psychotropic (antipsychotic) medications
- Care Planning to influence upstream versus downstream care
- Quality Assurance & Performance Improvement (QAPI)
- Health Information Technology/IT Interoperability

Why is Post Acute Care getting all the attention? It is all about variation

- July 2013 Institute of Medicine study, Variation in Health Care Spending, Target Decision Making, Not Geography
  - ✓ concluded - post-hospital services are the primary reason Medicare spends much more in some parts of the nation than elsewhere.
  - ✓ Uneven spending on post-acute care around the country accounts for 73 percent of the variation in Medicare spending.
  - ✓ 73% of the variation is explained by where the post-acute care is delivered and not by who delivers the care

Produce and prove value

"Knowing is not enough; we must apply.
Willing is not enough; we must do."
—Goethe

- "Post-acute care" includes home health care, skilled nursing care, hospice care, rehabilitation, and long-term care hospitals.
  - "there is little systematic coordination of a patient's care among multiple providers and settings" (MedPAC, 2012a, p. 36).
- "Chronic diseases and comorbid conditions are increasing, **exacerbating the clinical, logistical, decision-making, and economic challenges** faced by patients and clinicians" (IOM, 2012, p. S5).

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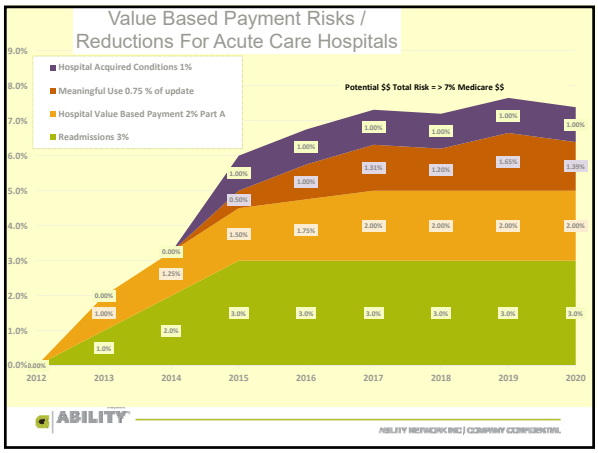

Hospital MSPB = Dollars for Value Measure

Three time periods for each claim type
- 3 days prior to index admission
- hospital index admission
- 30 days post discharge

Seven claim types
1. home health agency
2. hospice
3. inpatient
4. outpatient
5. skilled nursing facility
6. durable medical equipment
7. carrier – includes all Part B (physicians, etc..)

MSPB-PAC

- Between 2001 and 2013, Medicare PAC spending **grew at an annual rate of 6.1 percent** and doubled to $59.4 billion
- Payments to inpatient hospitals **grew at an annual rate of 1.7 percent** over this same period
- Study commissioned by the Institute of Medicine finds that **variation in PAC spending explains 73 percent of variation** in total Medicare spending
  - ► This is why policymakers want to compare care across settings

What Counts in MSPB-PAC

All of the following services during the treatment period are counted toward the episode:

1. The attributed PAC provider's claims
2. Physician/supplier Part B claims
3. Durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) claims during the treatment period

Note: Physician/supplier Part B and DMEPOS services are subject to certain clinically-determined exclusions where they are deemed to be outside the reasonable control of the attributed PAC provider.

PSPB-PAC Episode Definition

- Period a patient is under a PAC provider's care = **Treatment Period Services**
- Period after PAC provider's treatment which may be reflective of and influenced by the services rendered by the PAC facility = **Associated Period Services**
- The episode window is opened by a trigger event = **day of admission** to the respective facility or for HHA episodes this is the first day of a home health claim.
- The **treatment period ends at discharge** for SNF, LTCH, IRF, and for HHA end of episode or treatment at 60 Days post discharge
- Exclusions of claims for services that are clinically unrelated to PAC treatment
- In all settings, the associated services period ends 30 days after the last day of the episode's treatment period.

Beneficiaries Affected

In 2013:

- 1.7 million Medicare beneficiaries received SNF services
- 3.5 million beneficiaries received HHA services
- 122,000 beneficiaries received LTCH services
- 338,000 beneficiaries received IRF services

- And growing

Associated Period Services

Non-treatment services that occur within the associated services period for a given episode:

- All Medicare Part A and Part B services during the associated services period are counted toward the episode, with the exception of certain services, as described Section 3.1.5
- Trigger date (first admission) to discharge date = Treatment
- Next 30 days = Associated services period
- Period after PAC provider's treatment which may be reflective of and influenced by the services rendered by the PAC facility = **Associated Period Services**
- In all settings, the associated services period ends 30 days after the last day of the episode's treatment period.
- **30 + 30 = 60 days!**

MSPB –PAC SNF Payment FY-18

Measures Mapped to IMPACT Act Domains for SNF QRP-Proposed Measures (FY 2017 SNF PPS Published NPRM)

Domain	NQF ID	Measure Title	Reporting and Payment Timelines	Confidential Feedback Reports & Public Reporting
Resource Use and other Measures	Not Submitted for Endorsement	• Total Estimated Medicare Spending Per Beneficiary (MSPB)-PAC SNF QRP • Discharge to Community-PAC SNF QRP • Potentially Preventable 30-Day Post-Discharge Readmission Measure for SNF QRP	Claims-based data will be used for payment adjustments for fiscal year (FY) 2018 payment adjustment and subsequent years	One year of claims-based data will be used to inform confidential feedback reports beginning with CY 2016 and public reporting beginning with CY 201
Medication Reconciliation	Not Submitted for Endorsement	Drug Regimen Review Conducted with Follow-Up for Identified Issues-Post Acute Care SNF QRP	Initial Reporting October–December 2018 for fiscal year (FY) 2020 payment adjustment followed by CY reporting for that of subsequent FYs	Performance data will inform confidential feedback reports one year after the specified application date of assessment based measures. Public reporting must begin NLT two years after the specified application date of such measures

What can providers do to increase value? – create clinically integrated care paths!

- Clinical integration denotes a minimum level of coordination and alignment of goals among providers (physicians, hospitals, and other practitioners) caring for a population (Burns and Muller, 2008).
- To improve value, clinically integrated environments,
  - providers share clinical data,
  - agree on plans of care, and
  - collaborate to achieve favorable patient-centered outcomes
- Foster care coordination among individual providers of care, as well as share data and track service use and outcomes to measure progress
- Greater value clearly requires greater coordination among providers.

Focus for Clinical Integration

- Focus on a variety of activities, such as quality improvement,
- Care coordination and discharge processes, protocols for SNF, home health and other PAC referrals,
- Favoring efficient providers for referrals,
- Targeting high-risk individuals for disease management programs.
- COLLABORATION

Provider and Payer Interaction to improve Clinical Integration

"clinical services vary in the value they provide to patients, and that not all patients with a specific clinical condition receive the same level of benefit from a specific intervention" (Fendrick and Chernew, 2006, p. SP10).

FIGURE 4-1 Organization and payment methods.
NOTE: "Global case" is equivalent to bundled payment (discussed in the text). P4P = pay for performance.
SOURCE: Adapted from The Commonwealth Fund, 2008.

What detracts from value?

- Fragmentation
  - No overarching system as a guide, health care services are delivered across an increasing array of distinct and often competing providers and entities, each with different objectives, obligations, and capabilities (Cebul et al., 2008).
  - Providers practicing within the same geographic area, sometimes caring for the same patients, often work independently from and not communicating with one another (Bodenheimer, 2008; Shih et al., 2008).
  - As a fragmented health care delivery system we are not equipped to manage the continuum of health care for an aging population with complex needs.

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MSPB becomes VBP

SNFs will be ranked and compared in a similar way

Value of Care: National Distribution of Hospital Results on the Mortality (Death) and Payment Measures for Pneumonia Patients

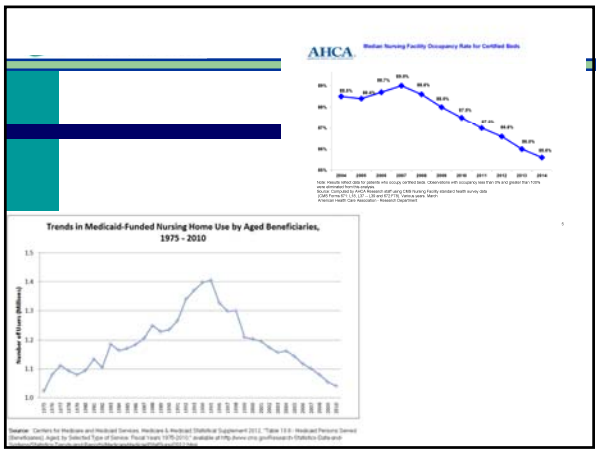
Worse mortality & lower payment 35 hospitals	Worse mortality & average payment 185 hospitals	Worse mortality & higher payment 47 hospitals
Average mortality & lower payment 588 hospitals	Average mortality & average payment 2651 hospitals SIBLEY MEMORIAL HOSPITAL	Average mortality & higher payment 424 hospitals
Better mortality & lower payment 50 hospitals	Better mortality & average payment 132 hospitals	Better mortality & higher payment 70 hospitals

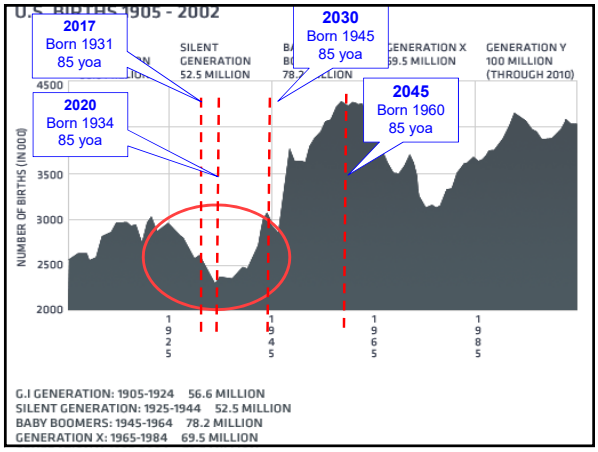
Drive Value

– How can we respond?

Short Cut – New Rules

- *Defend, protect & fortify*
- *Increase Productivity / Efficiency*
- *Innovate*
- *Differentiate*
- ***Engage v. Bunker***
- ***COLLABORATION***





Where do we start

- *How can disparate actors move effectively from vision to the implementation of cross-continuum collaboration?*
- *When no one actor has all the answers or the authority, the usual committee of working group isn't adequate to the task.*

"Take your partner by the hand…"

- ***Steps to the dance…***
- *Leadership*
- *Trust*
- *Shared experiences*
- *Early wins*
- *Inclusive*
- *Data, data, data*
- *Focus on end-users*

Leadership

- *Leadership*
  - *Visibility*
  - *Support*
  - *Focus &*
  - *Endurance*
  - *Leadership – measures*

Trust

- *One-on-One*
  - *Reliable*
  - *Transparent*
  - *Personal*

Shared Experiences

- *Integration between / among*
  - *"Walk a mile in my shoes…"*
  - *Work-a-Day / Work-a-Week*
  - *Functional v. management*
    - *–Trust, personal*
    - *–Early "wins", durable*

Realities

- *Occupancies are poor*
  - *The age qualified markets are declining*
  - *Increased options / choices*
  - *Negative perception*
  - *The economy*
  - *The role of "Intermediaries"*
- *The need for change is URGENT*
- *"Soft" skills are needed*

The Need to Respond - UR

- *Defend, protect & fortify*
  - *–Manage to Loyalty*
- *Increase Productivity / Efficiency*
- *Innovate*
- *Differentiate*
- *Collaborate*

Efficiency

Technical, Productive, Allocative

- Technical
  - Maximum improvement from resources
- Productive
  - Best health outcome for given costs or reduction in cost for the same outcome
- Allocative
  - Best outcomes for society

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Facts of Life

- *The age qualified market is shrinking*
- *Continued pressure on payments*
- *Continued pressure on utilization*
- ***Efficiencies & productivity are the keys to effective differentiation***
- ***Collaboration is the "new frontier"***

Conclusions

- *Defend, protect & fortify*
  - *Manage to Loyalty*
- *Increase efficiency*
- *Innovate*
- *Differentiate*
- *Collabroate*

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