

Health Care Reform Marches Onward: Keeping Your Agency in Step

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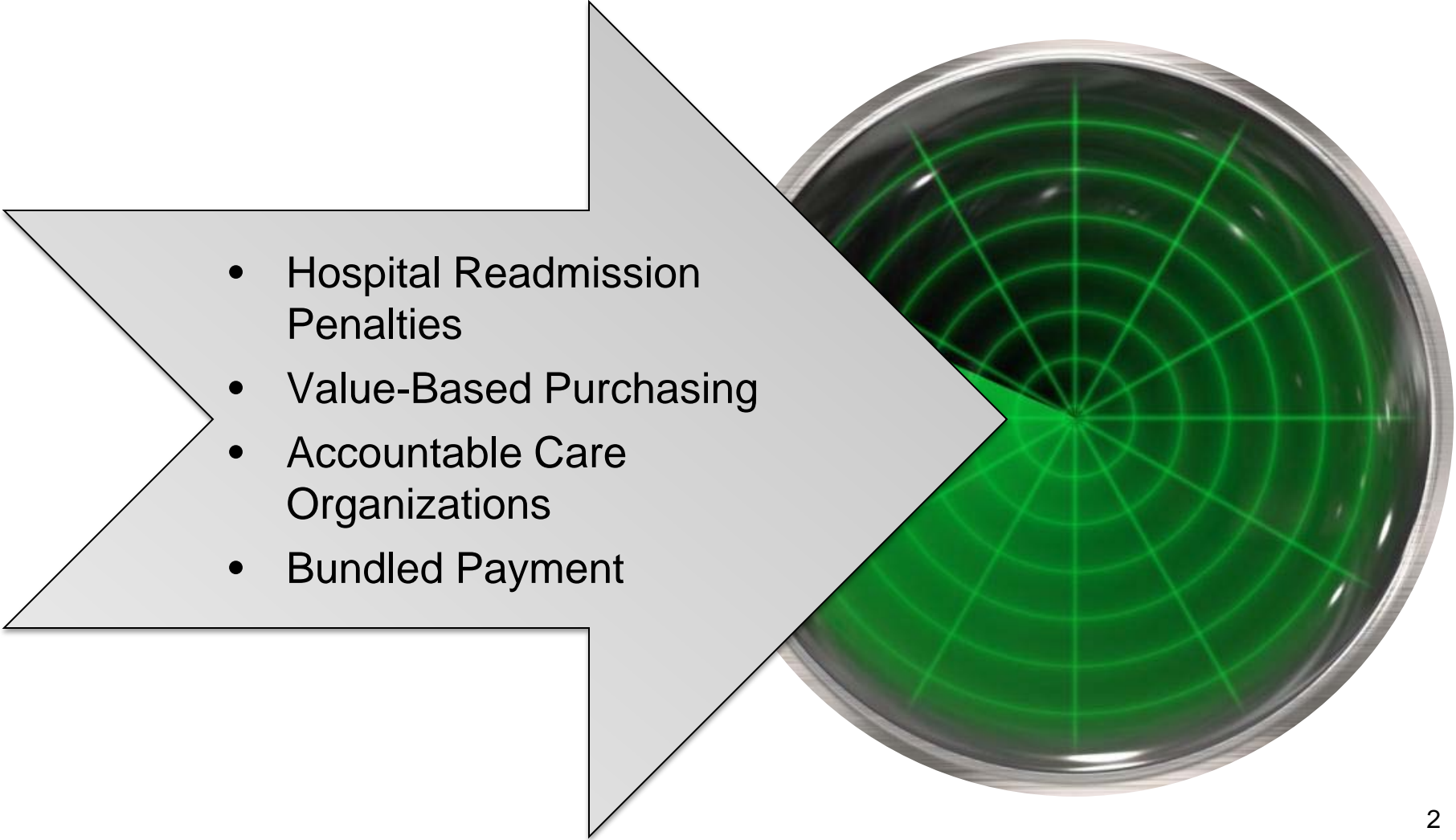


Topics for Presentation and Discussion

- Reforming Health Care Through Payment Reform (ACA) or Bending the Medicare Cost Curve
 - Hospital Readmission Penalties
 - Value-Based Purchasing
 - Accountable Care Organizations (ACOs)
 - Bundled Payment
- Home Health and Hospice: Providing Solutions
 - Care Transitions Program
 - Home Monitoring
 - Partnerships: ACOs, Hospitals, Post-Acute Providers



What Is On Our Health Care Reform Radar?

- 
- Hospital Readmission Penalties
 - Value-Based Purchasing
 - Accountable Care Organizations
 - Bundled Payment

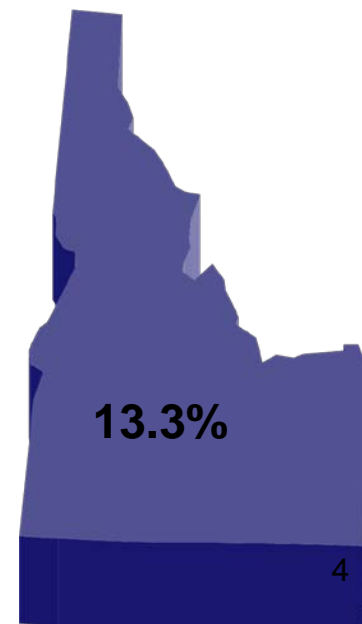
- Hospital Readmission Penalties



Hospital Readmissions: What's The Problem?

- **Percentage of Medicare beneficiaries readmitted within...**
 - 30 days of initial discharge = 19.6%
 - 90 days = 34%
 - 12 months = 56.1% ¹
- **Unplanned readmissions cost Medicare = \$17.4B (2004) ¹**
- **Average Medicare payment for potentially preventable readmission = \$7,200 (2005) ²**
 - Only \$1,400 less than payment for original stay
- **Lowest readmission rate in the U.S. = Idaho, 13.3% ¹**

Sources: 1. "Rehospitalizations among Patients in the Medicare Fee-for-Service Program," *New England Journal of Medicine*, April 2, 2009, 360:14; 2. MedPAC 2007 Report to Congress



Top Five Conditions Requiring Readmissions

- **Medical Conditions:**
 - Heart failure
 - Pneumonia
 - COPD
 - Psychoses
 - Gastrointestinal problems
- **Surgical Conditions:**
 - Cardiac stent placement
 - Major hip or knee surgery
 - Vascular surgery
 - Major bowel surgery
 - Other hip or femur surgery

Source: "Rehospitalizations among Patients in the Medicare Fee-for-Service Program," *New England Journal of Medicine*, April 2, 2009, 360:14

Health Reform: Reducing Hospital Readmissions – October 1, 2012

- CMS will rank hospitals based on 30-day readmission rate for **heart attack, heart failure, and pneumonia**
 - May not be limited to preventable, avoidable readmissions
 - Applies even if readmitted to another hospital
- In 2015, the program will expand to include **COPD, CABG, PTCA, and other vascular conditions** for total of seven conditions
 - Secretary authorized to expand policy to additional conditions beyond these seven
- Requires Secretary to publish patient hospital readmission rates for certain conditions
- Does not apply to critical access hospitals

Penalty for Excess Hospital Readmissions

- Poor performing hospitals will have all Medicare payments reduced by an amount equal to value of payments for excess readmission
 - Those in bottom quartile (nationally) from prior year have percentage of **total** Medicare payments withheld
 - All 30-day readmissions counted except two:
 - AMI with planned readmission for stent or CAB
 - Even if to another hospital
- Hospitals can lose up to 3% of all Medicare payments in 2015

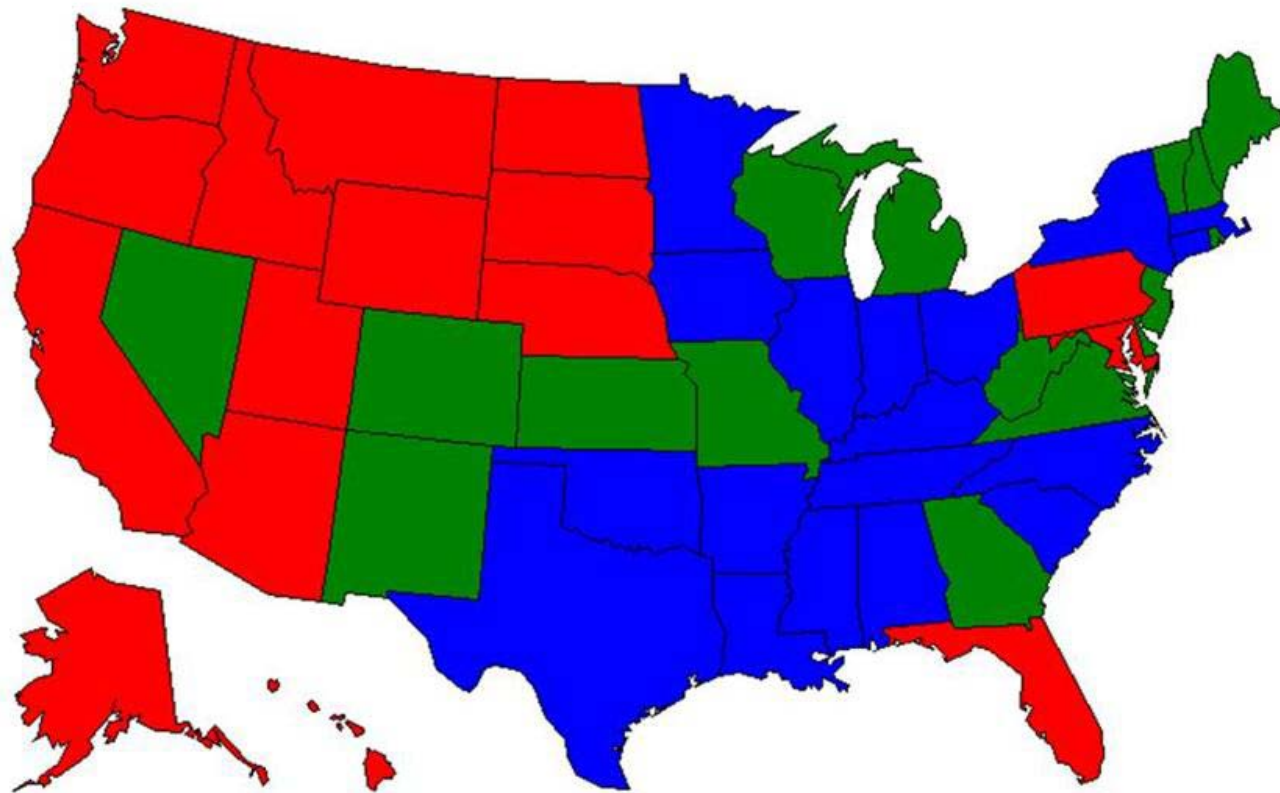


Why Post-Acute Is Key to Managing 30-Day Readmissions

PAC Setting	Percent Discharged from Hospital to PAC Setting	Percent Rehospitalized After Using PAC Setting	Percent Died in PAC Setting	Percent Discharged to a Second PAC Setting	Most Common Second PAC Setting Used
SNF	17.3%	22.0%	5.4%	29.3%	Home health
Home Health	15.0	18.1	0.8	2.3	Hospice
Inpatient Rehabilitation	3.2	9.4	0.4	56.8	Home health
Hospice	2.1	4.5	82.2	2.4	Home health
Long-term Care Hospital	1.0	10.0	15.5	53.4	SNF
Inpatient Psychiatric	0.5	8.7	0.4	25.4	SNF
TOTAL	40.0%	18.0%	6.2%	19.8%	

Home Health Readmissions by State

Percent of Admits for Home Health Patients by State



hhgro ■ 26.8% or less ■ 26.9%-30.9% ■ 31.0% or more

- Value-Based Purchasing



Value-Based Performance Payment

Value-Based Performance Payment is a generic term for payments that:
“improve beneficiary health outcomes and experience of care by using payment incentives and transparency to encourage higher quality, more efficient professional services.”

Key objectives:

1. Encourage use of evidence-based medicine
2. Reduce fragmentation, duplication, and inappropriate use of services
3. Encourage effective management of chronic disease
4. Accelerate the adoption of health information exchange
5. Empower and engage consumers

Key assumptions:

1. Performance-based payments will drive change
2. Different practice arrangements will be accommodated
3. Multidisciplinary team members will be recognized
4. Accountability will be across multiple levels and sites of services

Source: Development of a Plan to Transition to a Medicare Value-Based Purchasing Program for Physicians and Other Professionals, Issue Paper, Public Listening Session, December 9, 2008; CMS



Value-Based Purchasing Programs

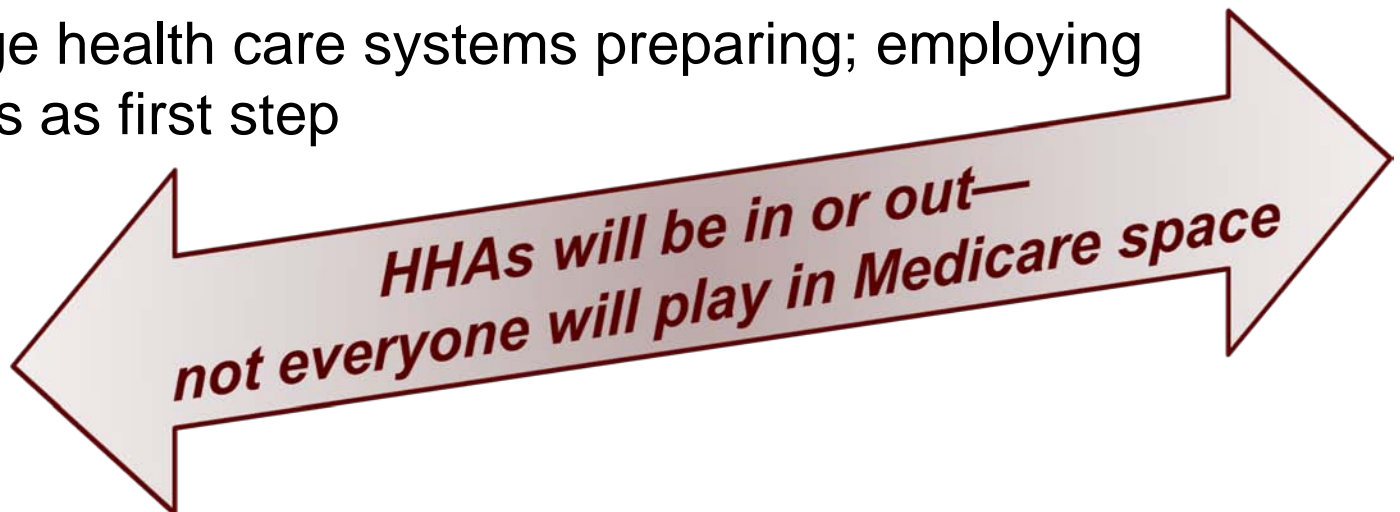
- **For hospitals (FY2012)**
 - Ties percentage of hospital payment to performance on quality measures for common, high-cost conditions but ***does not include a readmissions measure***
 - Includes critical access or low-volume hospitals
 - Funded by 1% decrease in Medicare payments beginning FY2013, rising to 2% in FY2017
- **For SNFs and home health:** HHS Secretary must submit a plan to Congress by FY2012 for transitioning skilled nursing facilities and home health agencies to a value-based payment (VBP) system
- **For hospice:** HHS Secretary authorized to establish a pilot program to test VBP for hospice providers, no later than January 1, 2016
- **For physicians:** By 2015, CMS will phase in over two years, a budget-neutral payment system that adjusts Medicare payments based on the quality and cost of care they deliver

- Accountable
Care
Organizations

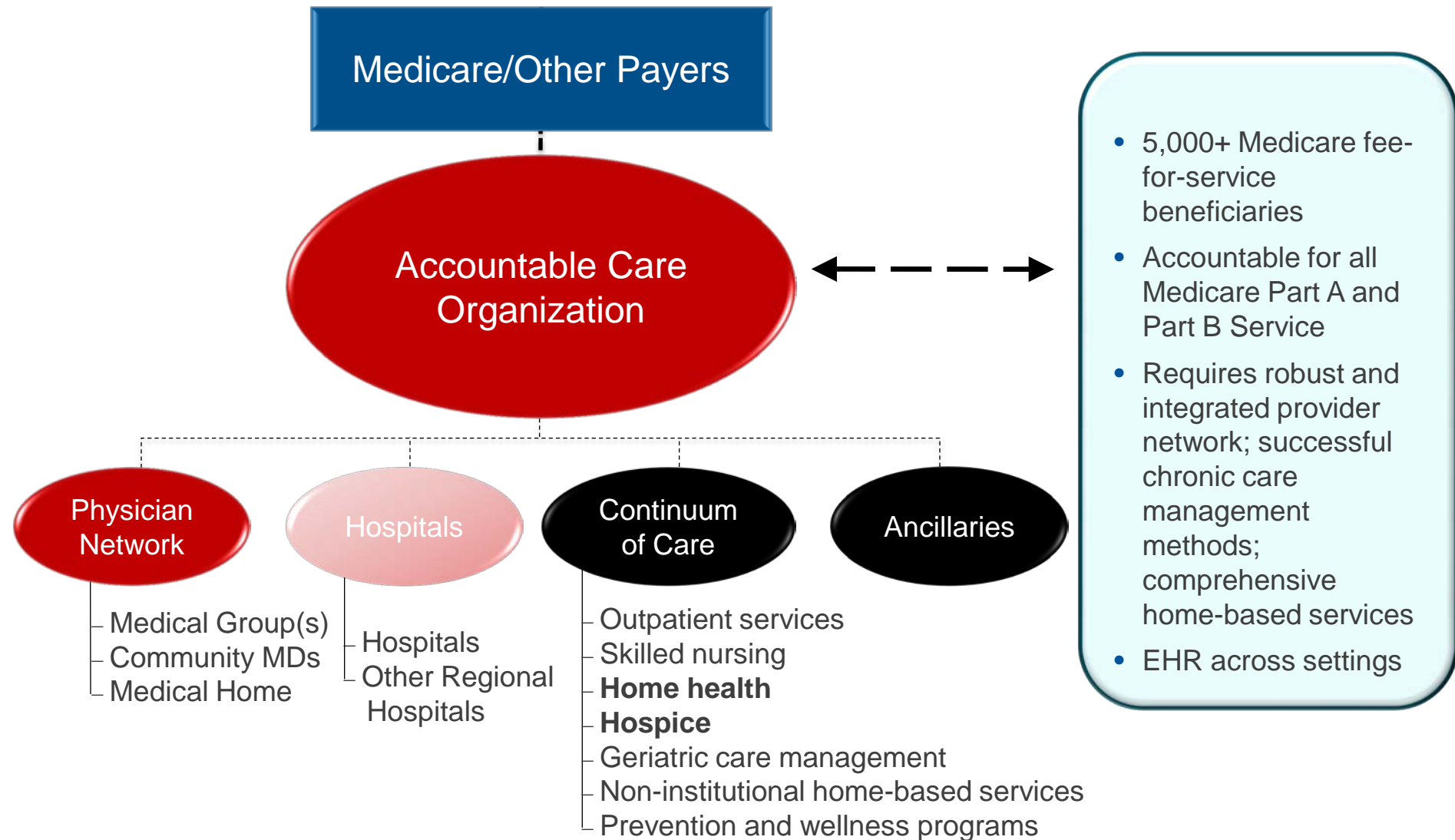


Accountable Care Organizations (ACOs)

- New shared savings program on January 1, 2012
- Integration of physicians, hospitals, post-acute providers, outpatient, and ancillaries
- Responsible for **all Part A and Part B care**; more than 5,000 Medicare beneficiaries; three-year contracts with CMS
- *Objective*: reduce overall Medicare costs
- *Incentive*: ACOs share in cost savings versus “normal” market-based payment for Medicare beneficiaries
- Many large health care systems preparing; employing physicians as first step



Accountable Care Organizations Model



How Will Post-Acute Be Paid by ACOs?

- Bundled payment example:



Average Medicare acute and post-acute episode cost = $> \$30,000$

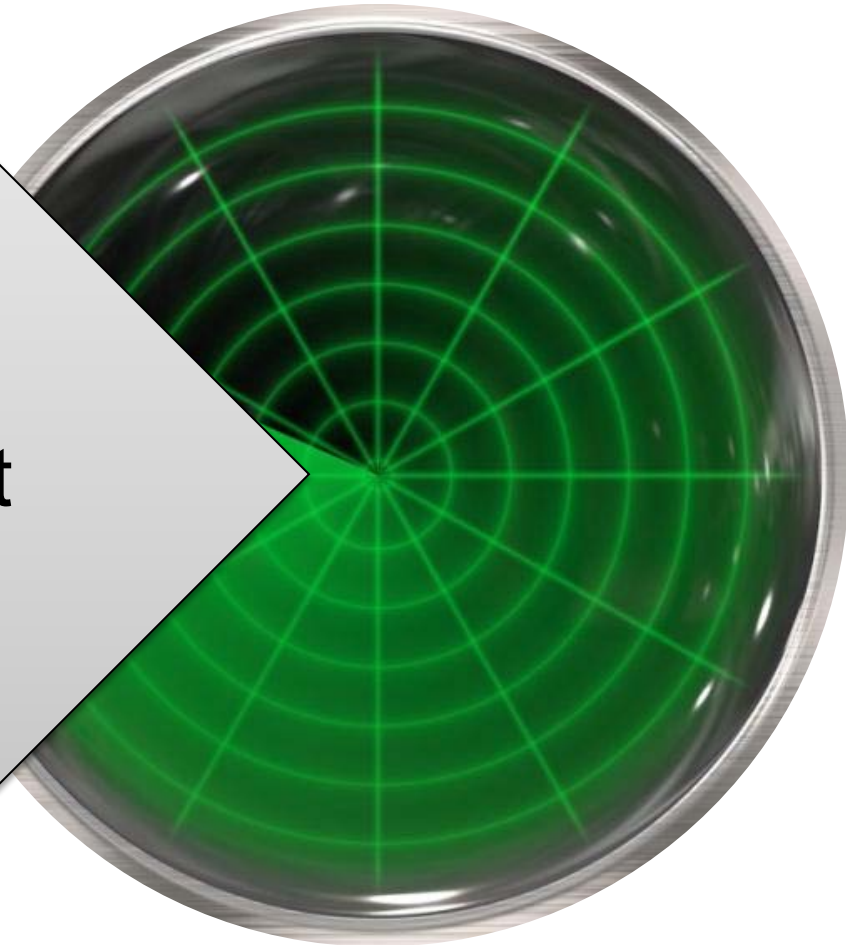


SNF-HHA combination cost = $\$12,000 - \$15,000$



- Capitation PMPY: \$ to manage post-acute and long-term care (home or SNF) for ACO members based on actuarial analysis of population of members

- **Bundled Payment**

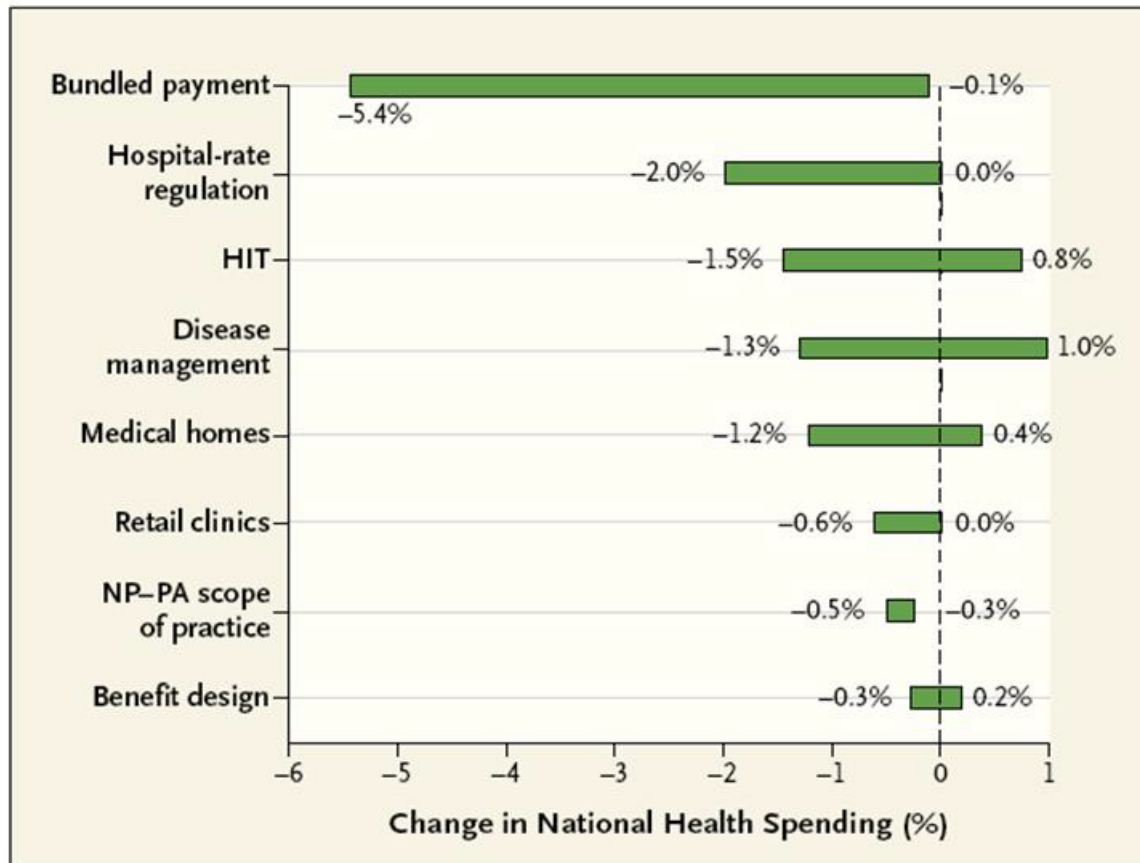


Bundled Episodic Payment

- **Bundling** = payment to a single provider entity of one amount for the full range of care during a hospitalization episode
 - Episodic payment related to acute hospitalization: -3 through +30 days
 - Hospitalization, re-hospitalization, post-acute care, outpatient hospital services including ED, physicians
- Pilot begins January 1, 2013; if spending reductions, expand at least by January 1, 2016
- Initial focus on one or more of eight conditions
- Payment either single bundle or via bids



Why Bundling is Key to Bending the Curve



Estimated Cumulative Percentage Changes in National Health Care Expenditures, 2010 through 2019, Given Implementation of Possible Approaches to Spending Reform.

* Source: *Perspectives: Controlling US Health Care Spending – Separating Promising from Unpromising Approaches*, Hussey, Peter, Ph.D., et. al., *NEJM*, 11/09

CMS Acute Care Episode (ACE) Bundled Payment Pilot

- “Bundle” includes all services related to the inpatient stay; five hospitals in pilot
- 28 Cardiovascular and 9 Orthopedic DRGs
- Demonstration length: 2009–2011
- Medicare fee-for-service beneficiaries
- Competitive bidding
- Gainsharing with physicians
- Shared savings with beneficiaries
- Planned expansion to 200–300 new sites in 2011, at least one pilot including post-acute care



**Medicare Acute Care Episode Demonstration
Shared Savings Payment**

TFS Group, Inc.
P.O. Box 1001, McLean, VA 22102
ph: 877-402-3693

CHECK



Name _____
Street Address _____
City, State ZIP _____

Dear _____:

Medicare is conducting a number of projects designed to improve the quality of health care for people with Medicare and reducing the costs of care. In one of our current projects, the Acute Care Episode Demonstration, some hospitals and their doctors are charging Medicare discounted fees for certain surgical procedures. Under this project, hospitals must provide detailed reports on the quality of care related to these surgical procedures. **To encourage people with Medicare to use these hospitals, Medicare is sharing up to half of its savings with patients who undergo one of these procedures.**

The attached check for \$_____ represents your share of what Medicare saved on your recent stay at _____(hospital)_____, which ended on ___(discharge date)_____. You are responsible for paying any Federal, state, and other taxes that may be owed on this amount. At the end of the calendar year, you will receive an IRS Form 1099 reflecting this amount as taxable income.

Please contact Medicare's contractor, TFS Group, Inc., at 1-877-402-3693 if you have any questions regarding this check. If you have any questions regarding this project or your hospital stay, please contact _____(hospital)_____ at _____(hospital's demo information number)_____.

Thank you for being a part of this important project.

Sincerely,

Cynthia Mason
Project Officer
Acute Care Episode Demonstration
Office of Research, Development, and Information

Summary of Starting Dates in ACA

ACA Provision	Start Date
Hospital 30-day readmission penalties	October 1, 2012
Hospital value-based purchasing	October 1, 2012
Plan for SNF and HHA value-based purchasing (starting date unknown)	October 1, 2011
Accountable care organizations (ACOs)	January 1, 2012
Bundled payment pilot	January 1, 2013

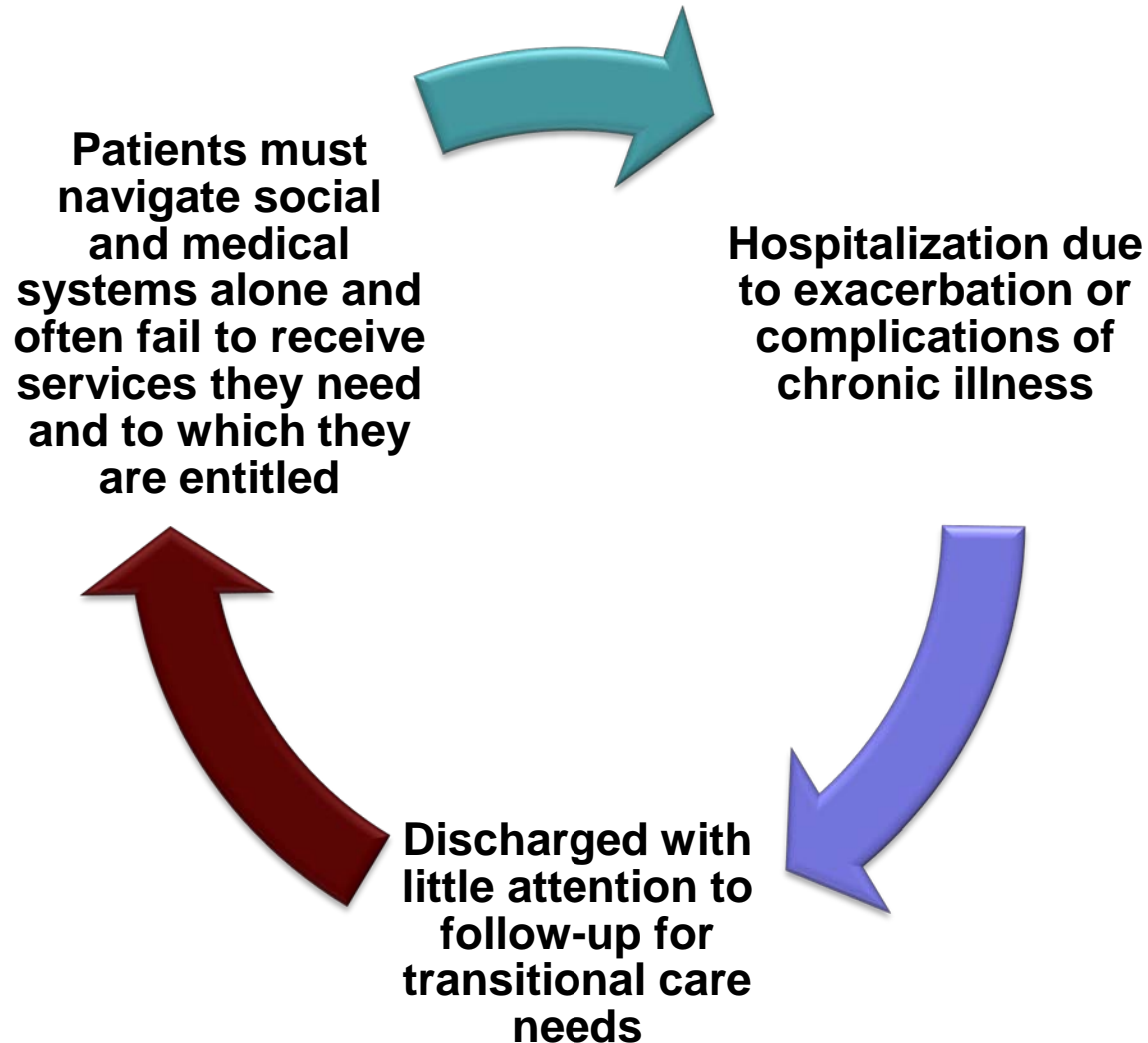
What Are Solutions Home Health and Hospice Offer in Health Care Reform?



Planning for 2012–2015

Payment and Delivery System Changes	Implications for Home Health and Hospice
Reductions in hospital readmission rates and penalties	<ul style="list-style-type: none">• Increased care coordination• Data-driven PAC decisions• More home health technology• More effective use of hospice & palliative care
Accountable care organizations and bundled payment	<ul style="list-style-type: none">• Hospital-physician-post acute partnerships essential• Greater home health-hospice electronic information and connectivity• Evidence-based care protocols• Fewer home health visits & more use of home technology• Bundled PAC payment, financial risk/gain sharing, capitated payments• Risk/gain sharing with suppliers, manufacturers, physicians• Home health and hospice have leading roles

Need for a Solution: Broken Health Care System for Chronic Care Management



Solution 1: Care Transitions Intervention (CTI)—The Program

- Program initiated prior to hospital discharge and continues four weeks post-discharge
- RN Transition Coach™ meets with patient in the hospital, completes home visit 48–72 hours post-discharge, and holds 2–3 telephone consultations within the first 30 days post-discharge
- Focus of transition coach: support and teach self-management skills to improve patient's ability to manage chronic disease and to navigate the health care system



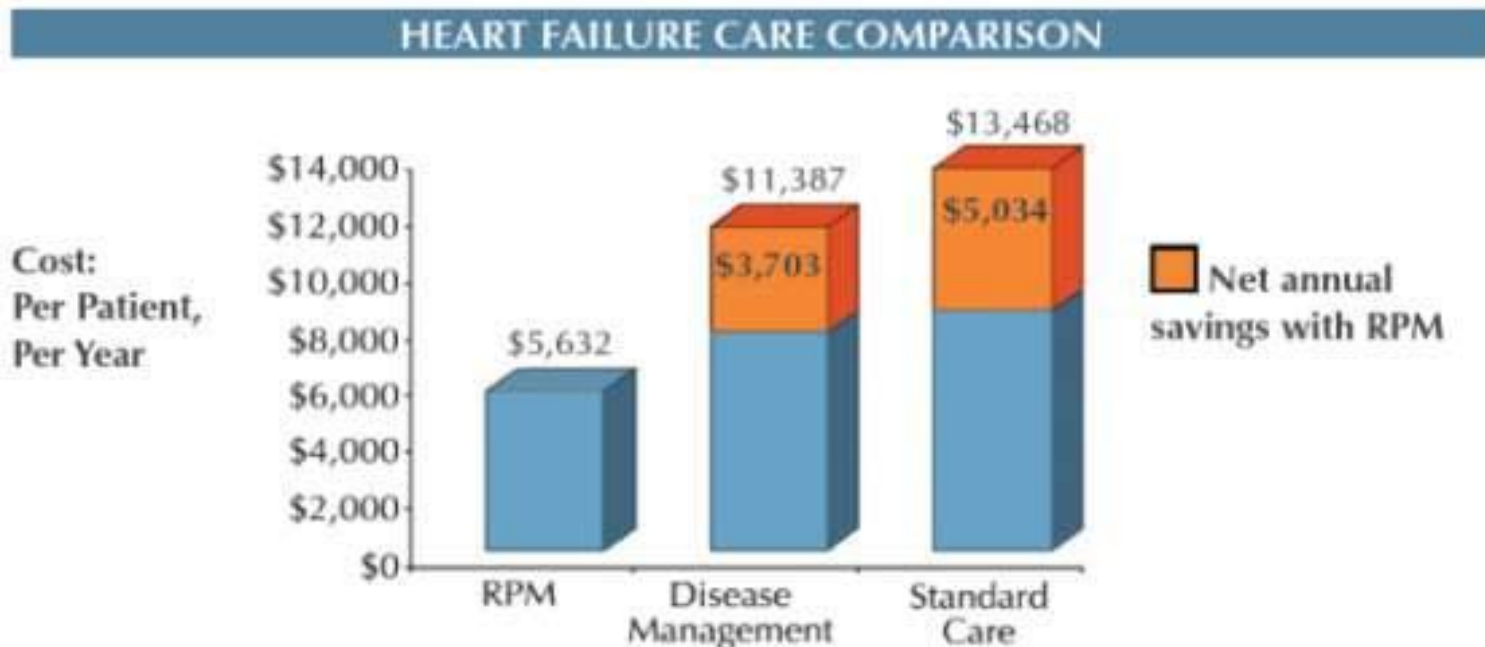
CTI: The Tools

- Key tools and processes include:
 - Personal health record (PHR)
 - Medication reconciliation
 - Identification of personal health goals
 - Identification of “red flags” associated with chronic disease
 - Development of plan for early response to changes in disease condition



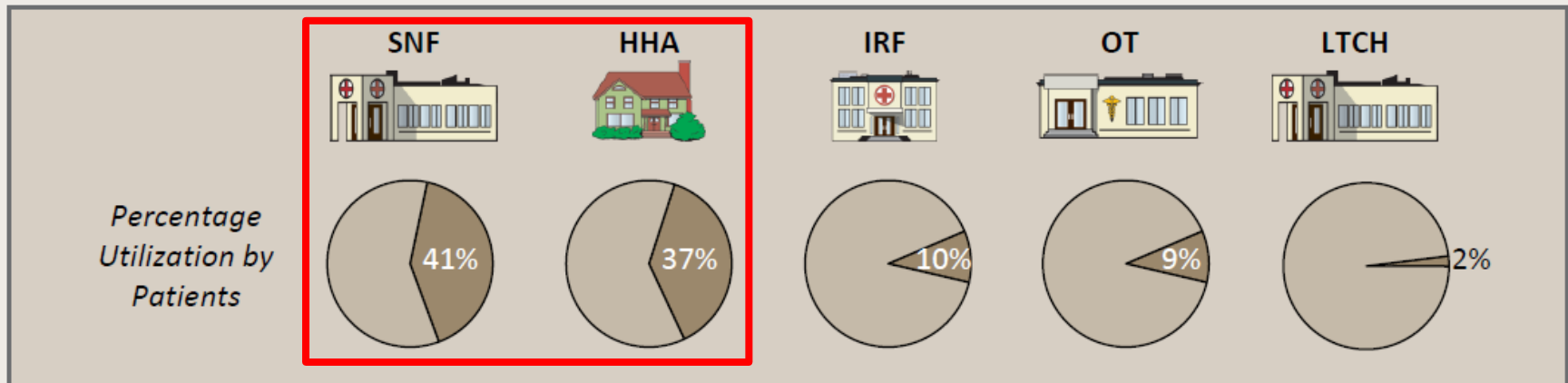
Solution 2: Remote Patient Monitoring (RPM)

- NEHI projections of savings using remote patient monitoring:
 - 60% reduction in hospital readmissions from standard care alone
 - 50% reduction in hospital readmissions from DM
 - Prevent 460,000–627,000 heart failure-related hospital readmissions/year
 - NEHI estimates an annual national cost savings of up to \$6.4 billion



Solution 3: Value-Based Hospital and PAC Partnerships

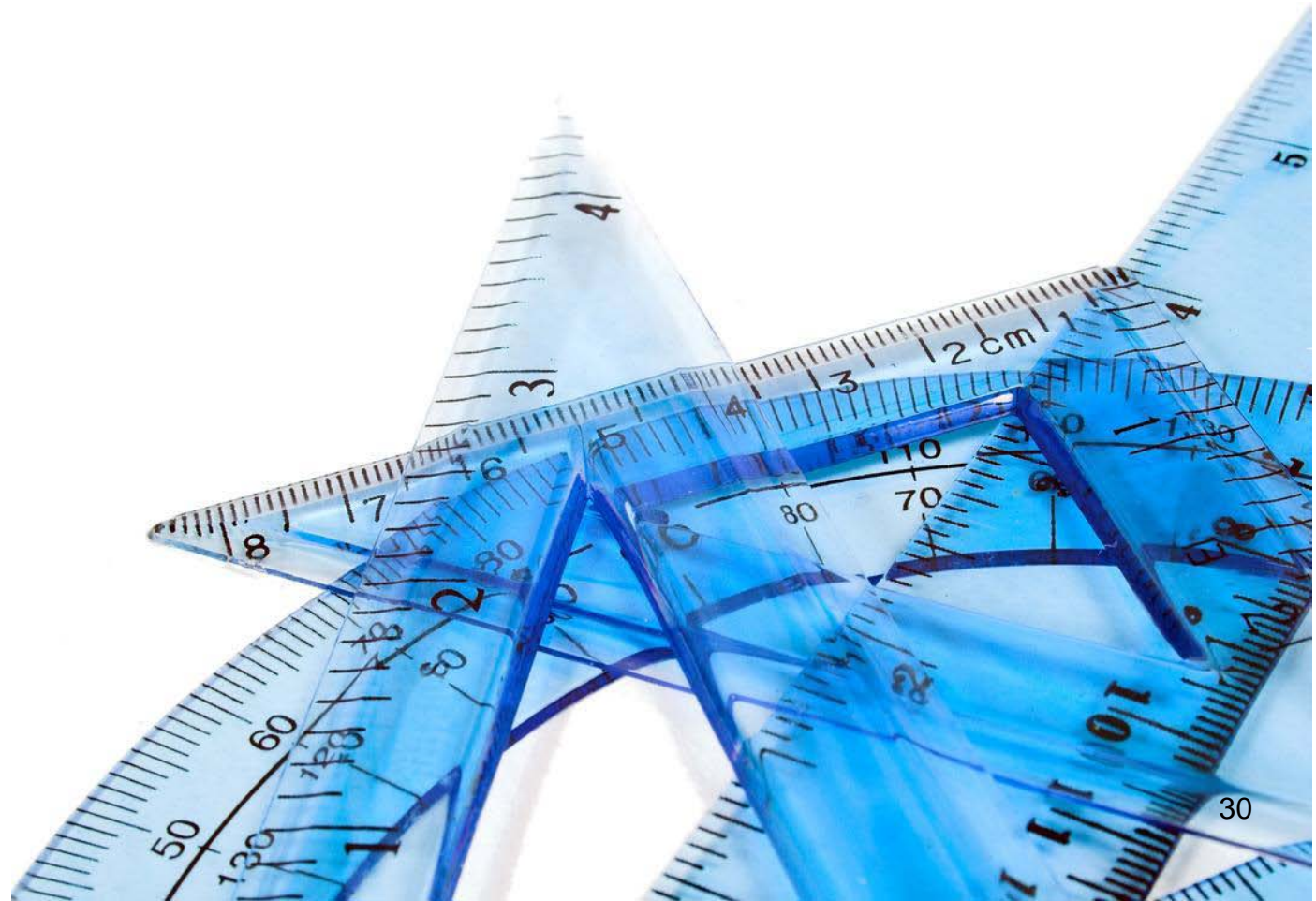
Hospital Discharges to PAC Providers



- Considerations for determining their partners:
 - Quality, cost performance of agency
 - Current referrals to agency
 - Use of technology; ability to share clinical and financial information
 - Geographic coverage area
 - Strength and type of existing relationship

Which Solutions are Best for You?

Start With Measuring The Right Data



Happy Home Health Data

	Agency		State		National	
	Current	Previous	Current	Previous	Current	Previous
Acute Care Hospitalization	33%	32%	26%	29%	24%	25%
Oral Medication Improvement	40%	31%	55%	50%	67%	65%
Unplanned ED Visits	88%		97%		97%	

Decline

Improvement

Defining Specific Goals for Reduction in Readmissions & ED

- 5-day Readmissions
- 15-day Readmissions
- 30-day Readmissions
- Readmissions by diagnosis by X%
- HH patient readmissions by X%
- Readmissions for patients discharged to SNF by X%
- ED admissions for indigent patients for CHF by X%
- ED visits for HO patients by X%

Defining Additional Specific Goals

- 95% of patients seen by PCP within 5 days of discharge
- 95% of home health patients on tele-health managed in home (no ED or hospital admission while monitored)
- Increase hospice length of stay by X% to match industry best practice benchmarks by terminal condition



Tracking Data Elements

- PCP
- Hospitalist/s
- Discharge principal diagnosis
- Cost of care
- Reimbursement
- Co-morbidities at DC
- LOS in acute care
- CNS/PC/GNP
- Readmission to ER
- Readmissions to acute
- Medication discrepancies
- Education provided
- PCP visit within 7 days post-discharge
- Standing orders/protocols initiated
- Were the right labs ordered

System Issues Identified

- Workflow process change: redesign and eliminate waste and duplication
- Integration of care and practices across settings
- Patient care goals in place



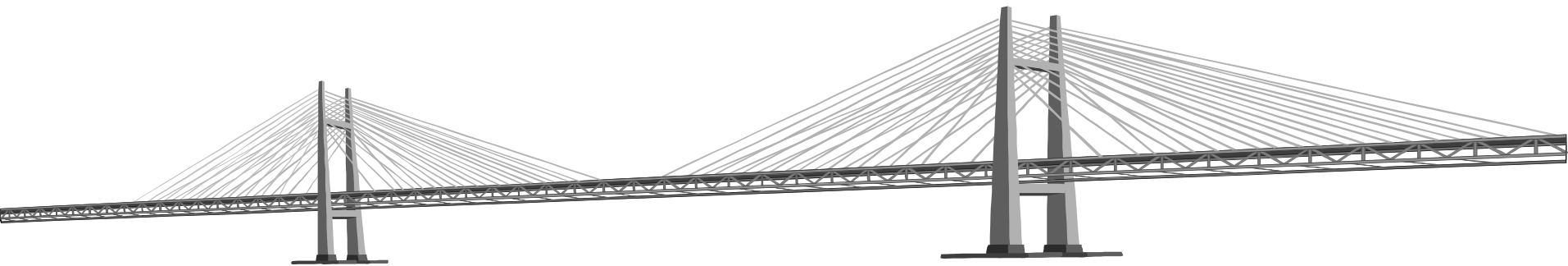
Methodologies and Processes to Reduce Rehospitalizations: Home Health

- Integrated patient care/clinical paths
 - Evidence based
 - Part of EMR and documentation systems
- Well-defined transitional care elements
- “Front loading” patient contact at SOC
- Tele-health: remote monitoring for complex patient populations



Methodologies and Processes to Reduce Rehospitalizations: Palliative Care/Hospice

- Earlier identification of chronic disease decline within each care setting
 - Evidence-based criteria
- Palliative care “bridge” program to follow and intervene between home health and hospice levels of care
 - Integrated/shared team between palliative care and hospice
 - Determine causes of ED visits and increased rehospitalizations



Planning is Key

- Identify and develop plans for communication and inclusion for each X-system key departments and individuals to collaborate with home health/hospice
- Identify current related processes impacted by each change
- Determine level of integration of current staff and staffing needs and current functions and workflow processes to be considered
- Identify key political potential partner issues
- Know your data and present to your future partner and fine-tune to meet their goals

Whether you are a
freestanding agency or part of
a health system

Lessons Learned: Critical Elements

- Developing patient and caregiver “ownership”:
 - Behavioral modification based on their goals
 - Motivational interviewing techniques
 - Coaching versus directing



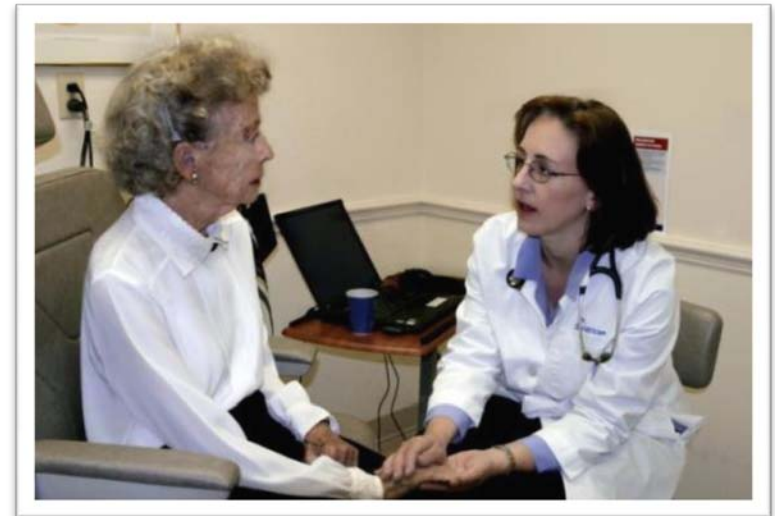
Medication Reconciliation



- Thorough
- Consistent—never ends
- Track discrepancy rates
- Use data to analyze “failed” system
- Make system changes
- Use data to analyze patient errors
- Identify and implement systems to decrease patient errors

Addressing Psycho-social Issues

- Palliative care discussions and planning
- Assessing and treating depression
- Transportation issues
- Financial issues related to care
- Legal issues
- Caregiver competence



A Final Thought...

“The real voyage of discovery consists not of finding new lands but of seeing the territory with new eyes.”

Marcel Proust



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