Developing and Operating Post-Acute Networks in Value-Based Programs

Sheldon Hamburger
Post-Acute Networks in VBP

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Implicit in this presentation
Background

- Value-based models
  - ACO (MSSP), BP (CJR), “risk-based”
- “Fixed-fee” care
- Part of a broader industry move
  - Shifting risk to provider (=payer)
- CMS rapid move to alternative models
- CJR model
“...HHS goal of 30 percent traditional FFS Medicare payment through alternative payment models by the end of 2016... 50 percent by the end of 2018”

HHS Press Office 1-26-15
The long-term impact of BPCI will depend on CMMI’s ability to persuade interested but non-risk-bearing participants to bear risk.

AJMC, November, 2015

..if by persuade you mean require
Agenda

- Post-acute in “value-based” programs
- Identifying post-acute opportunity
- Designing a post-acute network
- Developing your network
- Operational issues
- Monitoring performance
Agenda

- Post-acute in “value-based” programs
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### Post-Acute Care in VBP

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage</th>
<th>Amount</th>
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<tr>
<td>Total Program</td>
<td>100%</td>
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<td>Anchor Stay</td>
<td>48%</td>
<td>$54,000,000</td>
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<tr>
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<tr>
<td>SNF</td>
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<tr>
<td>Ambulatory</td>
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<tr>
<td>HHA</td>
<td>5%</td>
<td>$6,000,000</td>
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<tr>
<td>Readmissions</td>
<td>13%</td>
<td>$15,000,000</td>
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<tr>
<td>IRF</td>
<td>4%</td>
<td>$5,000,000</td>
</tr>
<tr>
<td>LTAC</td>
<td>1%</td>
<td>$1,000,000</td>
</tr>
<tr>
<td>Other</td>
<td>2%</td>
<td>$2,000,000</td>
</tr>
</tbody>
</table>
Post-Acute Care in VBP

BPCI Participants by Provider Type (10/1/15)

- HHA, 6.6%
- LTACH, 0.1%
- IRF, 0.6%
- Hospital, 27.0%
- SNF, 46.6%
- PGP, 19.1%
Post-Acute Care in VBP

Average Daily Rates for Medicare

- Hospital: $2,000
- LTAC: $1,800
- IRF: $1,600
- SNF: $1,200
- HHA: $200
Post-Acute Care in VBP

- What is the partner’s role?
- When/where/how are they used?
- When/where/how should they be used?
- Questions lead to.....
- How can we optimize utilization?
- Can we shift to lower “cost” settings?
- Do we need these partners at all?
Post-Acute Care in VBP

Fighting the status-quo
- Hospitals incentives - discharge
- No incentives post-discharge
- Post-acute providers incentives - maintain
- No incentives to release

Value-based programs
- Hospitals own the spend
- Creates the missing incentives
Post-Acute Care in VBP

- Key post-acute players (vary by VBP)
  - Direct: SNF, HHA, IRF, LTAC
  - Indirect: Readmissions
Post-Acute Care in VBP

Today’s pathway
Post-Acute Care in VBP
Post-Acute Care in VBP

Trade SNF for HHA
(Trade $450/day for $150/day)
Post-Acute Care in VBP

Bypass SNF for HHA
(extra IP days?)
Post-Acute Care in VBP

Trade SNF for “hotel”
(Trade $450/day for $???/day)
Post-Acute Care in VBP

Eliminate “classic” post-acute (self-directed PT)
Agenda

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• Identifying post-acute opportunity
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• Developing your network
• Operational issues
• Monitoring performance
Agenda

- Post-acute in "value-based" programs
- **Identifying post-acute opportunity**
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Identifying Opportunity

• Opportunity vs. risk
• Not all spend is opportunity
• Use historical data
• Can you effect change?
• If so, at what cost (to you)?
• Care process reengineering
Identifying Opportunity

Average Episode Payments by Setting

- Index Admit
- Professional
- Readmission_Professional
- Readmission
- SNF
- HHA
- Outpatient
- IP Psych
- Hospice
- IP Rehab
- DME
- Transfer

Comparison of episode costs across different quarters from baseline to Qtr 3 2014.
Identifying Opportunity

Pays for ~3% here

Savings here

~3%
Identifying Opportunity
Identifying Opportunity

![Bar chart showing cost breakdowns by duration and service type. The chart highlights costs for 1-30 Days, 31-60 Days, and 61-90 Days with various service categories such as Readmission, Readmission_P, Professional, SNF, HHA, IP Rehab, Outpatient, and DME.](image-url)
Identifying Opportunity

Average Episode Payments by Setting

- Baseline
- Qtr 1 2013
- Qtr 2 2013
- Qtr 3 2013
- Qtr 4 2013
- Qtr 1 2014
- Qtr 2 2014
- Qtr 3 2014

Legend:
- Index Admit
- Professional
- Readmission_Professional
- Readmission
- SNF
- HHA
- Outpatient
- IP Psych
- Hospice
- IP Rehab
- DME
- LTC
- Transfer
Identifying Opportunity

Average Episode Payments by Setting

- Baseline
- Qtr 1 2013
- Qtr 2 2013
- Qtr 3 2013
- Qtr 4 2013
- Qtr 1 2014
- Qtr 2 2014
- Qtr 3 2014

Legend:
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- Readmission_Professional
- Readmission
- SNF
- HHA
- Outpatient
- IP Psych
- Hospice
- IP Rehab
- DME
- LTC
- Transfer
Identifying Opportunity
# Identifying Opportunity

<table>
<thead>
<tr>
<th>First Post Discharge Setting</th>
<th>Episode Count</th>
<th>Total Net Episode Payments</th>
<th>Average Net Payment Per Episode</th>
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<tbody>
<tr>
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<td>170</td>
<td>$3,330,864</td>
<td>$19,593</td>
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<tr>
<td>Hospice</td>
<td>1</td>
<td>$15,511</td>
<td>$15,511</td>
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<tr>
<td>IP Rehab</td>
<td>14</td>
<td>$703,390</td>
<td>$50,242</td>
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<tr>
<td>Readmission</td>
<td>2</td>
<td>$69,583</td>
<td>$34,791</td>
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<tr>
<td>Self-Care</td>
<td>2</td>
<td>$42,098</td>
<td>$21,049</td>
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<tr>
<td>SNF</td>
<td>143</td>
<td>$4,701,915</td>
<td>$32,881</td>
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<td><strong>Grand Total</strong></td>
<td><strong>332</strong></td>
<td><strong>$8,863,362</strong></td>
<td><strong>$26,697</strong></td>
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## Identifying Opportunity

<table>
<thead>
<tr>
<th>SNF Name</th>
<th># Episodes</th>
<th>Total Payments</th>
<th>Average Payment</th>
<th># Readmits</th>
<th>Readmit Rate</th>
<th>Average LOS</th>
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<tr>
<td>SNF 1</td>
<td>82</td>
<td>$779,133</td>
<td>$9,502</td>
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<td>19</td>
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<tr>
<td>SNF 2</td>
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<td>13%</td>
<td>27.4</td>
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<td>SNF 3</td>
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<td>5%</td>
<td>28.4</td>
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<td>$198,958</td>
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<td>29.3</td>
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<td>SNF 6</td>
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<td>$163,762</td>
<td>$12,597</td>
<td>2</td>
<td>15%</td>
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<td>$247,794</td>
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<td>SNF 13</td>
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<td>SNF 14</td>
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<td>$13,591</td>
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<td>SNF 15</td>
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<td>SNF 16</td>
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<td>$12,085</td>
<td>$4,028</td>
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<td>33%</td>
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Identifying Opportunity

SNF Referrals

The Aristone Group
## Identifying Opportunity

<table>
<thead>
<tr>
<th>SNF Name</th>
<th># Episodes</th>
<th>Total Payments</th>
<th>Average Payment</th>
<th># Readmits</th>
<th>Readmit Rate</th>
<th>Average LOS</th>
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<tr>
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<td>$6,201</td>
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<td>$3,428</td>
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<td>$3,586</td>
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<td>11.9</td>
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<td>$2,265</td>
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<td>100%</td>
<td>6.6</td>
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<td>$0</td>
<td>$0</td>
<td>0</td>
<td>0%</td>
<td>15.2</td>
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<tr>
<td>SNF 16</td>
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<td>0</td>
<td>0%</td>
<td>6.1</td>
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# Identifying Opportunity

<table>
<thead>
<tr>
<th>HHA</th>
<th># Episodes</th>
<th>Total Payments</th>
<th>Average Payment</th>
<th># Readmits</th>
<th>Readmit Rate</th>
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<tbody>
<tr>
<td>Our own HHA</td>
<td>132</td>
<td>$422,123</td>
<td>$3,198</td>
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<tr>
<td>Competitor</td>
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<td>$35,124</td>
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<tr>
<td>Competitor</td>
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<td>$15,784</td>
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<td>22%</td>
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<tr>
<td>Competitor</td>
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<td>$23,549</td>
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<td>0%</td>
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<tr>
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<td>0%</td>
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<tr>
<td>Competitor</td>
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<td>$18,213</td>
<td>$3,036</td>
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<td>17%</td>
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<td>Competitor</td>
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<td>$4,026</td>
<td>1</td>
<td>17%</td>
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<tr>
<td>Competitor</td>
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<td>$17,918</td>
<td>$3,584</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Competitor</td>
<td>4</td>
<td>$72,123</td>
<td>$18,031</td>
<td>1</td>
<td>25%</td>
</tr>
</tbody>
</table>
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- Post-acute in “value-based” programs
- **Identifying post-acute opportunity**
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- Post-acute in “value-based” programs
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Designing A Post-Acute Network

• Why a post-acute network?
  – Ensures best quality/performance
  – Easier to manage
  – Creates standardized/compliant care
  – Develops competition toward improvement
Designing A Post-Acute Network

• Strategy
  – Use “top-shelf” partners
  – Limit the network
  – Create leverage
  – Move care to lower-acuity (=spend) settings
  – Initiate innovation (e.g., telehealth, retail)
Designing A Post-Acute Network

- Focus areas
  - Partnerships
  - Care reengineering
  - Education
  - Technology
  - Performance
  - Patient satisfaction
Successful partnerships
- Set proper expectations (contracts)
- Communication
- Responsiveness
- Inclusion, sharing, learning together

What about community partners?
- Parish nurses, pharmacists, geriatricians, etc.
Designing A Post-Acute Network

• Care reengineering
  – Shouldn’t increase workload
  – Should adapt to “normal” workflow
  – Support by real-time access to data
  – Provides guidance subject to judgement
  – Iterative process
    • For improvement
    • Review of relevance and effectiveness
Designing A Post-Acute Network

• Care engineering
  – Episode/disease specific
  – Risk stratified
  – End-to-end review
  – Promote evidenced-based
  – Focus on transition points ("handovers")
  – ID your quick wins with high ROI
    • e.g. Med-Rec
Designing A Post-Acute Network

• Education
  – **Must** have a comprehensive plan
  – Initial and **ongoing** training
  – Include **everyone** (internal & external)
  – Based on **lessons-learned**
Designing A Post-Acute Network

Technology

Do
- Use what you have
- "Manual" processes
- "Quasi"-tech

Don’t
- IT department
- Interfaces
- Total solutions
Designing A Post-Acute Network

• Performance metrics/KPIs
  – Understood/accepted metrics
  – Ability to easily measure, capture, report
  – What is it now, where does it need to be
  – How will we get there together?
  – What is the change rate/timing?
  – Who gets these and when?
• Patient satisfaction
  – HCAPHS, Press Ganey, etc.
  – Not DRG specific / post-acute
  – Design/develop your own
  – Purchase a tool
  – Patient is a partner – need their buy-in
Agenda

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Developing Your Network

• Themes
  – Mutual partnership
  – Understanding of PAC complexity
  – Partners have limitations
  – Turnover rates, limited clinical expertise
  – General lack of physician support
  – Your need to support – not as a “vendor”
Developing Your Network

• Focus areas
  – Selection
  – Contracting
  – Integration
  – Complexities
Developing Your Network

• Selecting partners
  – Overall strategy to create credibility
  – Regimented methodology
  – RFP from the C-suite
  – Open to “everyone”
    • Establish trust, fairness
    • Accept questions/changes
  – Must result in “the best”
  – Basis for your recommendations
Developing Your Network

100+ providers
30 candidates
10 finalists
4 network
Developing Your Network

High-quality SNFs in short supply
In 11 metro areas in Medicare’s mandatory bundled-payment demo, less than half of the skilled-nursing facilities have adequate quality ratings to serve joint-replacement patients.

Source: Modern Healthcare analysis of CMS regulations and data
Developing Your Network

• Identify specific performance criteria
  – Star-rating
    • 5 Star overall CMS rating
    • 4 Star CMS quality rating
    • 3 Star staffing
    • 4 Star CMS RN staff rating
  – Readmission rates
  – Technological capabilities
  – Process/data sharing
  – Adherence to new care pathways
Developing Your Network

- Sample requirements list
  - Referral responsiveness
  - Medication availability
  - QI program
  - Commitment to collaboration
  - Patient & family centeredness
  - Performance reporting
  - Resident & family satisfaction
Developing Your Network

- Contracting
  - Formal, letter, verbal
  - Specify requirements, terms, RFP
  - Mutual performance standards
  - Remediation process
  - Safe harbor
  - Preference in future business
  - Adherence to care pathways, t-health, etc.
  - Gainsharing
## Developing Your Network

**SNF**
- Collaborate
- Monthly metrics report
- Monthly meetings with hospital
- Accommodate increased patient volume

**ACO**
- Collaborate
- Refer patients
- Promote quality
- Data transparency
- Support services
Developing Your Network

• Integrating partners into your program
  – Rejected players are future partners
  – Multi-tiered: “preferred” and “aligned”
  – Formal integration plan/process
  – Ongoing interaction/exchange of info
  – Continuous improvement culture
Developing Your Network

- Aligning partner performance
  - Set expectations at start
  - Contract, kickoff
  - Regular meetings: group and 1on1
  - Continuous review, critique, improvement
  - Initial progress is easy, tougher later
Developing Your Network

• Complexities
  – High-risk ($) patient
  – Comorbidities
  – Behavioral health factors
  – Socioeconomic factors
  – You’ll need new competencies
Agenda

• Post-acute in “value-based” programs
• Identifying post-acute opportunity
• Designing a post-acute network
• Developing your network
• Operational issues
• Monitoring performance
Agenda

- Post-acute in “value-based” programs
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- Operational issues
- Monitoring performance
Operational Issues

• Driving patients to your network
• Maintaining performance
• Education
• Remediation
Operational Issues

• Driving patients to your network
  – Biggest issue
  – This is a sales job
  – That’s why selection process is key
  – Education of entire staff
  – Evaluate every non-preferred transition
  – Elective vs ED
Operational Issues

- Maintaining performance
  - Regular meetings to review metrics
  - Regular review of exceptions
  - Group and 1on1
  - Joint development/improvement
  - Is it improvement or new waste?
  - Are changes pervasive and scaling?
  - Linking to MSSP, PCMH, ACO, etc.
Operational Issues

• Follow patients thru post-acute care
  – Patient experience
  – Transitions
  – Behavioral health
  – Connectivity
  – What’s being shared (or not)?
  – Inbound (off-hours) calls
    • Navigator? Call center?
    • If center what protocols to respond and log?
Operational Issues

• Patient-focused transitions of care
  – Risk stratification
  – Standardized discharge summary
  – Medication reconciliation
  – Post-discharge follow up (patients/drs)
  – Dedicated phone/email contact (navigator)
  – Consultation (palliative care, complexities, etc.)
Operational Issues

• Considerations
  – How to provide discharge notifications?
  – How/who will contact patients within 2 days of discharge?
  – How do you ensure that primary physicians will follow up?
  – How will you measure/track success of your TOC program?
Operational Issues

- Risk factors for readmission (8Ps)
  - Problems with meds
  - Psychological
  - Principal diagnosis
  - Physical limitations
  - Poor health literacy
  - Poor social support
  - Prior hospitalization
  - Palliative care

Source: Society of Hospital Medicine
Operational Issues

- **Behavioral health issues**
  - Screen, assess, diagnose, treat
  - Therapy and medicine
  - Depression, suicide, danger risks
  - Cognitive screening
  - Education and support of the veteran, spouse, family members/caregivers
Operational Issues

• Education
  – The network
  – How they were chosen
  – Why it’s better
  – Answering questions/objections
  – Collateral (brochures, video, internet)
  – Across the continuum
Operational Issues

• **Education**
  - Ongoing process, 3rd party tools
  - Regular meetings to review metrics
  - Regular review of exceptions
  - Rapid feedback to everyone
  - Complexity of (re)training across settings
  - Varied audience (clinical, financial, competitive)
  - Refresh, new hires
Operational Issues

• Transparency leads to improvement
  – Want to see how they compare (not “blind”)
  – Natural competition lead to improvements
  – Example: compete on readmission rates
  – Refinement of pathways/protocols
Operational Issues

• Remediating underperforming partners
  – Established process in contract
  – No surprises – regular updates
  – Bigger issue with a preferred than aligned
  – Delivering bad news
  – Helping them improve
Operational Issues

• Staffing
  – Care navigator
  – Interdisciplinary team
  – Clinical/quality review
  – Compliance review (less often)
  – Financial review
  – Patient satisfaction
  – Site/setting level champions
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Monitoring Performance

- Measuring and use of KPIs
- Issues in data collection
- Presentation in real time
- Taking action
Monitoring Performance

• Measuring and use of KPIs
  – Can’t improve what you can’t measure
  – Measure twice, cut once
  – Must align with project goals
  – Don’t do too much at once/from the outset
  – “Dashboard” comes later
Monitoring Performance

• Measuring and use of KPIs
  – Financial, clinical, patient satisfaction
  – What do you have today?
  – Pick a limited set of new key drivers
  – Questions to ask:
    • Do we have it today? Where do we get it?
    • Priority for launch? Who is the user?
    • How often would the user need to see updates?
    • How is it deployed to the user?
Monitoring Performance

• Easy! examples:
  – Readmission rates – by setting
  – Length of stay (LOS) – by setting
  – Referral rates – by setting
    • Preferred, aligned, other, total
  – DVT, infection control
  – Where are patients coming from (in ED)
  – Analysis of inbound calls to ID unmet needs and readmissions issues
Monitoring Performance

• Easy? examples:
  – Monthly occupancy/census
  – CMS inspection deficiencies
  – DPH complaints
  – Patient/family satisfaction
  – Time to return to work
Monitoring Performance

• Issues in data collection
  – Data Capture
    • Fit in existing workflow/system
    • Must measure what you want
    • Requires cross functional teams
  – Data Integration
    • Key identifiers (unique)
    • Disparate systems
Monitoring Performance

- Presentation in real time
  - Right data, right place, right time
  - Integration into existing systems (IT)
  - Complex, expensive, impossible?
  - Often a “phase 2” item
  - Accomplished via “external” systems
Monitoring Performance

- If not real-time....
  - Frequency (daily, weekly, monthly, ....)
  - Blind reporting vs. identified
  - Delivery modes: email, portal, meetings
  - Start early and often (even w/o data)
  - Initial data sets are small but easy to use
  - Use to improve
    - Readmission causes, out-of-network
    - Falling off protocol, extended LOS
Monitoring Performance

Example Scorecard Outline

Number of ACO Sub-acute Patient Admissions
Sub-acute Patient Readmission Rates for ACO patients
Overall facility LOS
Average ACO Sub-acute LOS
Average Patient Pain Scores
Infection rates
Average Sub-acute reimbursement per episode
Monthly Occupancy (total)
  - Sub-acute
  - Long Term
Deficiencies from CMS inspections
DPH Complaints
Patient & Family Satisfaction
Monitoring Performance

<table>
<thead>
<tr>
<th></th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>June</th>
<th>July</th>
<th>Aug</th>
<th>Sept</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
</tr>
</thead>
<tbody>
<tr>
<td># Referrals</td>
<td>10</td>
<td>12</td>
<td>13</td>
<td>8</td>
<td>15</td>
<td>11</td>
<td>4</td>
<td>7</td>
<td>12</td>
<td>12</td>
<td>7</td>
<td>9</td>
</tr>
<tr>
<td>Referral rate</td>
<td>43%</td>
<td>48%</td>
<td>41%</td>
<td>30%</td>
<td>52%</td>
<td>35%</td>
<td>13%</td>
<td>24%</td>
<td>38%</td>
<td>31%</td>
<td>18%</td>
<td>22%</td>
</tr>
<tr>
<td>Avg. LOS</td>
<td>9.2</td>
<td>8.1</td>
<td>11.2</td>
<td>15.1</td>
<td>10.1</td>
<td>11</td>
<td>10.4</td>
<td>11.2</td>
<td>14.1</td>
<td>9.4</td>
<td>9.2</td>
<td>10.1</td>
</tr>
<tr>
<td>Readmission rate</td>
<td>30%</td>
<td>33%</td>
<td>46%</td>
<td>25%</td>
<td>7%</td>
<td>45%</td>
<td>25%</td>
<td>29%</td>
<td>8%</td>
<td>42%</td>
<td>29%</td>
<td>56%</td>
</tr>
</tbody>
</table>

In total, by SNF, by bundle
## Monitoring Performance

### Process Metrics

<table>
<thead>
<tr>
<th>Hospital Quality Measure</th>
<th>Hospital Performance Measure</th>
<th>Program Goal</th>
<th>Measurement Standard</th>
<th>Current Measure</th>
<th>Where was Measure Published</th>
<th>Association that compiled the measure</th>
<th>How to Measure (Numerator/Denominator)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication Management</td>
<td>Percentage of patients in the hospital that had an assessment of medication intake, patient and family were counseled about their medication, and medication management was a part of the patient's plan of care</td>
<td>Improved transitions of care and reduction in hospital readmissions</td>
<td>100%</td>
<td></td>
<td>National Transitions of Care Collaborative-Category 1 of 7 essential Intervention Categories</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transition Planning</td>
<td>Percentage of patients in the hospital setting that used a formal transition planning tool such as a standard Transition Form (AMDA Universal Transfer Form) or Patient Plan of Care tool developed in the hospital and extended to the SNF facility</td>
<td>Improved transitions of care and reduction in hospital readmissions</td>
<td>100%</td>
<td></td>
<td>National Transitions of Care Collaborative-Category 2 of 7 essential Intervention Categories</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Monitoring Performance

• Taking action
  – Ongoing comparison to targets
  – Early ID of failures / change direction
  – Escalation of issues (remediation process)
  – Lessons learned from success & failure
  – Partner replacement
Lessons Learned

- From actual providers……
- Selection process critically important
- Articulate clear vision for the network
- Transparency at all steps along the way
- Establish trust in a fair process
- Ensure validity of metrics
- Be flexible in adopting changes
Lessons Learned

• Actual reported results……
• Network improved care community-wide
• All PAC providers working to improve
• Better care integration
• SNFs are eager, responsive
• Patients are doing better
Lessons Learned

- Still issues.........
- Public quality metrics are imperfect
- PAC provider performance consistency
- Harder/longer than we thought
- Excluded providers are not happy
- Wish we had help
Recap

✓ Post-acute in “value-based” programs
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✓ Operational issues
✓ Monitoring performance
It’s Your Choice

Fee-based

Value-based
SNF or Ritz?

http://seniorhousingnews.com/2016/02/23/best-of-post-acute-2015-genesis-mainstreet-push-the-envelope/?hsenc=p2ANqtz-0plPDVy37kK8acNrrNSH7VPYCTNE0yjjXnHmh_vAvzYEEFuY4jyelyXK_aeeiploetGz4qbOeix-5iGk2X0Nkuu4BnnJdt6Krt32CABWonFl1vE&_hsmi=26569356
Post-Acute Networks in VBP

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