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 **HEALTH
DIMENSIONS
GROUP**

October 30, 2010

Aging Services Providers: Success Through Partnerships in a New Era of Health Care Delivery and Payment

**House of Delegates
AAHSA - LeadingAge**

Drivers of Partnerships for Future Success of Aging Services Providers

- 
- Accountable Care Organizations
 - Bundled Payment
 - Hospital Readmission Penalties



Accountable Care Organizations and Aging Services Providers



- ACO responsible for Medicare Part A and Part B:
 - Clinical care management (clinical integration)
 - Capture data for continuum of care
 - Measure, monitor costs and quality

How Will Post-Acute and Medicare Services in LTC Be Paid by ACOs?

- **Medicare FFS + bonus:** shared savings
- **Bundled payment:** Example



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



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



- **Capitation PMPY:** \$ to manage post-acute and Medicare services in long-term care (home or NF) for ACO members based on actuarial analysis of member population

Why Post-Acute Is Key to Managing Health Care Costs

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%	

Three Strategic Partnership Imperatives for Aging Services Providers

Partner with hospitals and ACOs to address biggest concerns:

- Length of stay (LOS)
- Pending re-admission penalties

Partner with other providers to enhance your post-acute and home care continuum

Partner with like providers to create one-stop chronic care management

Strategy includes care transitions management and electronic health record

Finding and Creating Our Partnerships



Strategic Partnership Imperative 1

**Partner with hospitals
and ACOs to address
biggest concerns:**

- **Length of stay
(LOS)**
- **Pending
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penalties**

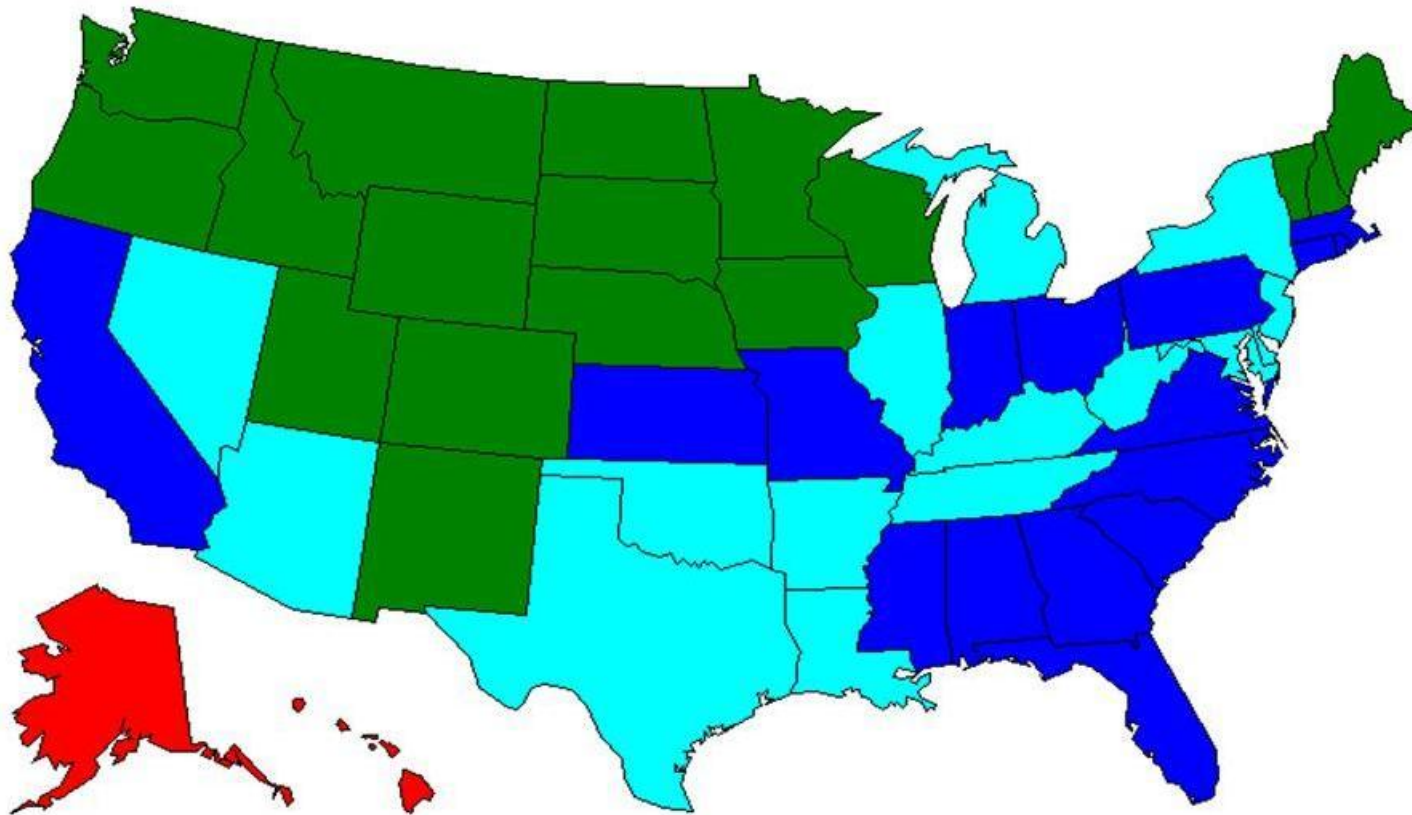


What Do Hospitals (and Physician Group ACOs) Want from SNFs and HHAs?

1. “Quality” Providers = (what this means to hospitals or physician group ACOs)
 - Easy/quick transfers from hospital
 - No/low 30-day readmissions to hospitals
 - Low ED/admissions
 - Proven capabilities to manage high acuity patients
 - Good feedback from patients, families, and physicians
2. Physician staff recognized by hospital or from physician group practice
3. One-stop shopping for post-acute care and well-managed care transitions among venues
4. In the future, EHR

SNF 30-Day Hospital Readmission Rates by State

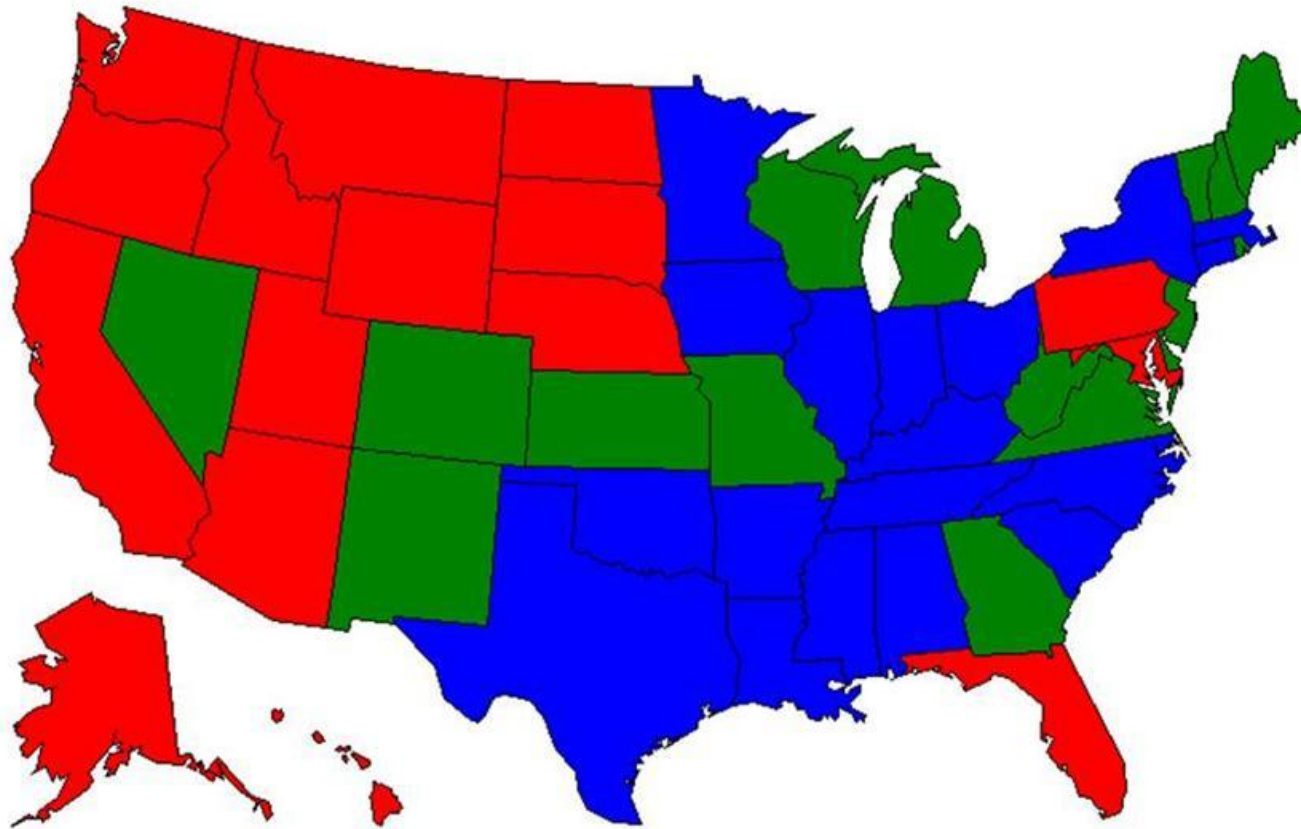
Percent of Admits for Short Term Nursing Home Residents by State



shortgro ■ Missing ■ 18.3% or less
■ 18.4%–22.4% ■ 22.5% or more

Home Health 30-Day Hospital 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

Data-Driven Hospital Relationships

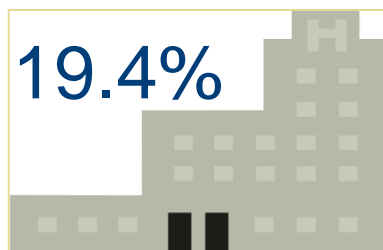
- Partner with hospitals to meet burning needs, especially concerns about **readmission penalties FY2012**: pneumonia, AMI, CHF, and reduce excess **LOS for all conditions** discharged to SNFs
- Customize subacute programs to hospitals; and learn to use hospital MedPar data

MS-DRG	MS-DRG Description	SNF Discharges	Acute Hospital Days	CMS GMLOS Days	ALOS at Hospital	CMS GMLOS	Total Excess Hospital Days	LOS Over (Under) GMLOS
480	Hip and femur procedure except major joint w/MCC	50	400	380	8.0	7.6	20.0	0.40
193	Simple pneumonia and pleurisy w/MCC	40	245	212	6.1	5.3	33.0	0.83
286	Circ disorder except ami, w/card cath w/mcc	35	180	175	5.1	5.0	5.0	0.14
291	Heart failure and shock w/mcc	30	135	150	4.5	5.0	(15.0)	(0.50)
640	Nutritional and miscellaneous metabolic disorders w/mcc	28	124	104	4.4	3.7	20.4	0.73
Total		183	1,084	1,021	5.9	5.6	63.4	0.35

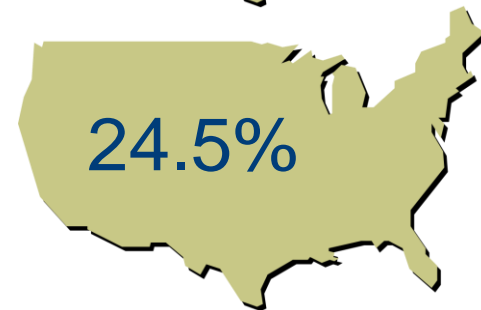
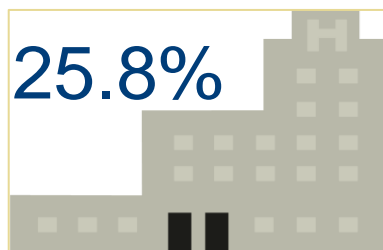
Data-Driven Hospital Relationships

- Identify 30-day readmission rates by condition: hospital versus nationally

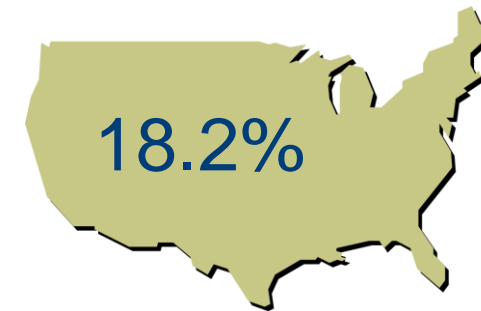
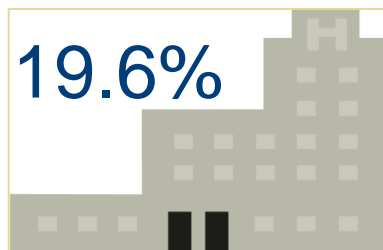
Heart Attack



Heart Failure



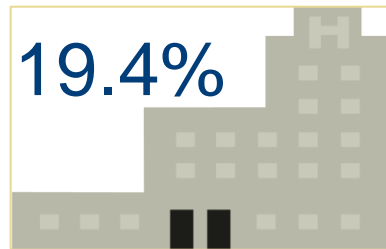
➔ Pneumonia



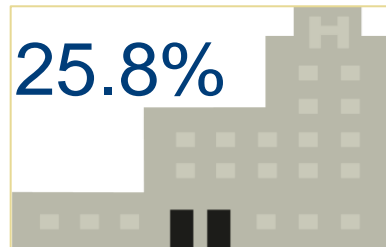
Demonstrate Your 30-Day Readmission Rates

- Demonstrate your 30-day readmission rates by condition and your plans to continue to decrease

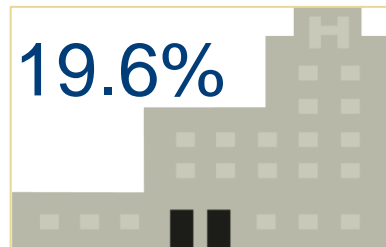
Heart Attack



Heart Failure



Pneumonia



Hospital and Physician Group ACO Partnership Takeaways

- Relationships becoming data driven
 - What are your patient outcomes? How many Medicare A go home?
 - What is your 30-day readmission rate by condition, especially those for which hospitals soon will be penalized: AMI, CHF & pneumonia?
- Subacute units must be able to manage patients who typically would be “911”
 - Increased nursing skills and RNs
 - Physician/NP intensive management of subacute patients
 - Coverage 24/7
 - Use of protocols, e.g., Interact, that help SNFs manage higher-acuity patients



Strategic Partnership Imperative 2

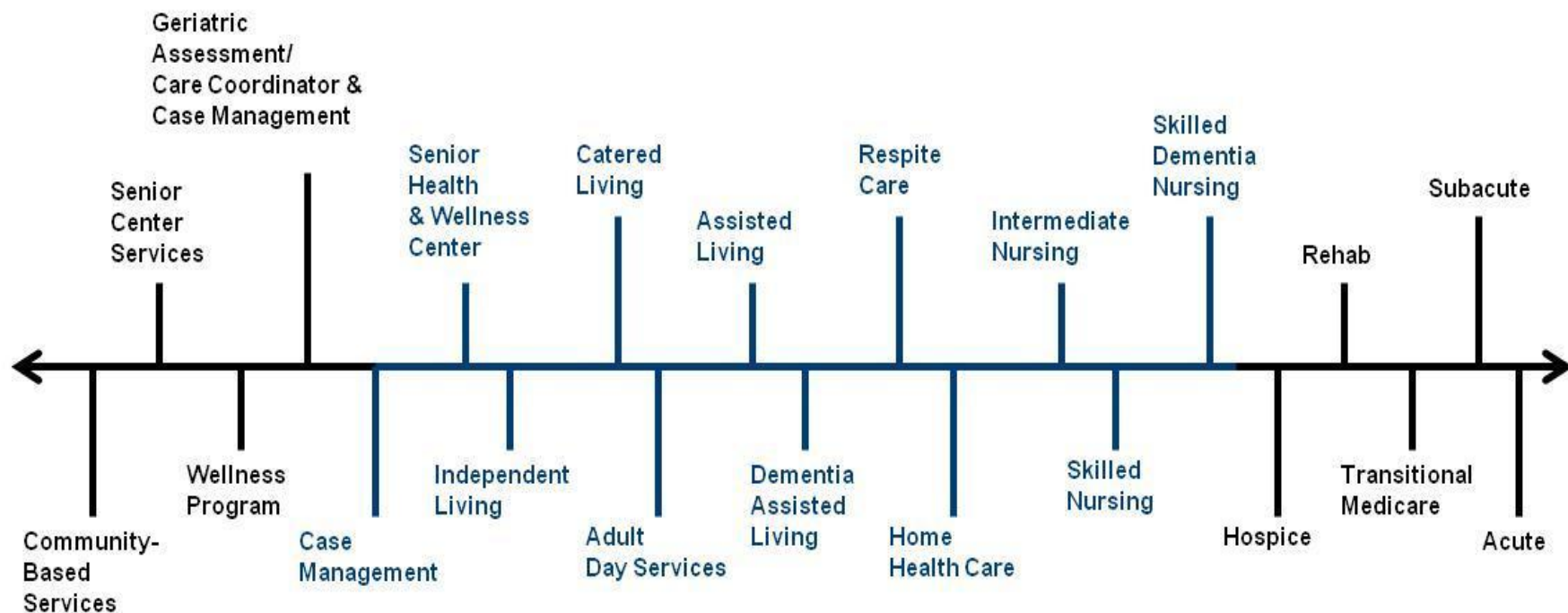


**Partner with other
providers to
enhance your
post-acute and
home care
continuum**



The New Reality for Aging Service Providers: Partnerships with Other Providers

- Provide an array of aging services, not just skilled nursing and long-term care; be the **navigator** or **partner** for services or venues you do not offer = care management
- Become the *preferred partner* for integrated health systems or ACOs from whence Medicare dollars will flow



Strategic Partnership Imperative 3



**Partner with
like providers
to create
one-stop
chronic care
management**

Not-for-Profit Accountable Care Readiness Strategy: Aging Services Provider Partnerships

- Create a not-for-profit consortium within a market that has more value than any organization individually
- Benefits:
 - One-stop shopping for hospitals and ACOs
 - Benchmarks for hospital readmissions and ongoing comparison
 - Post-acute provider partnerships in geographic areas creating care continuum with standardized protocols
 - Care management projects
 - Bundling experiments with Medicare Advantage Plans as we learn to take risks
 - Apply for grants for demonstration projects



Why Care Transitions Management: Because Current System Is Broken

Patients must navigate social and medical systems alone and often fail to receive services they need and to which they are entitled

Hospitalization due to exacerbation or complications of chronic illness

Discharged with little attention to follow-up for transitional care needs

Solution: Partner with Hospital, ACO, or Payer on Care Transitions

- Transitions coach
- Pre-discharge meeting/planning with patient and family
- Transition hospital to SNF-home or home (with or without home health)
- Home visit and telephonic follow-up for 4-7 weeks



Care Transitions Programs

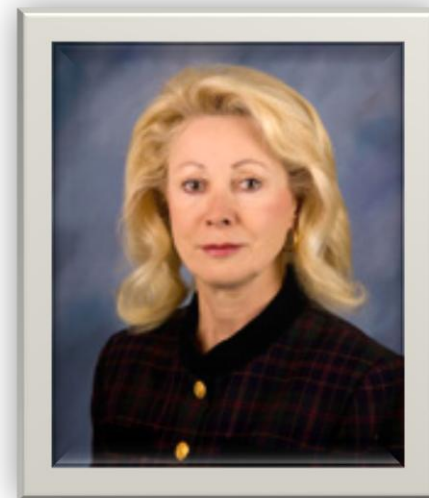
- Key tools and processes:
 - Personal Health Record (PHR)
 - Medication reconciliation
 - Identification of personal health goals
 - Identification of “red flags” associated with chronic disease
 - Plan for early response to changes in disease condition
- A **partnership** opportunity for post-acute providers with hospitals, ACOs and payers



**“This time, like all times, is a very good one
if you know what to do with it.”**

– Emerson

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