# What Makes an Attractive Post Acute Provider?

## Encore Rehabilitation


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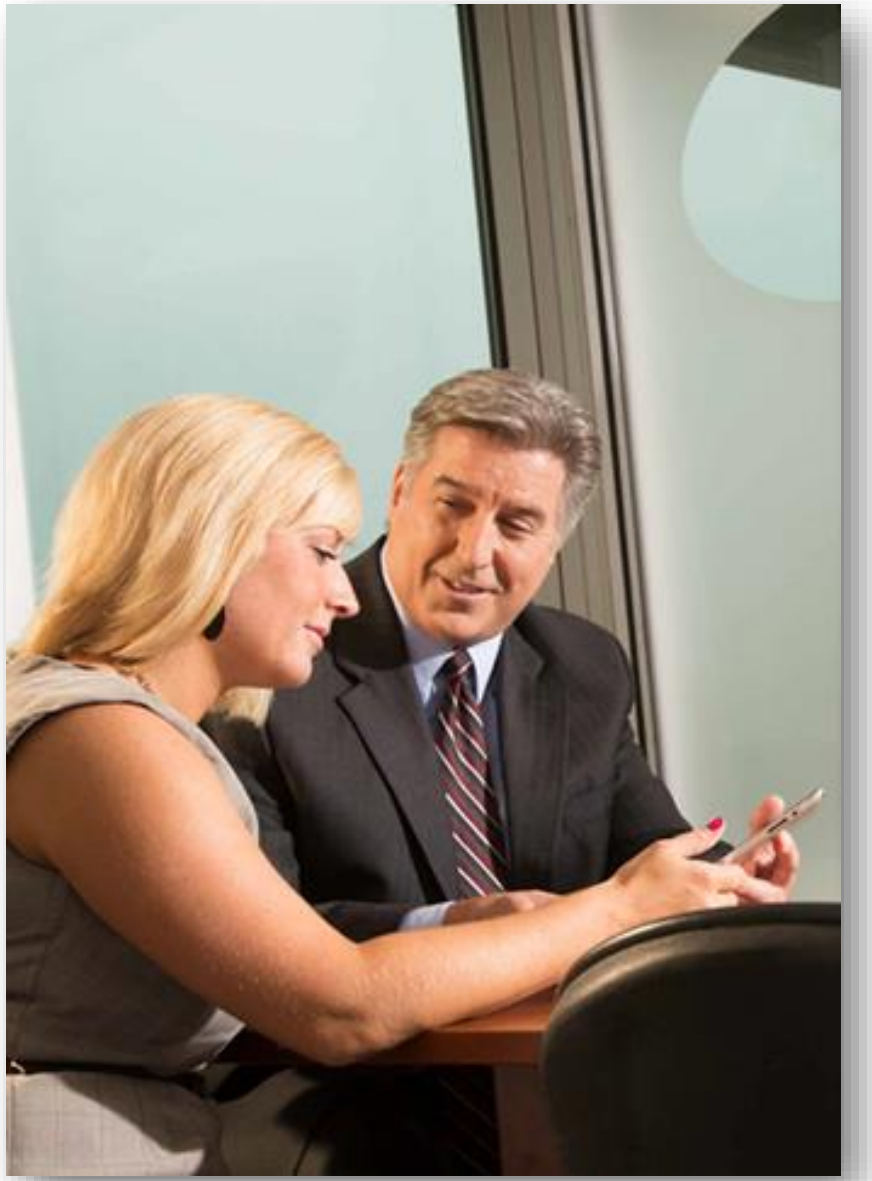
# Learner Objectives

- The attendee will learn strategies to prepare reports, systems and procedures to enhance their ability to attract and build new relationships with ACO's and bundled programs as well as to further prepare for other aspects of health care reform.
- The attendee will understand CMS initiatives that might impact payments in the post-acute arena and how they may encourage alliances.
- The attendee will learn how to create a comprehensive ‘marketing’ package including rehab outcomes for developing post-acute relationships and census development.



**“Instead of payment that asks, How much did you do?, the Affordable Care Act clearly moves us toward payment that asks, How well did you do?, and more importantly, How well did the patient do?”**

Donald Berwick, MD, former Administrator CMS

**“Its not just financial data. It’s also clinical data, quality data, market data, and how it is all integrated so that you can pull it all together and know what your true cost is and what your true outcomes are. They will drive how you are able to enter agreements…”**

Jenny Barnett, former EVP of Finance CHE Trinity in Livonia, Michigan

## Historic Precedent For Medicare

## Moving Medicare from Rewarding Volume to Value

### January 2015 Announcement

- HHS Secretary Sylvia M. Burwell announced measurable goals and a timeline to move the Medicare program, and the health care system at large, toward paying providers based on the quality, rather than the quantity of care
- First time in the history of the program that explicit goals for alternative payment models and value-based payments set for Medicare
- Creation of national Health Care Payment Learning & Action Network to accelerate the transition and foster collaboration between private payers, employers, providers, consumers, and state/federal partners

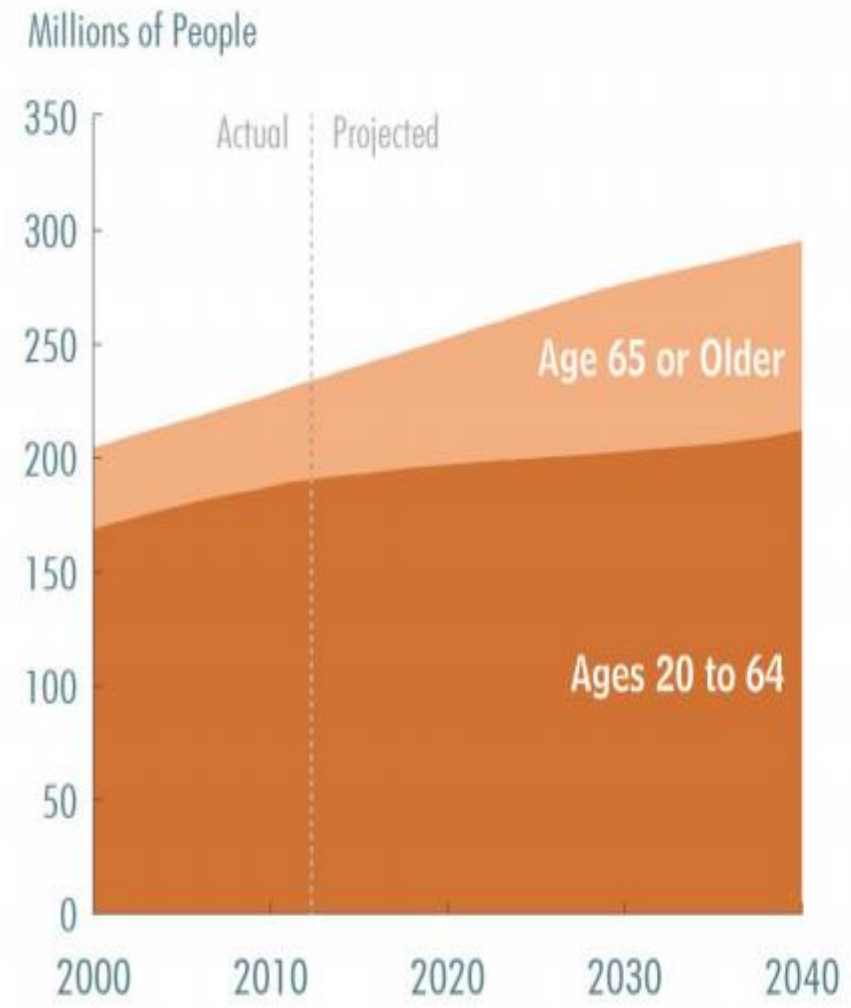
Goals

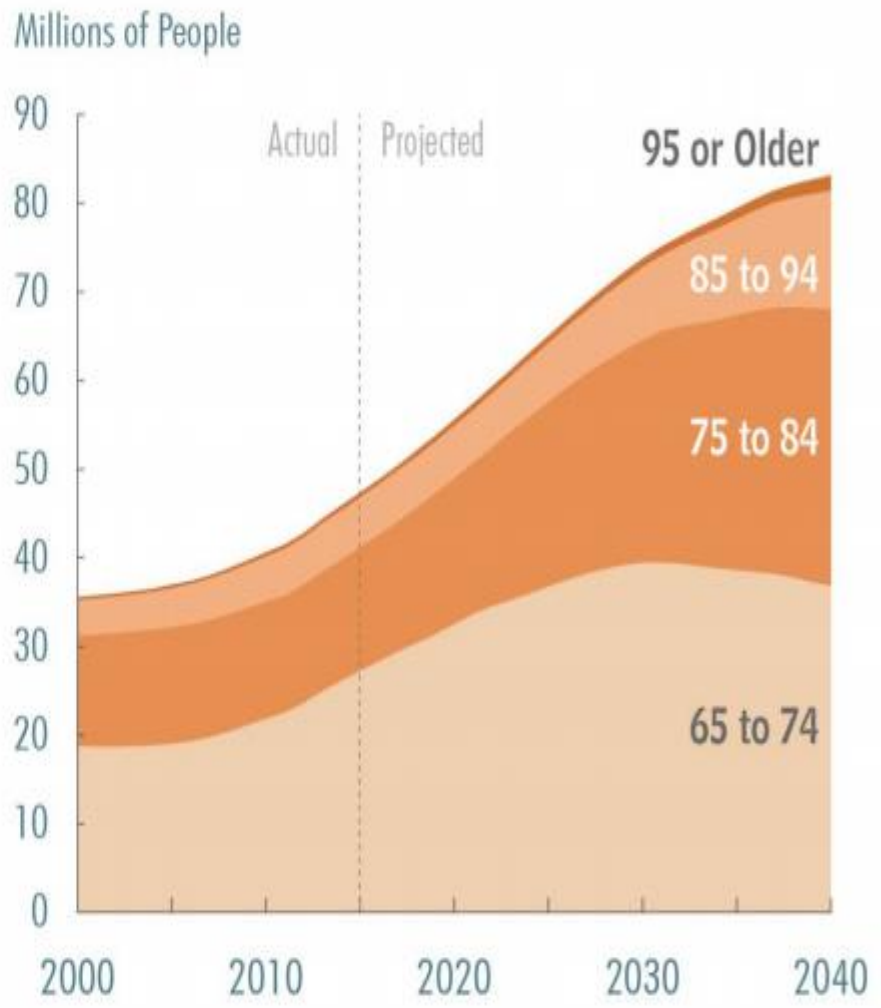
1. Alternative Payment Models:
    1. 30% of Medicare payments are tied to quality or value through alternative payment models by the end of 2016- **GOAL ALREADY MET JANUARY 2016**
    2. 50% by the end of 2018
2. Linking FFS Payments to Quality/Value:
    1. 85% of all Medicare fee-for-service payments are tied to quality or value by 2016
    2. 90% by the end of 2018

# Better Care, Smarter Spending, Healthier People: Improving Our Health Care Delivery System 3-03-2016

- Medicare spending per beneficiary is projected to grow 5.8 % in 2015. If projection holds, then 2015 will be the 6th consecutive year in which growth per beneficiary was roughly in line with overall inflation economy-wide.
- **Health outcomes are improving and adverse events are decreasing**
- **Providers are engaged**
  - There are 433 Shared Savings Program ACOs with 7.7 million assigned beneficiaries in 49 states plus Washington, DC

# Changes in Population by Age Group (6-2015)



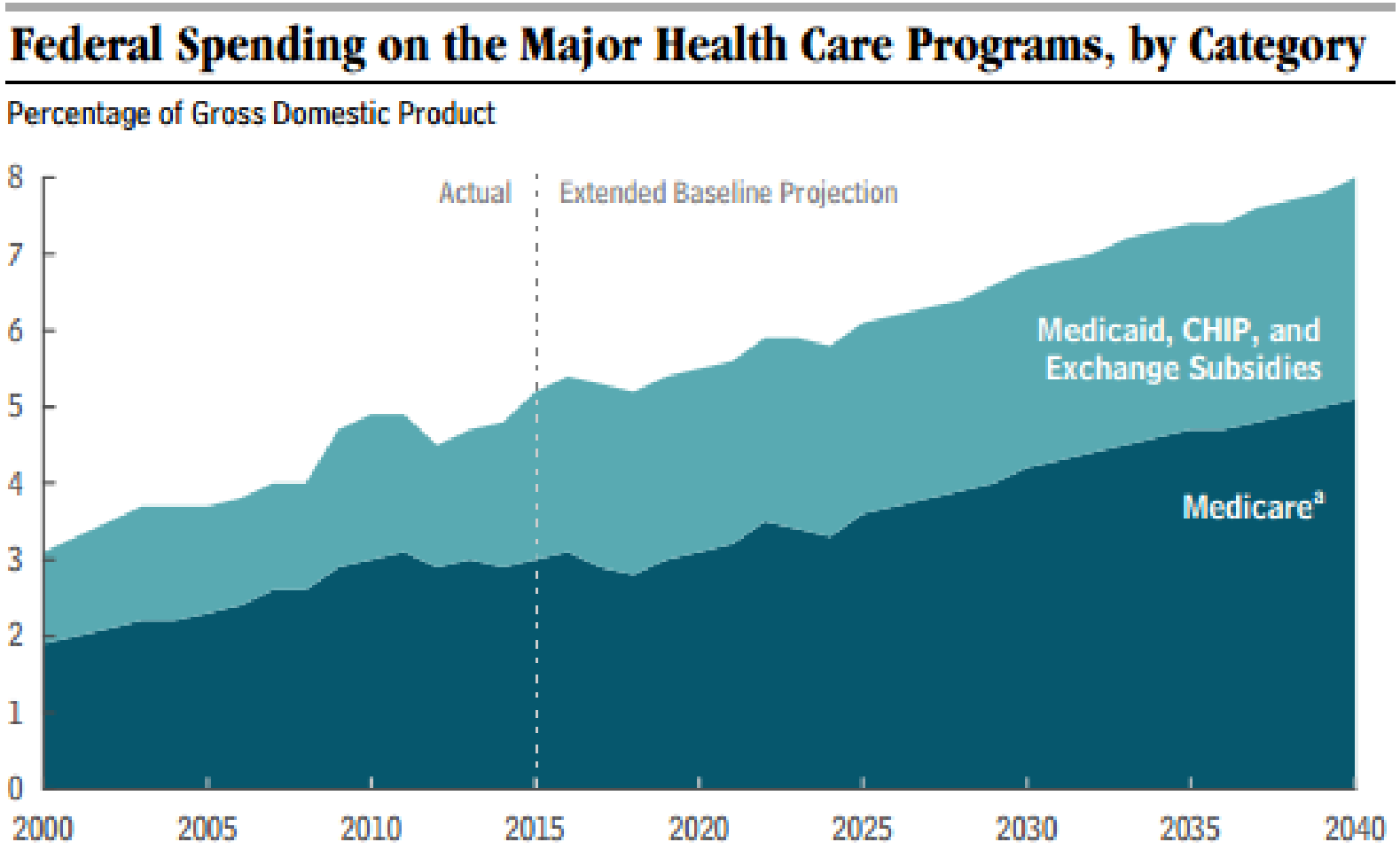



# Why address healthcare spending?

- As lawmakers searched for ways to reduce the national deficit, Medicare became a prime target.
- With baby boomers entering retirement age, the costs of caring for elderly and disabled Americans are expected to soar.
- As of January 19, 2016, (CBO) projected growth in federal spending for Social Security and major health care programs will grow faster than economic output per capita (mainly attributable to the aging of the population and rising health care costs per person).

| % of Population | Health Spending | Median Cost $ |
|---|---|---|
| Lowest 50% | 2.7% | $234 |
| Top 5% | 50% | $43,038 |
| Top 1% | 23% | $97,859 |

# Federal Spending on Major Health Care Programs, by Category (6/2015)



# Medicare PAC Initiatives
# Hospitals -Paying for Value

- Hospital Incentives:
  - Hospital Value-Based Purchasing Program (VBP)
    - Links incentive payments on performance (clinical process, outcomes and patient experience)
    - At risk for base operating DRG amounts
    - Incrementally increased to 2.% by FY 2017
    - Hospitals can earn back an incentive payment percentage less than, equal to, or more than the applicable DRG
  - Hospital Readmission Reduction Program (HRRP)
    - Penalizes hospitals for unnecessary excess readmissions on high cost conditions
  - Bundled Payments for Care Improvement (BPCI)
    - 48 Bundles
    - CJR-Comprehensive Care for Joint Replacement

# Financial Impact of Hospital VBP and HRRP

Base operating DRG payment amount x VBP adjustment factor

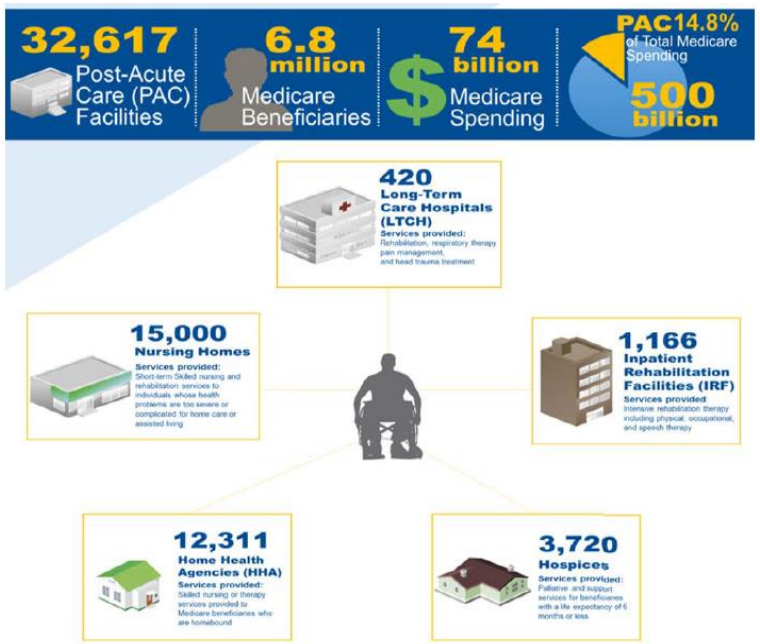
- If greater than one, hospital will have higher payment due to VBP performance
- If value is equal to one, hospital payment will not be changed
- If value is less than one, hospital payment will be lower due to the VBP performance

| | FY 2014 | FY 2015 | FY 2016 | FY 2017 |
|---|---|---|---|---|
| Hospital Readmissions Reduction Program (HRRP) | 2% | 3% | 3% | 3% |
| Hospital Value Based Purchasing (VBP) | 1.25% | 1.5% | 1.75% | 2% |
| Total Impact | 3.25% | 4.5% | 4.75% | 5% |

# Improving Medicare Post Acute Care Transformation- IMPACT ACT

- Bi-partisan bill introduced in March, U.S. House & Senate, passed on September 18, 2014, and signed into law by President Obama October 6, 2014
- The Act requires the submission of standardized assessment data by:
  - Long-Term Care Hospitals (LTCHs): LCDS
  - Skilled Nursing Facilities (SNFs): MDS
  - Home Health Agencies (HHAs): OASIS
  - Inpatient Rehabilitation Facilities (IRFs): IRF-PAI
- The Act requires that CMS make interoperable standardized patient assessment and quality measures data, and data on resource use and other measures to allow for the exchange of data among PAC and other providers to facilitate coordinated care and improved outcomes

# Why Post Acute Care Matters- 14.8% of Total Medicare Spending




## Nursing Homes

**Services provided:** Short-term Skilled nursing and rehabilitation services to individuals whose health problems are too severe or complicated for home care or assisted living.

No. of Facilities: **15,000**

Average length of stay: **39** days

Beneficiaries: **1.7** million

**MDS** – Minimum Data Set submissions: **20 million**

Medicare spending: **$28.7** billion

http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/index.html

# Quality Measure Domains & PBJ Implementation Dates

(So far- not exhaustive)

| Quality Measure Domains | SNF | IRF | LTACH | HH |
|---|---|---|---|---|
| Skin Integrity | 10/1/16 | 10/1/16 | 10/1/16 | 1/1/17 |
| Incidence of Major Falls | 10/1/16 | 10/1/16 | 10/1/16 | 1/1/19 |
| Functional Status/ Cognitive Status | 10/1/16 | 10/1/16 | 10/1/18 | 1/1/19 |
| Medication Reconciliation | 10/1/18 | 10/1/18 | 10/1/18 | 1/1/17 |
| Transfer of Health Information and Care Preferences | 10/1/18 | 10/1/18 | 10/1/18 | 1/1/19 |
| *Payroll Based Journal (PBJ) | 6/1/16 | | | |

# CMS Innovation Models
# 7 Categories To Reduce Costs & Improve Quality

- Accountable Care
- Episode-based Payment Models
- Primary Care Transformation
- Initiatives Focused on Medicaid and CHIP Population
- Initiatives Focused on Medicare-Medicaid Enrollees
- Initiatives to Accelerate the Development and Testing of New Payment and Service Delivery Models
- Initiatives to Speed the Adoption of Best Practices

# Medicare Shared Savings Program

**Medicare Shared Savings Program** —For fee-for-service beneficiaries

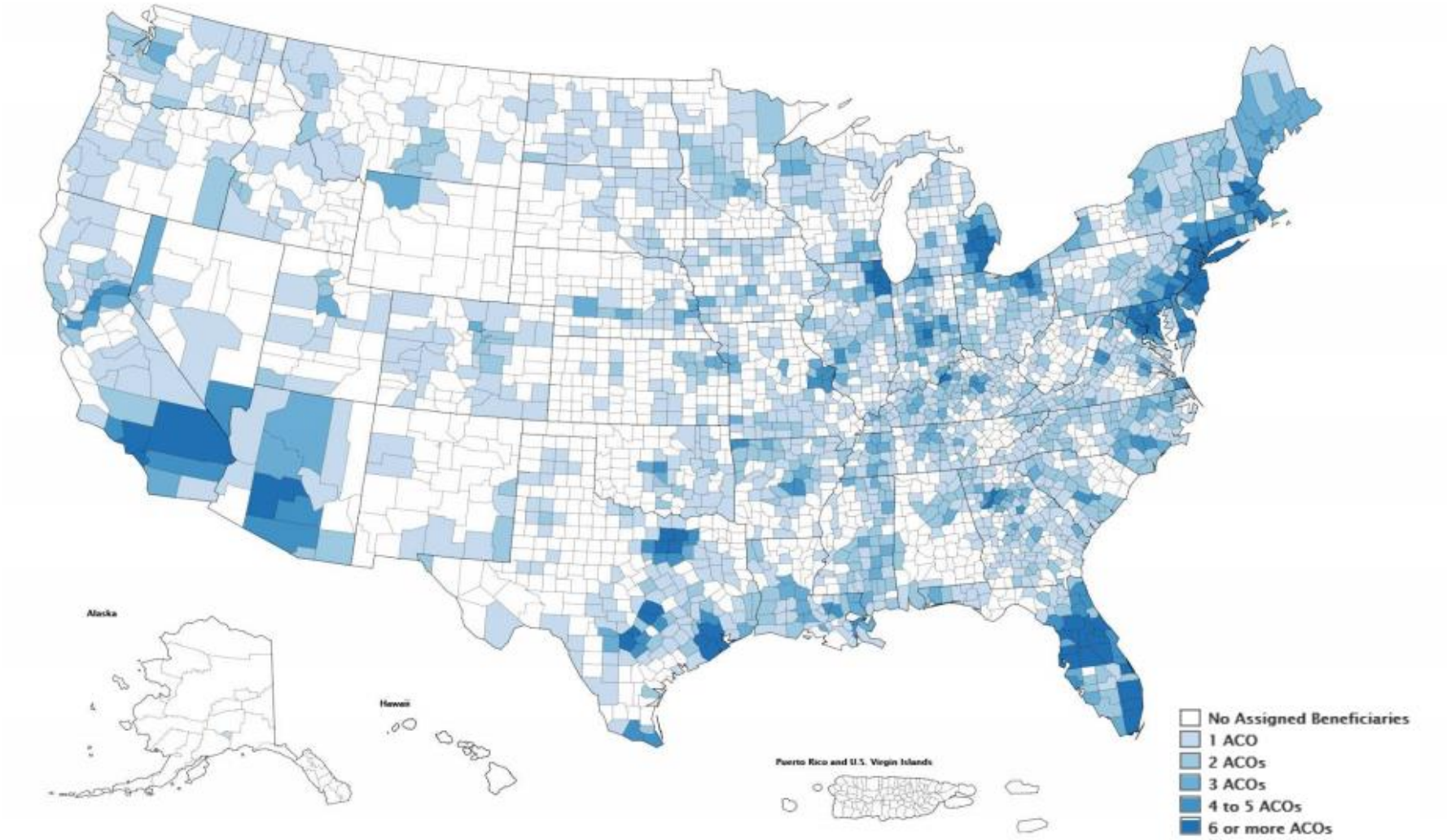
- Final Rule Changes begins 6/2015
- 444 ACOs have been established in 49 states, serving over 8.9 million Americans with Medicare

- ACO Investment Model - For Medicare Shared Savings Program ACOs to test pre-paid savings in rural and underserved areas
- Advance Payment ACO Model - For certain eligible providers already in or interested in the Medicare Shared Savings Program
- Comprehensive ESRD Care Initiative - For beneficiaries receiving dialysis services
- Next Generation ACO Model - For ACOs experienced in managing care for populations of patients
- Pioneer ACO Model - Health care organizations and providers already experienced in coordinating care for patients across care settings

# Changes to the Medicare Shared Savings Programs- Final 6/2015 and Proposed 1/2016

- In June 2015- a final Rule adopted policies designed to
  - Facilitate continued participation by ACO's in the program
  - Encourage ACO's to take on performance based risk
  - And to codify existing guidance, reduce administrative burden and improve function and transparency.
- Current Proposed Rule would shift ACO benchmarks away from historical spending
  - Change to regional spending fee-for-service costs
  - Would change an ACO's rebased benchmark by a percentage(increased over time) of the difference between fee-for-service and the ACO's historical spending
  - And allow greater flexibility in participation commitment periods

# Medicare Shared Savings Program ACO Assigned Beneficiary Population by ACO by County



# Bundled Payments for Care (BPCI)
# 4 models

- **Model 1-** Retrospective Acute Care Hospital Stay Only
  - Focuses on the acute care inpatient hospitalization (Pays physician's separately)
  - There is 1 participant and will conclude 2/2016
- **Model 2** –Retrospective Acute Care and Post Acute Care Episode and the bundle includes
  - The anchor hospitalization and all concurrent professional services,
  - Plus all other services delivered within the designated episode length of 30, 60, or 90 days.
  - All individual providers that deliver services to any patient in a BPCI episode continue to be paid on a fee-for-service basis.
  - Total spending is reconciled retrospectively against an established target price
  - There are 609 participants

# Bundled Payments for Care (BPCI) 4 models

- Model 3- Retrospective Post Acute Care Only- Most Common
  - **Home health agencies (HHAs),**
  - **Skilled nursing facilities (SNFs),**
  - **Inpatient rehabilitation facilities (IRFs),**
  - **or Long-term care hospitals (LTCHs)).**
  - Episodes start when a patient is admitted to an episode-initiating post acute care provider within 30 days of an anchor hospitalization and the bundle includes all services within the designated episode length.
  - Individual providers are paid on a fee-for service basis with retrospective reconciliation against an established target price
  - There are 838 participants
- Model 4- Prospective Acute Care Hospital Stay Only
  - involves a prospective bundled payment arrangement, all services furnished by the hospital, physicians, and other practitioners during the Episode of Care, which lasts the entire inpatient stay
  - There are 9 awardees

# Bundled Payments for Care - Participants by Types of Facilities

- Acute Care Hospitals (385)
- Physician Group Practices (283)
- Home Health Agencies (99)
- Inpatient Rehabilitation Facilities (9)
- Long-Term Care Hospitals (1)
- Skilled Nursing Facilities (681)

| | Model 1 | Model 2 | Model 3 | Model 4 |
|---|---|---|---|---|
| **Episode** | All acute patients, all DRGs | Selected DRGs, hospital plus post-acute period | Selected DRGs, post-acute period only | Selected DRGs, hospital plus readmissions |
| **Services included in the bundle** | All Part A services paid as part of the MS-DRG payment | All non-hospice Part A and B services during the initial inpatient stay, post-acute period and readmissions | All non-hospice Part A and B services during the post-acute period and readmissions | All non-hospice Part A and B services (including the hospital and physician) during initial inpatient stay and readmissions |
| **Payment** | Retrospective | Retrospective | Retrospective | Prospective |

# CJR- Comprehensive Care for Joint Replacement- Effective 4/1/2016

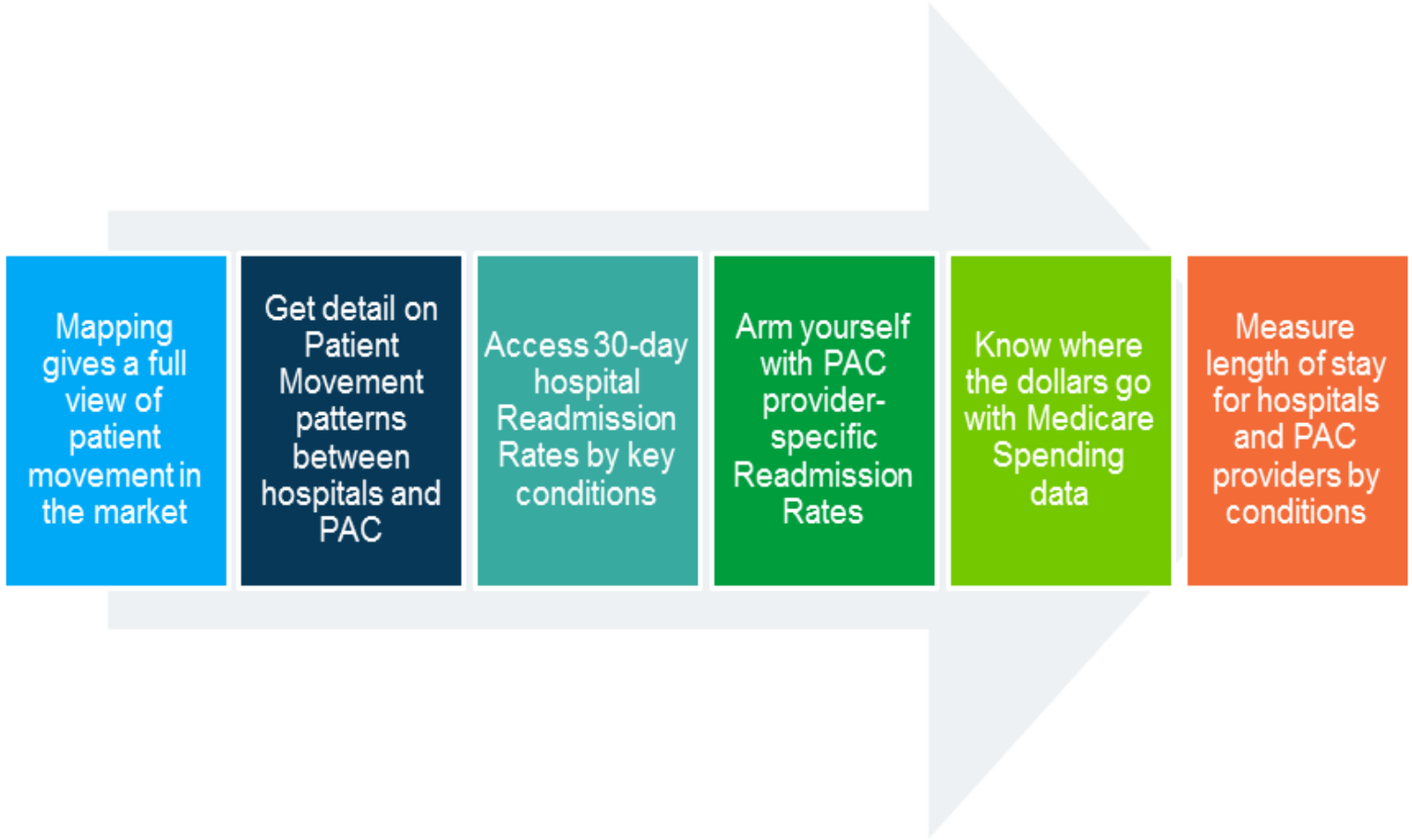
- CMS has implemented a new Medicare Part A and B payment model under section 1115A of the Social Security Act
- Acute care hospitals in certain selected geographic areas will receive retrospective bundled payments for episodes of care for lower extremity joint replacement (LEJR).
- Hospitals will be held accountable for the quality and cost of episodes of care for LEJR- which will serve as motivation for coordination of care between hospitals, physicians and post acute settings
  - The episode starts with the surgical procedure for:
    - MS-DRG 469 (LEJR with complications/co-morbidities)
    - MS-DRG 470 (LEJR without complications/co-morbidities)
- The cost of all services (with few exceptions) paid under Medicare A and Medicare B for 90 days post surgery are counted to allow full recovery period for beneficiaries
- At the end of each performance year, actual spending will be compared to targeted spending to determine additional payment to the hospital or payback to Medicare from the hospital

# Advanced Primary Care Initiatives

- CMS started initiatives to test innovations in advanced primary care including:
  - Mechanisms to encourage more comprehensiveness in primary care delivery;
  - Improve the care of complex patients;
  - Facilitate robust connections to the medical neighborhood and community-based services
  - Move reimbursement from encounter-based towards value-driven, population-based care
- Programs include
  - Comprehensive Primary Care Initiative- 445
  - Federal Qualified Health Centers (FQHC )Advanced Primary Care Practice Demonstration- 434
  - Advanced Primary Care Initiatives- under development
  - Graduate Nurse Education Demonstration-5
  - Independence at Home-13 Independent Practices and 1 Consortium
  - Multi-Payer Advanced Primary Care Practice-5
  - Transforming Clinical Practices Initiative-39

# Data, Data, Data
# What to do with it?

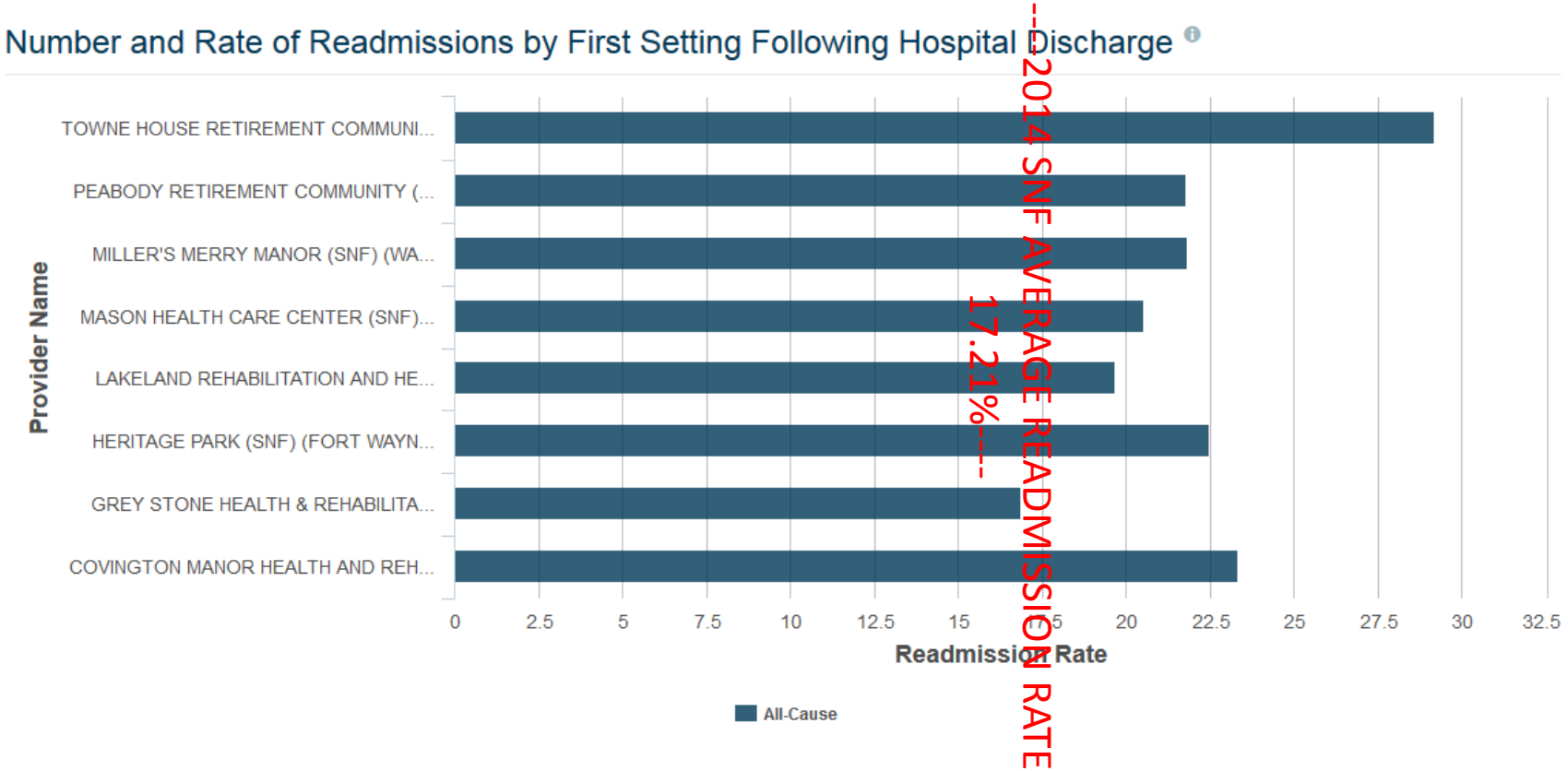
# Example: Avalere Vantage Care Positioning System



# TOP SNF COMPETITORS

| Sender | Receiver | Volume | Percent of Senders Discharges |
|---|---|---|---|
| KOSCIUSKO COMMUNITY HOSPITAL (STACH) (WARSAW,IN) (150133) | MASON HEALTH CARE CENTER (SNF) (WARSAW,IN) (155003) | 106 | 9.99 |
| KOSCIUSKO COMMUNITY HOSPITAL (STACH) (WARSAW,IN) (150133) | MILLER'S MERRY MANOR (SNF) (WARSAW,IN) (155049) | 92 | 8.67 |
| KOSCIUSKO COMMUNITY HOSPITAL (STACH) (WARSAW,IN) (150133) | GRACE VILLAGE HEALTH CARE FACILITY (SNF) (WINONA LAKE,IN) (155635) | 82 | 7.73 |
| KOSCIUSKO COMMUNITY HOSPITAL (STACH) (WARSAW,IN) (150133) | WARSAW MEADOWS (SNF) (WARSAW,IN) (155566) | 35 | 3.3 |
| | | | |
| LUTHERAN HOSPITAL OF INDIANA (STACH) (FORT WAYNE,IN) (150017) | COVENTRY MEADOWS (SNF) (FORT WAYNE,IN) (155756) | 141 | 2.7 |
| LUTHERAN HOSPITAL OF INDIANA (STACH) (FORT WAYNE,IN) (150017) | COVINGTON MANOR HEALTH AND REHABILITATION CENTER (SNF) (FORT WAYNE,IN) (155446) | 124 | 2.37 |
| LUTHERAN HOSPITAL OF INDIANA (STACH) (FORT WAYNE,IN) (150017) | TRANSITIONAL CARE UNIT OF ST JOSEPH (SNF) (FORT WAYNE,IN) (155356) | 49 | 0.94 |
| LUTHERAN HOSPITAL OF INDIANA (STACH) (FORT WAYNE,IN) (150017) | LUTHERAN LIFE VILLAGES (SNF) (FORT WAYNE,IN) (155586) | 44 | 0.84 |
| LUTHERAN HOSPITAL OF INDIANA (STACH) (FORT WAYNE,IN) (150017) | KINGSTON CARE CENTER OF FORT WAYNE (SNF) (FORT WAYNE,IN) (155479) | 42 | 0.8 |
| LUTHERAN HOSPITAL OF INDIANA (STACH) (FORT WAYNE,IN) (150017) | WELLBROOKE OF WABASH (SNF) (WABASH,IN) (155806) | 36 | 0.69 |
| | | | |
| PARKVIEW REGIONAL MEDICAL CENTER (STACH) (FORT WAYNE,IN) (150021) | LIFE CARE CENTER OF FORT WAYNE (SNF) (FORT WAYNE,IN) (155266) | 17 | 0.25 |
| PARKVIEW REGIONAL MEDICAL CENTER (STACH) (FORT WAYNE,IN) (150021) | SUMMIT CITY NURSING AND REHABILITATION (SNF) (FORT WAYNE,IN) (155159) | 17 | 0.25 |
| PARKVIEW REGIONAL MEDICAL CENTER (STACH) (FORT WAYNE,IN) (150021) | WELLBROOKE OF WABASH (SNF) (WABASH,IN) (155806) | 17 | 0.25 |

# Compare SNF Performance: Readmission Rates

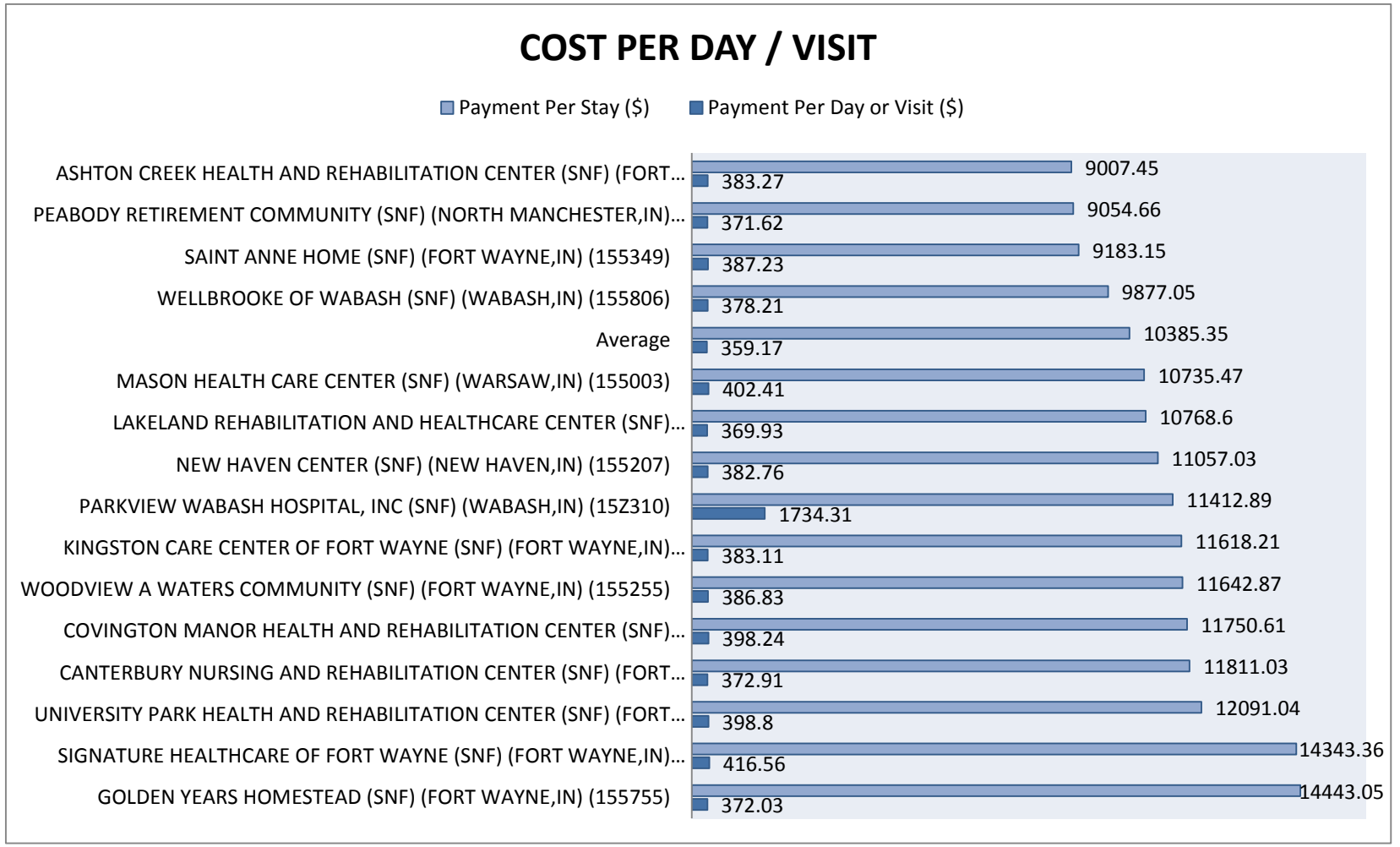


# HOSPITAL PERFORMANCE: EPISODE SPENDING PER BENEFICIARY

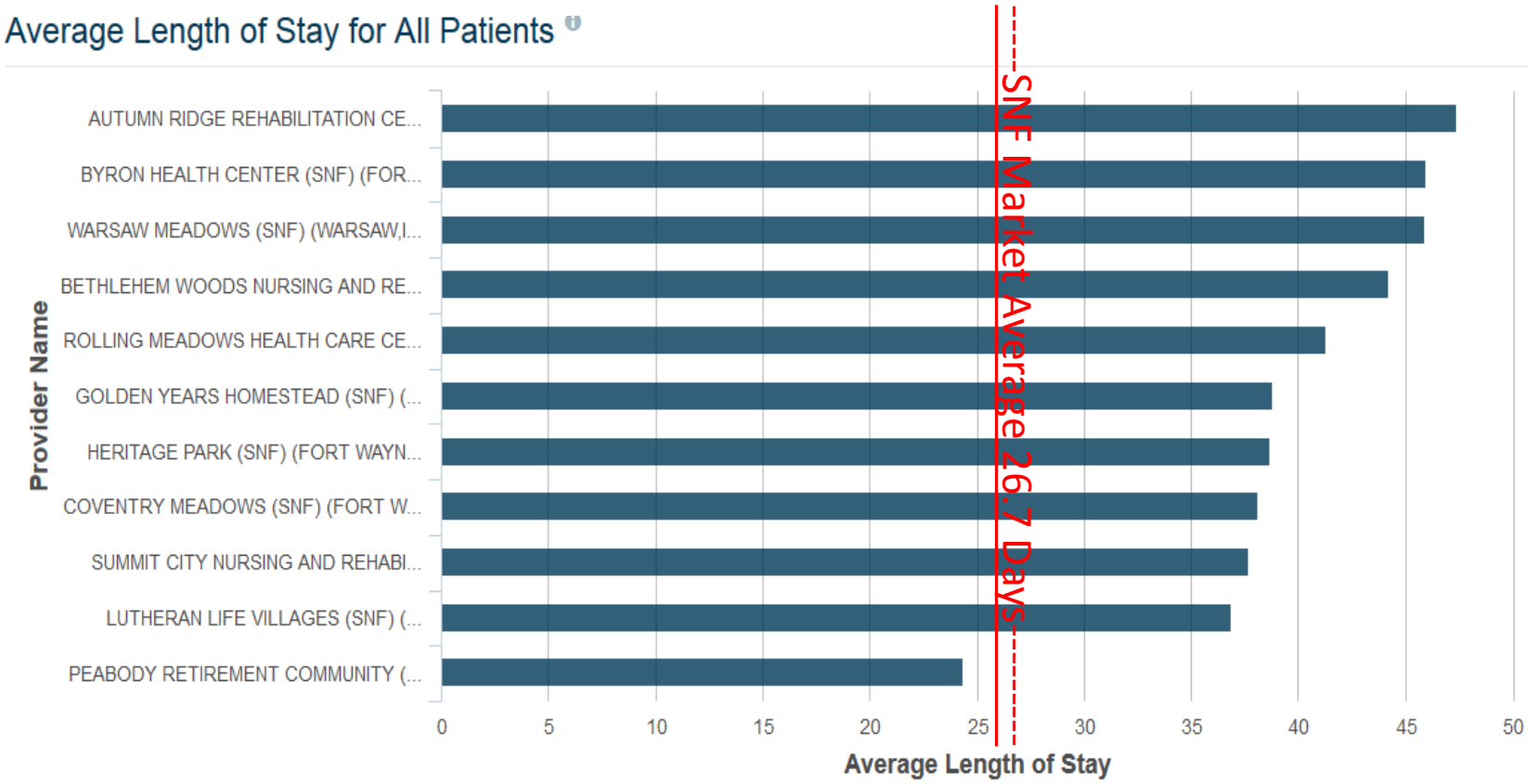
HIGHER THAN MARKET SPENDING MAY SCRUTINIZED - HOSPITALS WILL BEGIN TO TARGET READMISSIONS AND OTHER EFFORTS TO REDUCE EPISODE SPENDING

| Provider Name | Total Spending ($) | Inpatient Spending ($) | Outpatient Spending ($) | SNF Spending ($) | HHA Spending ($) | DME Spending ($) | Physician Spending ($) | Hospice Spending ($) |
|---|---|---|---|---|---|---|---|---|
| Market Average | 19920.86 | 1768 | 907.57 | 4123.57 | 324.14 | 102.86 | 2687.43 | 108.4 |
| State Average | 19070.87 | 2249.6 | 866 | 3773.33 | 556.45 | 121.7 | 2565.93 | 94.14 |
| KOSCIUSKO COMMUNITY HOSPITAL (STACH) (WARSAW,IN) (150133) | 16301 | 1751 | 686 | 5152 | 267 | 105 | 2033 | 104 |
| LUTHERAN HOSPITAL OF INDIANA (STACH) (FORT WAYNE,IN) (150017) | 21362 | 2471 | 1369 | 3604 | 316 | 153 | 3229 | 143 |
| PARKVIEW REGIONAL MEDICAL CENTER (STACH) (FORT WAYNE,IN) (150021) | 20522 | 2137 | 1260 | 4108 | 422 | 145 | 2732 | 127 |

# Compare SNF Performance: Spending



# Compare SNF Performance: Length of Stay



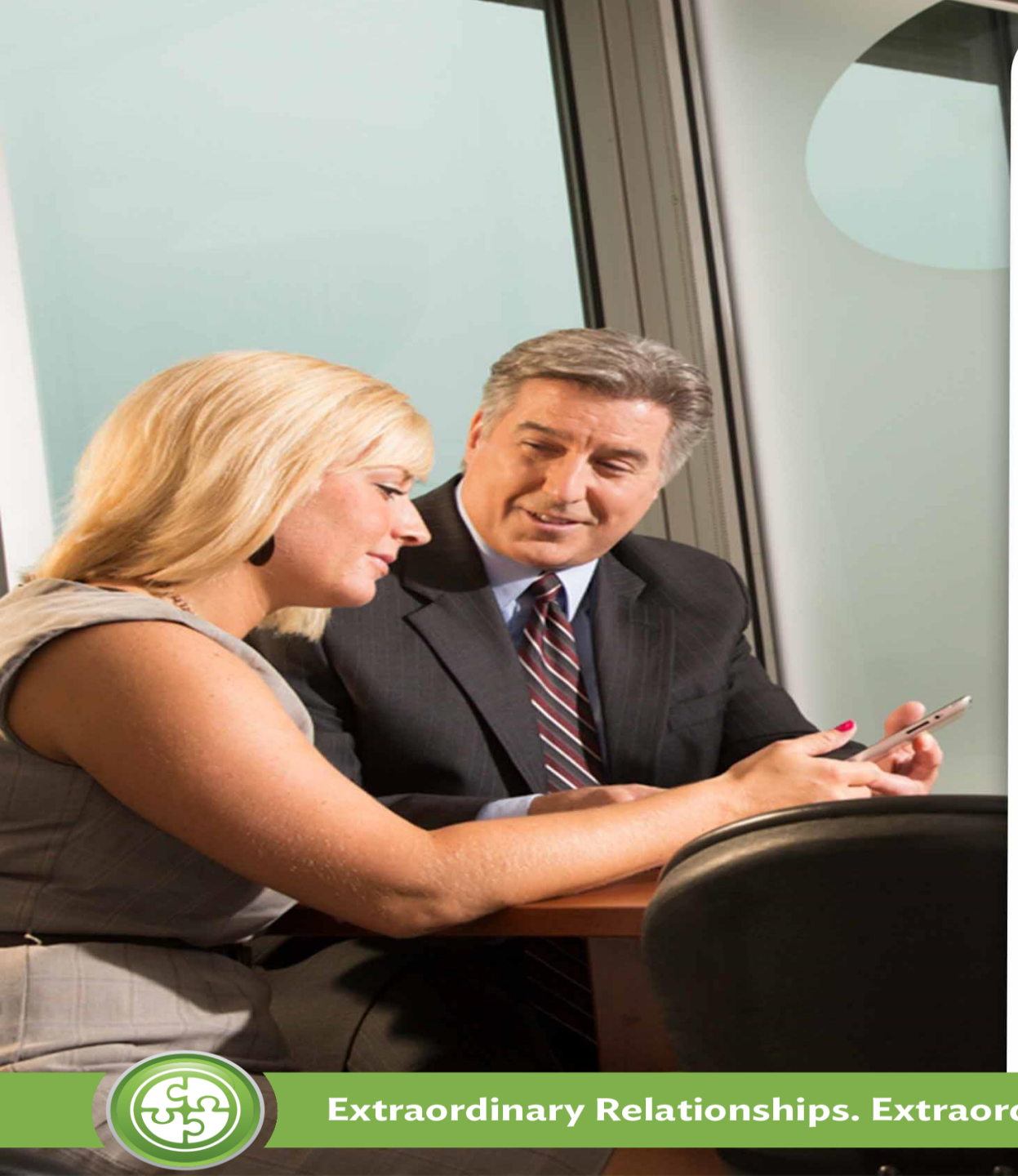
# Peabody retirement community Bundled Payment Calculator: All Patients All Conditions 30 Days

| Episode-Level Metrics | | | |
|---|---|---|---|
| **All patients all conditions** | **Facility** | **Market Area** | **State** |
| Number of episodes | NR | 2,986 | 45,098 |
| Percent of episodes with a rehospitalization | 16% | 15% | 15% |
| Percent of rehospitalizations for the same condition as the initial hospitalization | 0% | 0% | 0% |
| Percent of rehospitalizations that returned to a different hospital | 40% | 25% | 24% |
| Length of stay at initiator | 20.69 | 20.39 | 20.82 |
| Average episode payment | $9,852.67 | $9,980.71 | $11,075.80 |
| Average payment for episode with a rehospitalization | $13,278.13 | $16,429.30 | $18,441.63 |
| Average payment for episode without a rehospitalization | $9,204.61 | $8,884.04 | $9,749.81 |
| Average payment for initiating index stay | $7,873.97 | $7,708.98 | $8,410.20 |

# Key Enablers to Manage and Reduce Readmissions

## Peabody Retirement Community Readmission Reduction Plan

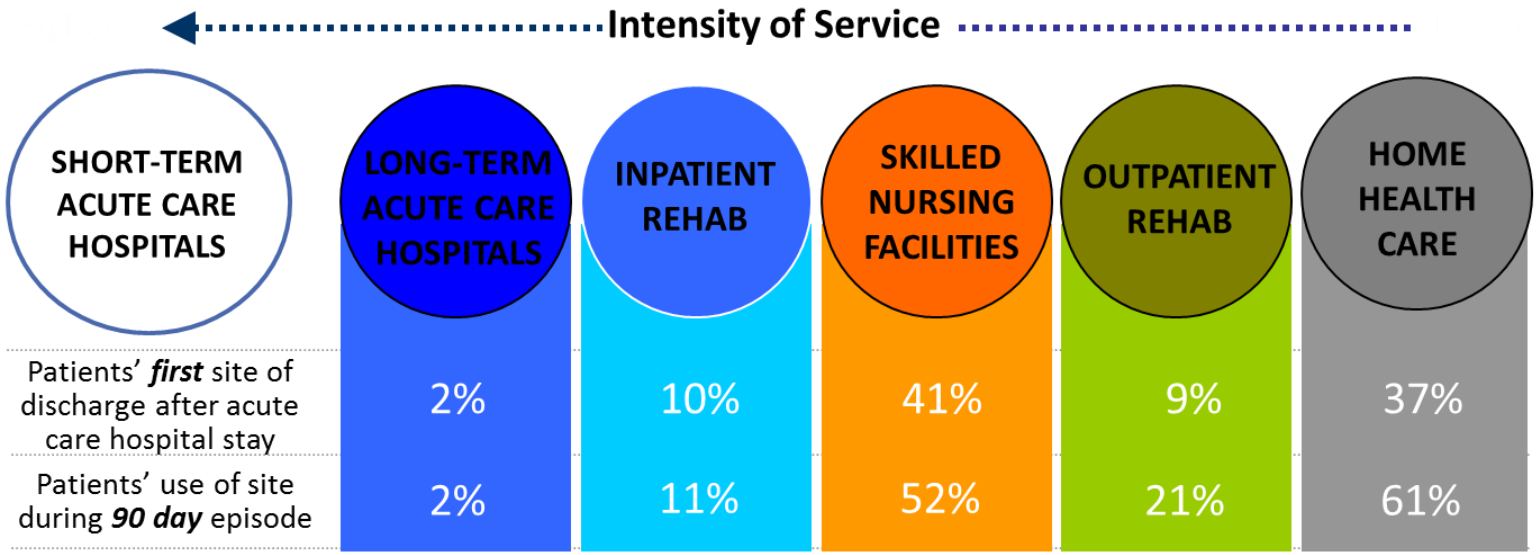
- **Measure** –Peabody Retirement Health and Rehab measures readmissions rates and understand the sources of readmissions.
- **Design and Document** –Peabody Retirement utilizes programs and systems targeted toward reducing readmissions and be able to successfully document the results of these programs.
- **Communicate**–Peabody Retirement communicates to staff and to other providers their readmissions rates and maintains a strong and successful effort at reducing rates.
- **Collaborate**–Peabody Retirement collaborates to facilitate high-quality partnerships, which will allow for better care coordination and improved care transitions
- **Peabody Retirement Community is the Post Acute Care Provider of Choice**



# Strategies- What Makes an Attractive Post Acute Partner

# Episode of Care Dynamics

**Medicare Patients' Use of Post-Acute Services Throughout an "Episode of Care" (1)**




35% of Medicare Beneficiaries are Discharged from Acute Hospitals to Post-Acute Care

***52% of the 35% are admitted to SNFs within 90 days ***

(1) Source: RTI, 2009: Examining Post Acute Care Relationships in an Integrated Hospital System

# How Are Hospitals being Measured?

Hospital Readmission Reduction Program (HRRP)

Applicable Conditions measured for Readmissions

- Adopted Medicare readmission measures for the applicable conditions of
  1. Acute Myocardial Infarction (AMI),
  2. Heart Failure (HF) and
  3. Pneumonia (PN)
  4. Patients admitted for an acute exacerbation of chronic obstructive pulmonary disease (COPD)
  5. Patients admitted for elective total hip arthroplasty (THA) and total knee arthroplasty (TKA).

# Profiling for Partnerships: How to Best Position Yourself as the Preferred Post Acute Setting

# Top Outcomes which SNF providers will be measured by hospitals include:

- **Lowest cost**, as measured by length of stay (LOS)
- **Perceived quality of care and outcomes**.
- **Readmissions**-Incidents of hospital readmissions
- **Communication and coordination of care**

# Who Do You Want to Partner With?

- Determine potential community partners
- Explore links with ACOs, Bundled Payment Care Initiatives and Managed Care Organizations

http://innovation.cms.gov/

- Make note of community providers' status:
  - Hospital strengths and weaknesses
  - Hospital's highest priorities
  - Readmission rates
  - Hospitals and physician relationships already established
  - Area's you can assist with – what do you have that they need?

# SNF Opportunity

Although LTACH and IRF have a lower 30 day readmission rate – 10% and 7.2% respectively, they are much more costly settings;

Home Health is the least costly setting yet their 30 day readmission rate sits at 29%

- SNF costs although greater than Home Health are moderate compared to LTACH and IRF
- SNF 30 day readmission rate is 21%
- MedPAC's target for 30 day readmission rate is 8%, so if the SNF can bring down their readmission rate while maintaining a lower cost they will be the setting of choice for hospitals

•*Dr. Kathleen Griffin, National Director of Post Acute and Sr. Services, Health Dimensions Group

# Who Do You Want to Partner With?

Once you decide on the community providers you can best align your facility with, then you can begin to position yourself for partnership by implementing these 3 steps:

1. Self Assess your clinical abilities and develop areas of need
2. Determine relationship strategies
3. Pull key data and outcomes for reporting

# 1. Self Assess and Develop

**What can you say about your ability:**

- To care for the higher acuity patient – what is the skill set of your nursing and therapy departments?
- To accept admissions 24/7?
- To turn around lab results?
- To provide radiological services 24 hr capability?
- To provide Advance Care Planning?
- To provide medication reconciliation
- To provide comprehensive discharge planning upon admission?
- To provide respiratory therapy services/pulmonary programming?
- To utilize EMR?

# 2. Determine Relationship Strategies

- Ensure systems are in place for admitting hospital discharged patients within 30 days
- Determine quarterly and/or monthly meetings with hospital personnel
  - Always bring data of interest
- Determine expectations of ER physicians /what clinical steps should the facility take prior to sending a patient to the ER
- Provide education to hospital staff related to SNF regulatory updates; also ask hospital to include your SNF in educational opportunities, particularly regarding nursing care
- Determine the need for a facility/hospital liaison for enhanced communication and timely actions

# 3. Pull Key Data and Outcomes for Reporting

- Quality Measures that help your facility become the  Preferred Discharge Destination
  - Patient/family satisfaction reports
  - Statistical reporting:
    - Patient functional outcome scores
    - LOS – overall and by diagnosis; current and goals
    - Discharge destination
    - Staffing – quantity and quality

      Therapy  and Nursing Expertise

# 3. Pull Key Data and Outcomes for Reporting (continued)

  - Re-hospitalizations by diagnosis, particularly COPD, CHF, Total Hip and Total Knee replacements, Pneumonia, MI
  - Re-hospitalization rates with goals/expectations
- Annual State Survey Results
- 5 Star Rating Status
- Data Collection from Peers (seek out statistical information from CMS, OIG, Pepper Reports, Avalere, etc)

# Quality Measures -Rehabilitation Outcomes Implementation

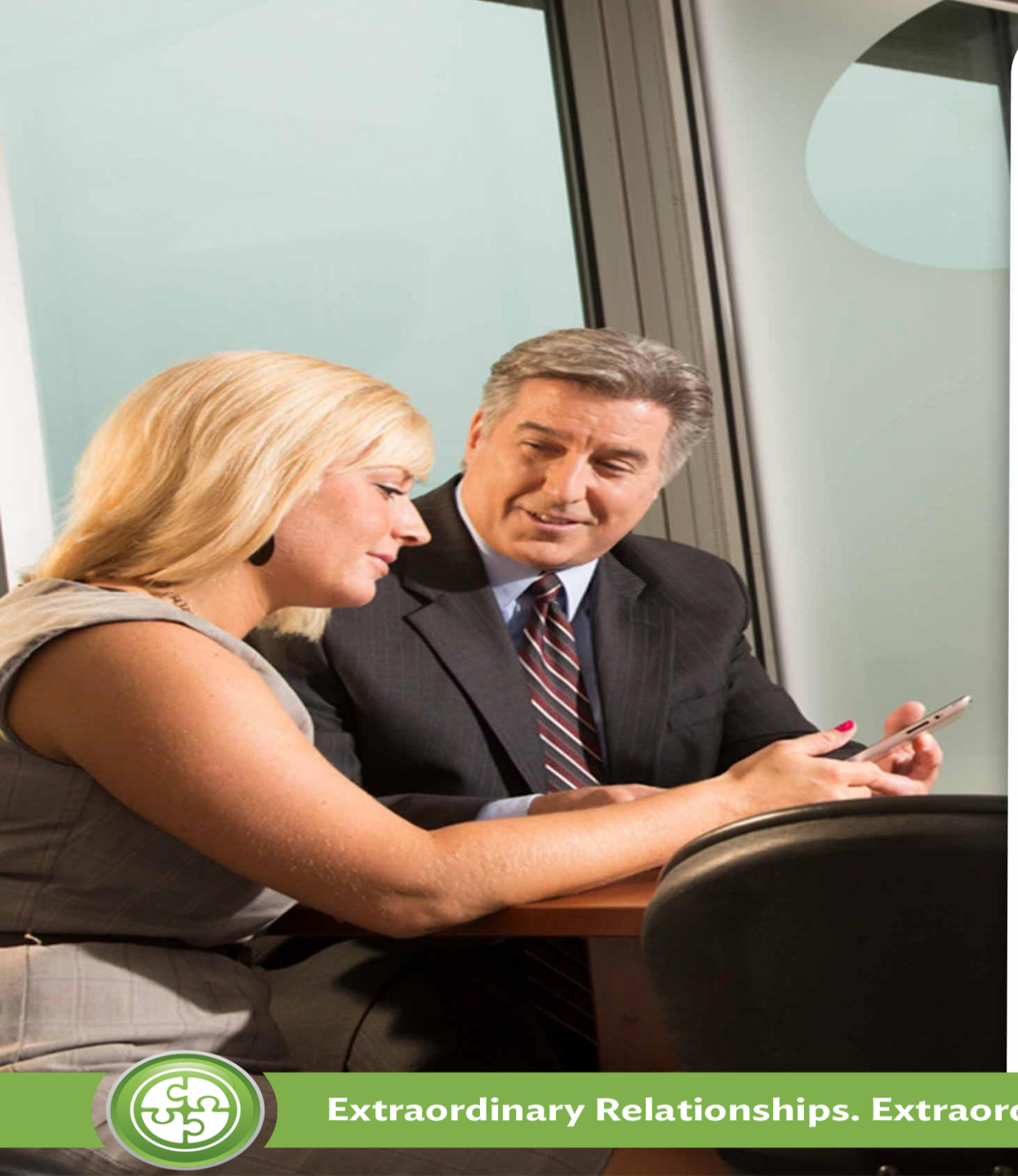
Ensure therapy is utilizing an outcomes measure program

- Establish a means of collecting rehabilitation data in a consistent manner to allow analysis prior to hospital meetings:
  - Follow changes in functional status
  - Measure the effectiveness of treatment
  - Track and report to assess quality and cost effectiveness of program
- Be knowledgeable of the systems used for obtaining outcomes/tool
  - Software/Services
  - Partnering with Contracted Therapy
    - Established Outcome tool/new subsets of Care Tool (mobility and self care)
    - Inter rater reliability
    - Report Capability/level of standardization
    - 3rd Party Surveys

# Utilizing Data: What to Share and How to Share It

Pull together a profile of the building to help “sell value” to ACO’s/hospitals and show metrics that highlight strengths of your facility/program

- What information do you have about your facility to share each month/quarter?
- What information do you have about your areas of improvement?
- What information do you have about your facility and others in your community/state/nation that can be compared in a favorable way?



# Reporting

# Facility Data for Reporting and Networking

Areas to Consider:

- Facility Key Facts
- Specialty Skilled Services
  - Nursing
  - Therapy
  - Other
- Discharge Destination
  - Return to Home
  - Re-hospitalizations
- Data by Diagnosis
- Cost/Length of Stay
- Resident Satisfaction/Reported Outcomes
- Rehab Outcomes
  - Patient Specific
  - All Inclusive

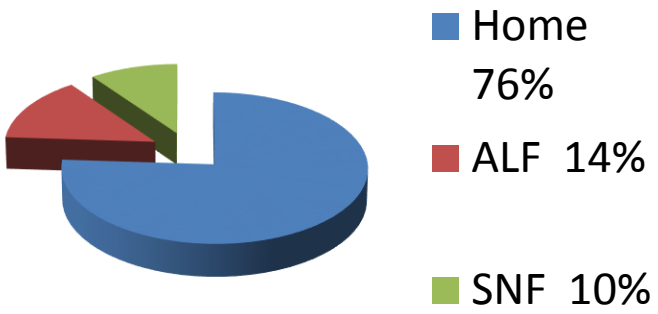
# Facility Report

## Facility Facts

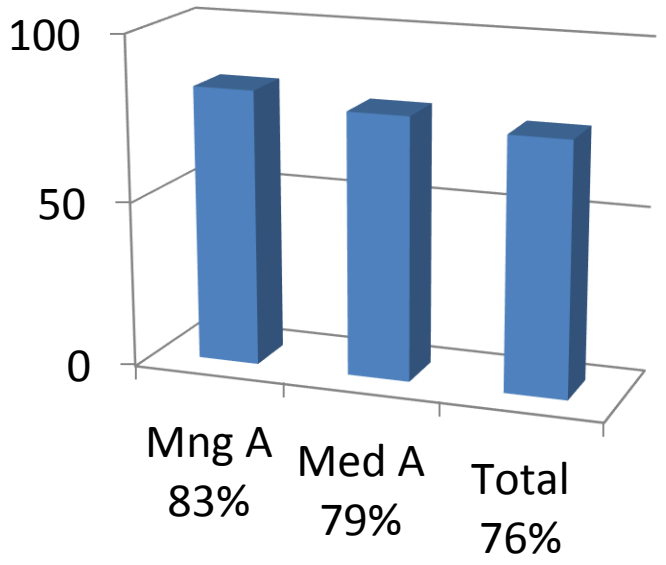
| | |
|---|---|
| **Age Range accepted** | Under 60 case by case |
| **Average Age** | 74 years old |
| **Bariatric Care** | Case by case |
| **Smoking/ Non-smoking** | Non smoking campus |
| **Respiratory Services** | Pulmonary Programming 7 days |
| **Orthopedic Specialty Program** | 14 to 18 day Stay |
| **Therapy Availability** | 7 days per week |
| **Therapy Intensity** | 77% receive 2.5 hrs per day |

# Facility Report

## Discharge Destination




## Return Home



# Facility Re-hospitalization

| | |
|---|---|
| **State of NJ Annual Average** | **11.1%** |
| **Facility Quarter 1 2015 Average** | **13.6%** |
| **Facility Quarter 1 2016 Average** | **11.7%** |

- Know the Acute Care Hospitals readmission rates and how they monitor the post acute continuum
- Establish effective communication between physician and nursing to address care issues proactively
- Share educational programs that have been put in place to impact the reduction of re-hospitalizations

# Facility Re-hospitalization by Diagnosis

## Share Improvements

| Diagnosis | Re-Hospitalization Rate for Q1 | Re-Hospitalization Rate for Q2 |
|---|---|---|
| COPD | 10% | 0 |
| CHF | 12% | 7% |
| Total Hip Replacement | 8% | 2% |
| Total Knee Replacement | 4% | 0 |
| Myocardial Infarction | 8%% | 5% |
| Pneumonia | 12% | 2% |

# Managing Appropriate Length of Stay – LOS

- Ensure that discharges are appropriate and that all safety and education are completed prior to D/C
  - Utilize methods to get patient and family buy-in throughout the episode of care; incorporate in Facility Care Planning
  - Home Assessments
- Weigh effective **care** and **costs**:
  - Premature discharges can result in subsequent readmissions back to acute care
  - Inefficiencies can result in unnecessary extended stays

*NOTE: Either of the above will be costly and detrimental*

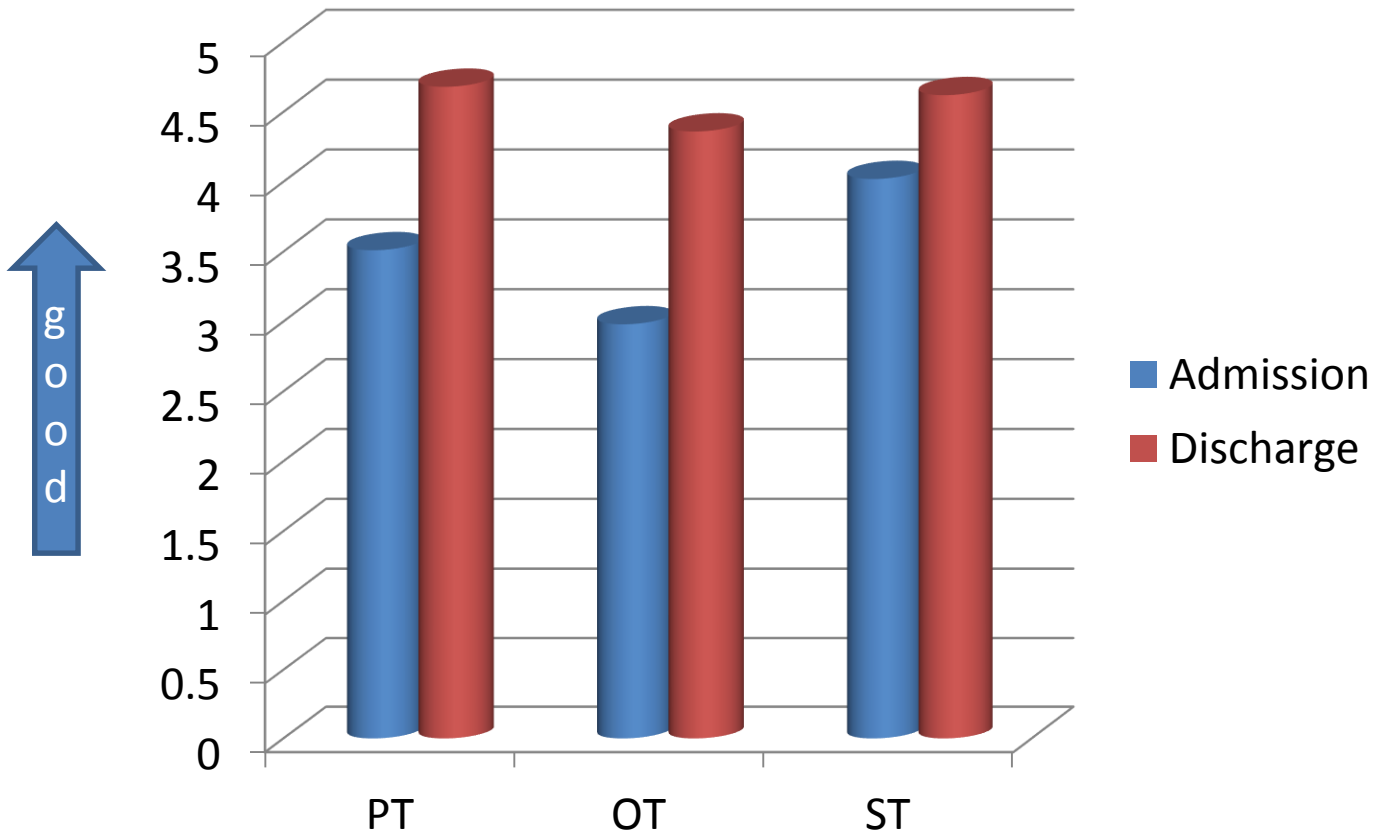
# Length of Stay - LOS In Days

## Share Ongoing Goals

| Diagnosis | Q1 LOS | Q2 LOS | Q3 Goal LOS |
|---|---|---|---|
| COPD | 23.55 | 20.83 | 19.00 |
| CHF | 24.10 | 20.33 | 19.00 |
| Total Hip Replace | 35.67 | 31.75 | 27.50 |
| Total Knee Replace | 17.15 | 15.40 | 14.00 |
| Pneumonia | 15.25 | 16.44 | 15.00 |
| MI | 16.23 | 14.00 | 14.00 |

# Facility Report

## Therapy Clinical Outcomes



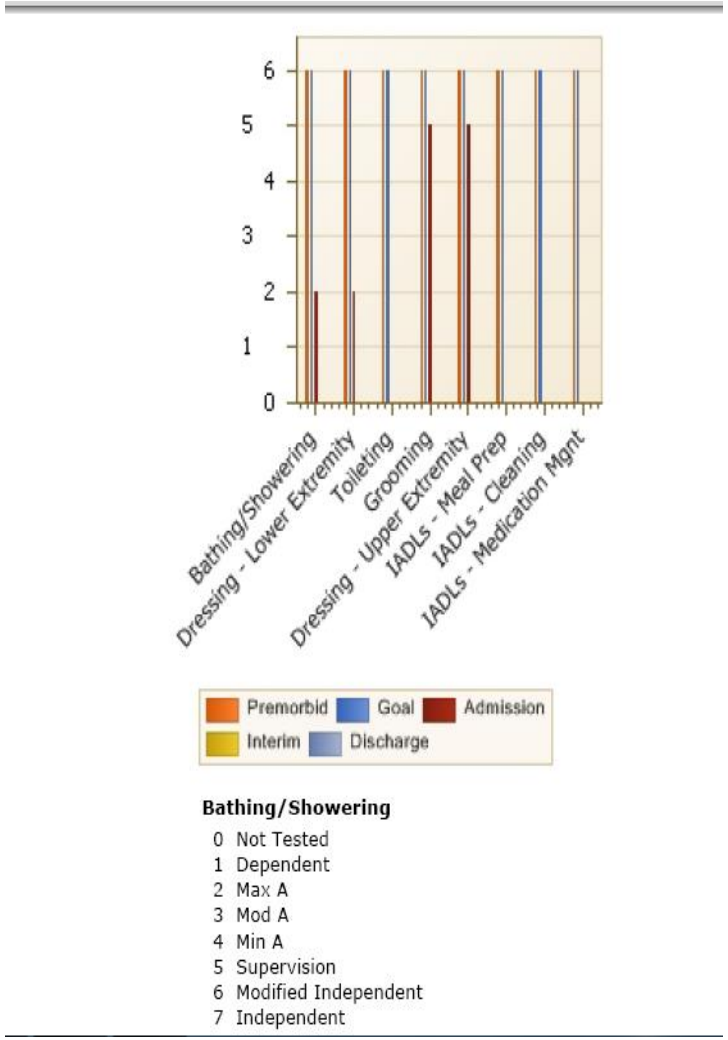

**Clinical Measures Outcomes Measure Scoring PT & OT**

1 = Dependent
2 = Maximum Assist
3 = Moderate Assist
4 = Minimum Assist
5 = Supervision
6 = Modified Independent
7 = Independent

**Clinical Measures Outcomes Measure Scoring Speech Pathology**

1 = Severe impairment
2 = Moderate to Severe Impairment
3 = Moderate Impairment
4 = Mild to moderate Impairment
5 = Mild Impairment
6 = Trace Impairment
7 = Within Normal Limits

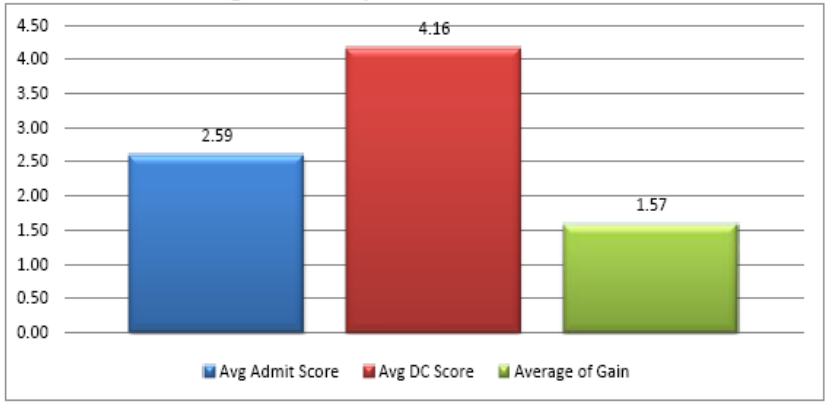
# Patient Specific Reports

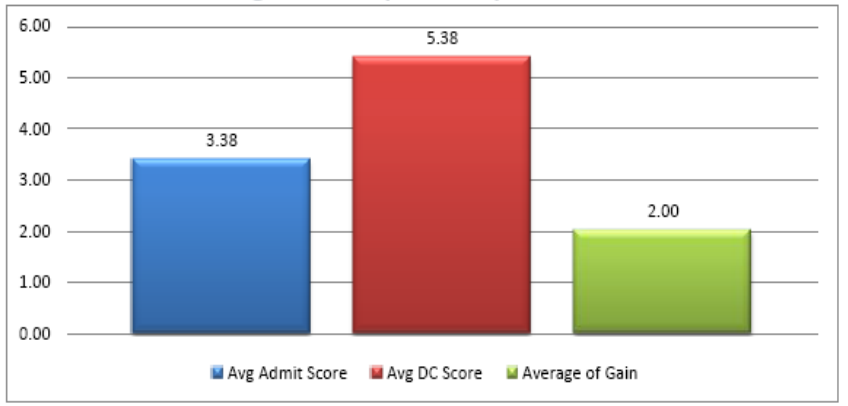


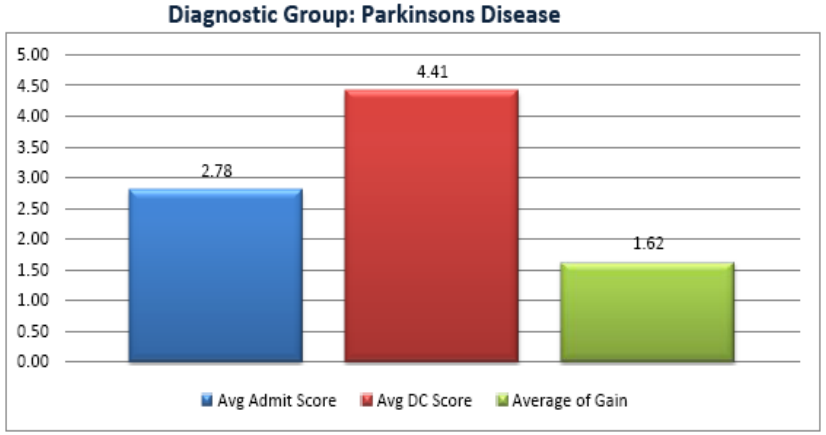

Does the Patient Agree?

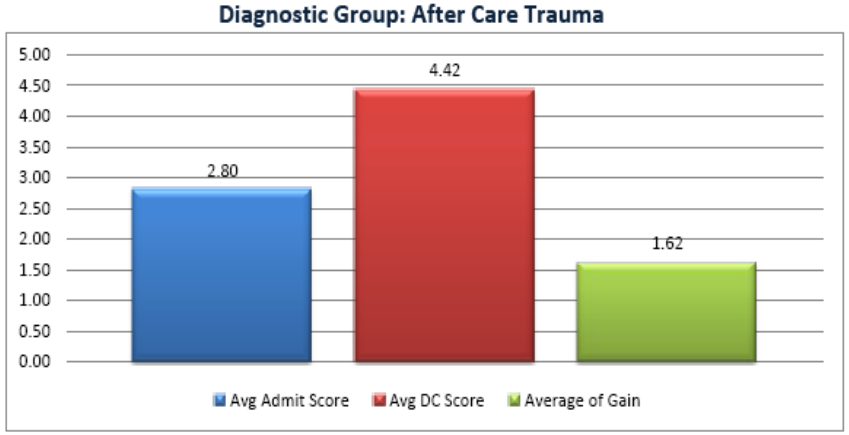
- Compare Therapy Report to Resident Reported outcomes and satisfaction surveys
  - What activities can you complete with increased independence?
  - Did your therapy program assist you in achieving your goals established upon admission?

# Facility Report




Diagnostic Group: Cognitive Disorder

Diagnostic Group: Chronic Skin Ulcer

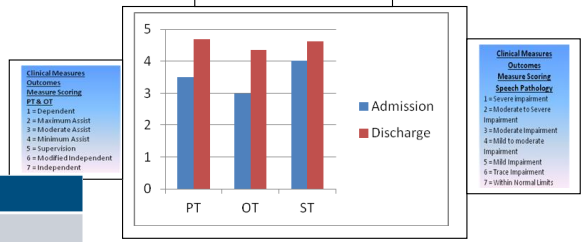
# Facility Report

***Facility Facts***

| | |
|---|---|
| Age range of residents | Under 60 case by case |
| Average Age | 77 years old |
| Bariatrics | Case by case consideration |
| Smoking | Non smoking campus |

| | |
|---|---|
| **Typical Length of Stay** | 24 days |
| **Therapy Availability** | 7 days/week |
| **Therapy Intensity** | 72% receive 2.5 hrs/day |
| **Specialty Services** | Memory Care |

**Clinical Outcomes**



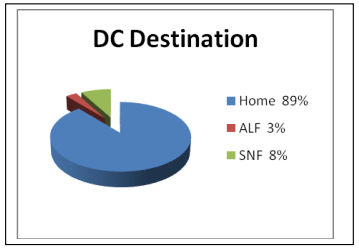

| | |
|---|---|
| **State of Florida Annual Average** | **23.4%** |
| **Facility Quarter 2 2014 Average** | **17.2%** |
| **Facility Quarter 2 2015 Average** | **13.3%** |

| Diagnosis | Q1 LOS | Q2 LOS | Q3 Goal LOS |
|---|---|---|---|
| COPD | 23.55 | 20.83 | 19.00 |
| CHF | 24.10 | 20.33 | 19.00 |
| Total Hip Replace | 35.67 | 31.75 | 27.50 |
| Total Knee Replace | 17.15 | 15.40 | 14.00 |
| Pneumonia | 15.25 | 16.44 | 15.00 |
| MI | 16.23 | 14.00 | 14.00 |

**Patient Satisfaction**

| | PT | OT | ST |
|---|---|---|---|
| Courtesy of therapist | 4.50 | 4.60 | 4.25 |
| Therapist explained treatment & program | 4.55 | 4.70 | 4.25 |
| Involved in setting goals | 4.40 | 4.63 | 4.25 |
| Therapist helped meet goals | 4.50 | 4.66 | 4.25 |
| **Likelihood to recommend Homeward Bound program** | **4.10** | | |

***Base upon rating 1-5 with 5 as the highest score




| | |
|---|---|
| ***Return to Hospital within 30 days*** | **11%** |

**Stonebridge** makes referrals to **SSM**:

| | |
|---|---|
| ✓ | E.D./Hospital |
| ✓ | Home Care |
| ✓ | Hospice |

# Resource Available to AHCA Members

**LTC Trend Tracker**

- Web based program that shows a dashboard of trends and statistics from CMS
- Reports of hospital readmissions and discharge to community rates
- Can build and save custom reports
- Easy, clean and fast to use
- www.ltctrendtracker.com

# Hospital CEOs considerations for determining referrals

- Return to Hospital rate
- Use of continuum services/referrals to hospital
- Use of ancillary services, i.e. lab, radiology

# Five Questions to ask Case Managers/Social Workers

1. What are the top 3-4 issues that influence a referral?
2. What most often influences the patient/family decision?
3. How often do families request to tour a facility prior to making a decision?
4. Do specialty services, i.e. respiratory therapy, massage therapy, specialists, make a difference?
5. What percent of referrals have insurance other than Medicare?

# Reasons Case Management or Social Worker refer to a SNF

1. Location of patient's home or family members' home
2. Insurance
3. PCP/physician referral
4. Speed of response once referral is made
5. Relationship with facility marketer/admissions staff
6. Patient/family previous experience at facility
7. Dialysis availability
8. Reputation of facility/referral from someone patient/family knows
9. Medicare.gov website reviews (Star rating)
10. Age of patient
11. Diagnosis
12. Smoking
13. Return to hospital rate
14. Transportation

# Marketing/Business Development

Get your data house in order!

- EMRs with complete, accurate, & solid data you can trust
- Specialization programs that give you the edge in reducing LOS and enhancing quality care
- Outcomes Reports showing your positive trends for lowering costs, boosting quality, and reducing return to hospital

# Case Study Profile – April 2015

**Facility Facts**

- Location: Southeast, Urban
- Facility: SNF- 120 beds, dually certified
- Ownership: For profit – Corporation, part of a small chain

- **Age Range accepted**
  - Under 65 case by case
- **Average Age**
  - 78 years old
- **Bariatric Care**
  - Case by case
- **Smoking/ Non-smoking**
  - Non smoking campus
- **Respiratory Services**
  - Upon request
- **Therapy Availability**
  - 7 days per week
- **Therapy Intensity**
  - 50% receive 2.5 hrs per day

**Star rating:** 

**Summary Overall**: Average

- Health inspection Rating: Above Average
- Staffing Rating: Much Below Average
- Quality Measure Rating: Average

**Competition: 20 facilities within 10 miles**

2-5 Star, 8-4 Star, 7-3 Star, 2-2 Star, 1-1 Star

**Reputation within the Community: 3/5 Stars**

**ALOS**: 26.00 days

**Facility Re-hospitalization Rate**: 17%

**Patient Satisfaction Scores**: 68% Top Box Scores

**Outcome Measurements** (General): Average improvement- 1.25 points

# Improvement Plan Implemented

From April 2015- December 2015

## Facility Activities

- Met with local hospital to establish relationship with key players and determine their needs and expectations of SNF partner; SNF/Hospital Liaison assigned
- Provided hospital with improved statistics each quarter during in person meeting; one meeting was held via conference call
- Added Respiratory Therapy – full service
- Initiated a clinical training for nursing including use of a decision flow sheet for identifying patient risk in a timely manner to reduce hospital readmission
- Modified Admission process to include a comprehensive D/C planning meeting within 24 hours; projecting LOS

## Rehab Activities

- Adjusted staffing levels to ensure therapy 7 X a week
- Implemented new "Specialty Orthopedic Program" with high intensity and frequency of treatment (as patients qualify) to ensure a shorter LOS with discharge to a lesser level of care
- Collected and shared functional outcome measure statistics by diagnosis for hospital statistical quarterly report
- Provided patients with their individual functional measure report at start of care and upon discharge; Patient Therapy Satisfaction also presented at discharge
- Provided a formal report on therapy Quality Assurance; focus on required documentation

# Case Study
# Profile – January 2016

**Facility Facts**

- Location: Southwest, Urban
- Facility: SNF- 120 beds, dually certified
- Ownership: For profit – Corporation, part of a small chain

- **Age Range accepted**
  - Under 65 case by case
- **Average Age**
  - 78 years old
- **Bariatric Care**
  - Case by case
- **Smoking/ Non-smoking**
  - Non smoking campus
- **Respiratory Services**
  - Pulmonary Programming 7 days
- **Orthopedic Specialty Program**
  - 14 to 18 day Stay
- **Therapy Availability**
  - 7 days per week
- **Therapy Intensity**
  - 66% receive 2.5 hrs per day

**Star rating:**

**Summary Overall**: Average

- Health inspection Rating: Above Average
- Staffing Rating: Much Below Average
- Quality Measure Rating: Average

**Competition: 20 facilities within 10 miles**

2-5 Star, 8-4 Star, 7-3 Star, 2-2 Star, 1-1 Star

**Reputation within the Community: 3+/5 Stars**

**ALOS**: 19.50 days

**Facility Re-hospitalization Rate**: 11.5%

**Patient Satisfaction Scores**: 75% Top Box Scores

**Outcome Measurements** (General): Average improvement- 1.85 points

# Case Study – Impact on SNF

Facility Average Census for 8 months of study:

| April Baseline | May | June | July | Aug | Sept | Oct | Nov | Dec | Ave. Improv. |
|---|---|---|---|---|---|---|---|---|---|
| 87% | 87% | 88% | 88% | 91% | 91% | 91% | 92% | 92% | 2.9% |

Hospital Referrals for 9 months of study:

| April Baseline | May | June | July | Aug | Sept | Oct | Nov | Dec | Ave. Improv. |
|---|---|---|---|---|---|---|---|---|---|
| 11 | 12 | 14 | 18 | 18 | 18 | 19 | 18 | 17 | 5.2 Ref/mnth |

# Summary- Final Thoughts

- ACO, Shared Savings Programs and Bundled Programs are showing their value through improved outcomes and cost savings
- Determine your current position in the community and where you want to see your SNF in the next 2 to 5 years;
- Are you a “contender” in the eyes of your community?
- Know your clinical data, quality data, market data, and how it is all integrated so that you can pull it all together and know what your true cost is and what your true outcomes are.
- Quality Measures are critical for determining where you are and where you need to go; pull data that is available to you and utilize to create your plan
- Build and/or enhance your community/hospital relationships and support that with facts and areas of improvement
- Focused planning and implementation, utilizing all departments and rehab partners will lead you to becoming the partner of choice

# Questions?
# Thank You