Objectives

1. Describe the new sales process and how it differs from the traditional
2. What matters most in distinguishing your organization
3. Show how Home Health and Hospice can provide value to the referral sources and boost THEIR bottom line

About Arnie Cisneros, PT

1. 30+ years as Physical Therapist
2. President of HHSM
3. Contracted with DMC Pioneer ACO
4. Contracted with multiple national ACO organizations on episodic payment reductions
Michael Deck
- 16 years experience in Home Health
- 3 years in Assisted Living
- Project Manager for HealthCare Synergy
  - Focus on HIE, interoperability, care continuum, and communications (non-traditional Medicare)

Patient Census
"Members of the baby-boom generation (born between mid-1946 and 1964) began aging into Medicare in 2011 at a rate of about 10,000 people per day, a rate that will continue until 2030. Over the next 15 years, Medicare's enrollment is projected to increase almost 50 percent—rising from 54 million beneficiaries today to more than 80 million beneficiaries in 2030."


Patient Census
"We announced today the participants in the Next Generation ACO model. In Next Gen, provider groups take full financial responsibility for a patient’s care and have innovative options like telemedicine, home visits, and direct consumer incentive and engagement options. It’s a model driven by all the lessons learned and feedback from previous participants and results. And the news is very good. With 21 new Next Gen ACOs, there will be over 475 total ACOs with 30,000 physicians participating around the country, including 64 that are 2-sided or full risk, up from 19 just last year and of course zero before the Affordable Care Act. My read of this news is that in 2016, we have not only more ACOs, but better ACOs. In total, 8.9 million Medicare FFS beneficiaries, or greater than 1 in 5, in 49 states and the District of Colombia, will now be a part of an ACO, with 1.6 million in better, more advanced models."

Traditional Marketing

- Target list:
  - Independent Physicians
  - Hospital Based Physicians
  - Skilled Nursing Facilities
  - Assisted Living Facilities

What do we “sell” them:

- 5 star ratings
- Quality of Care
- Insurance Coverage
- Geographic Location
- We sell the business of how we provide care for a patient.

Integrated Approach

- RFP
- Applications
- Interview
- Secondary Interview
- Agreements
How to succeed

- Accountable Care Organizations (ACOs) are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to their Medicare patients.

- The goal of coordinated care is to ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors.

Do ACO's truly focus on Care?

- Business of caring for a group but at the end of the day….

Why I didn’t succeed at the interview

- “We were given the opportunity to present about our agency for an ACO but we blew it…”

- We were not prepared to talk about financials.
Financial Statements

- Cost per episode
- Operating costs
- Employee / HR
- Misc costs

- Marketing personal are not privy to this data or understand it.

Truly comes down to price

Understanding of Financials
Can you tell me...
- For a PT only case with broken hip, what is...
  - Your total cost of caring for that patient
  - Your total amount of visits
  - Your total episode period
  - Your cost per visit
  - Your cost per episode

Finding ACA Value in the Home Health Model

Developing Value for the Integrated Era
- How do we improve on the care delivery model we’ve had for more than 25 yrs.?
- Where do we currently use methods that cost more than required to provide care?
- How can we change care focus from a volume-based platform to a value-centric model?
Developing Value for the Integrated Era

- Understand the ACA value Proposition
- Volume to Value shift – deliberate focus
- ACA model ties payment to outcomes
- Cost of Care becomes major factor
- Virtual Care Costs affected by readmits
- Functional Outcomes – bottom line
- Providers need to critically assess value

Making Sense of CMS Alternative Payment Models (Volume to Value)

Alternative Payment Models represent a new set of incentives that build on the recent progress of healthcare. They are slated to improve the efficiency and personalization of care programming by emphasizing care coordination and outcomes by controlling costs. Early returns from APM trials or pilot programs produced improved quality/cost results.
Connecting APMs to ACO Value Quotient

- Post-Acute Value – Role of Care Process
- Integrated Team goals become primary
- Value must be demonstrated beyond $$$
- Readmission data major concern for value
- Post-Acute issues lie with silo behaviors
- Marketing goal – create business alliance
- Risk/Gain – sharing elements possible
- Care Quality history – bottom line for value

Vetting Home Health Providers for the Integrated Era

- Publicly Traded Data – first stop for value
- Star Ratings – 4-5 star required for care ID
- Clinical Outcomes – Meds, Pain, SOB, Inc.
- Clinical Outcomes – Bathing, Gait, Transfers
- Process Measures – Timely Start of Care
- Quality Clinical Programs – related outcomes
- Global Programming – Provider-Neutral care
- Fiscal ID – Financial strength, solvency
Home Health Legacy Behaviors that compromise Value Identity

Legacy Home Health Behaviors re Value

- Timely Admissions – 24 hr. Start of Care
- Therapy – 24 - 48 hr. rehab admission
- Absence of Global Programming – PT/OT(?)
- Gaming of Clinical Care – Staging care, recert
- Volume – Based Clinical Pathways – generic
- Non – Compliant Programming – value(?)
- Missed Care Volumes (Visits), Lack of Skill
- 60 Day Care Focus/Post – Acute Programs

Legacy Home Health Behaviors re Value

- Concerns re mgmt. of Best Practice Care
- Under-Developed SOC Profile – Accurate OASIS
- Front – Line Staff Clinical Care Management
- Lack of Functional Chronic Care Management
- Inconsistent Care Volumes per diagnosis
- Lack of In – Episode care Management
- Absence of Acuity-Based Care – Front-line Staff
- Lack of “Discharge for Outcomes” Culture
Developing your Home Health Value Identity for the Integrated Era

- 24-hour Admissions – 7 Days/Week
- Single-Digit Readmissions – Unified Care Staff
- Global Program Bias – Agency, Clinician, Patient
- Standardized Care – via UTILIZATION REVIEW
- Create Individualized Care Programs – PAC pts.
- Create Frequency/Duration orders – Value ID
- Create “COMPLIANCE” – Based Care Plans
- Eliminate Missed Visits from Care Delivery Model

- Gain Skill at Caregiver Involvement
- Liaison Use for Care Transition Integrity
- IT use – Clinical Reporting for Coverage
- Telehealth for SNF pts. – manage readmits
- Reduce SNF LOS Volume – via clinical acuity
- Manage clinical staff - for care integrity/value
- Internalize Value Model – evolve efficient care
- Create New Programs/Positions/Support
Marketing your Home Health Value Identity for the Integrated Era

- Internalize “Why aren’t you a 5-Star Agency”
- Understand the shortfalls lack of UR presents
- Create Care Programs that match Team goals
- Create and market On-call Readmit strategies
- Market Post-Acute or Chronic Programming
- Resist Subjective Approach – “The best People”
- Market In – Episode Management – for value
- **MANAGE** to Improve Your Care – ongoing demo

Add Value to Referrals

- Quality of Care
- Financial Incentives
- Patient Population
- Experience
How important is Technology?

IMPACT Act of 2014

(a) Requirement for standardized assessment data

(1) In general

The Secretary shall—

(A) require under the applicable reporting provisions post-acute care providers (as defined in paragraph (2)(A)) to report—

(i) standardized patient assessment data in accordance with subsection (b);

(ii) data on quality measures under subsection (c)(1); and

(iii) data on resource use and other measures under subsection (d)(1);

https://www.govtrack.us/congress/bills/113/hr4994/text

IMPACT Timeline

How are we going to share clinical data?

Communication Methods

Health Information Exchange

An HIE moves patient information electronically among physician offices, hospitals and other health professionals directly involved in a patient’s care, such as pharmacies and labs. With an HIE, everyone involved in a patient’s care can “talk” electronically.
Is there one in my state?

What's this DIRECT?

Launched in March 2010 as a part of the Nationwide Health Information Network, the Direct Project was created to specify a simple, secure, scalable, standards-based way for participants to send authenticated, encrypted health information directly to known, trusted recipients over the Internet.

For Real
What data is being shared?

What type of data for Home Health

HITECH is over....

“The Meaningful Use program as it has existed, will now be effectively over and replaced with something better. ... For one, the focus will move away from rewarding providers for the use of technology and towards the outcome they achieve with their patients.”

Better communication?

And finally, we are deadly serious about interoperability. We will begin initiatives in collaboration with physicians and consumers toward pointing technology to fill critical use cases like closing referral loops and engaging a patient in their care. And technology companies that look for ways to practice “data blocking” in opposition to new regulations will find that it won’t be tolerated.


MIPS

What’s the Merit-Based Incentive Payment System (MIPS)?

The MIPS is a new program that combines parts of the Physician Quality Reporting System (PQRS), the Value Modifier (VM or Value-based Payment Modifier), and the Medicare Electronic Health Record (EHR) incentive program into one single program based on:

- Quality
- Resource use
- Clinical practice improvement
- Meaningful use of certified EHR technology


MIPS

- CPS Composite Performance Score
- APM Alternative Payment Model

Section 1848(q)(2)(A) of the Act, as added by section 101(c) of the MACRA, includes the meaningful use of certified EHR technology as a performance category under the MIPS, referred to in this proposed rule as the advancing care information performance category, which will be reported by MIPS eligible clinicians as part of the overall MIPS program. As required by sections 1848(q)(2) and (5) of the Act, the four performance categories shall be used in determining the MIPS CPS for each MIPS eligible clinician.

In general, MIPS eligible clinicians will be evaluated under all four of the MIPS performance categories, including the advancing care information performance category.

Section 1848(q)(5)(E)(i)(IV) of the Act, as added by section 101(c) of the MACRA, states that 25 percent of the MIPS CPS shall be based on performance for the advancing care information performance category. Therefore, we propose at §414.1375 that performance in the advancing care information performance category will comprise 25 percent of a MIPS eligible clinician’s CPS for payment year 2019 and each year thereafter.

With respect to the advancing care information performance category, we believe that MIPS eligible clinicians participating in MIPS APMs would be using certified health IT and other health information technology to coordinate care and deliver better care to their patients. Most MIPS APMs encourage participants to use health IT to perform population management, monitor their own quality improvement activities and, better coordinate care for their patients in a way that aligns with the goals of the advancing care information performance category. We want to ensure that where we propose reductions in weights for other MIPS performance categories, such weights are appropriately redistributed to the advancing care information performance category.

Final thought

- APM and ACO and other programs don't require a prior claim review.