Get A Seat at the Table
Develop Cross-Continuum Networks in the Competitive, Performance-Driven Senior Living Industry

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Today’s Attendees will:

1) Understand critical trends in the Senior Living Industry/PAC related to the impact of healthcare reform

2) Learn the importance of deciding between:
   - a traditional, clinical approach,
   - versus -
   - innovative, comprehensive, outcomes-driven clinical programming

3) Evaluate the benefits of developing outcomes-driven programs and care redesign opportunities that serve to fortify strategic collaborative partnerships
Hospitals & networks are:

• Seeking strategic partnerships to remain financially viable
• Demanding objective results & outcomes beyond simply discharge disposition & re-hospitalization statistics

Post-Acute Care Providers are:

• Focusing on “Triple Aim” model of health care reform
• Focus on more than simply operational metrics
• Meeting the expectations to deliver clinical efficacy, efficiency & positive outcomes to justify / fortify collaborative partnerships
Power of Purpose

Triple Aim and Care Delivery

- Patient Satisfaction
- Outcomes
- Quality Care
- Safety

- Outcomes
- Access to care

Better Health for the Population
Better Care for Individuals
Lower Cost Through Improvement

- Efficiency
- Efficacy
- Best Practice
### Impact Across the Continuum

<table>
<thead>
<tr>
<th>Hospital</th>
<th>SNF</th>
<th>Senior Living</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increasing hospital readmission penalties</td>
<td>In collection period for SNF readmission penalties</td>
<td>Looking to increase clinical capabilities to support aging in place models</td>
</tr>
<tr>
<td>Expansion of quality metrics/HAC penalties</td>
<td>Looking to develop preferred providers</td>
<td>Increasing on-campus health service offerings</td>
</tr>
<tr>
<td>Timely collection &amp; better understanding of PAC metrics</td>
<td>Focus on re-hospitalization mitigation strategies (e.g.: ER diversion programs)</td>
<td>At the center of resident care coordination</td>
</tr>
<tr>
<td>Additional payer &amp; convener expectations</td>
<td>Limited access to timely data for evaluation of partners</td>
<td>Looking to collect &amp; improve quality metrics</td>
</tr>
<tr>
<td>Usually share performance metrics with partner providers</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Power of Purpose**
Rapid, Large-Scale Changes

Final Rule 2017 - Mega Rule & beyond

- Proposed Final Rule 2018, Proposed Pre-Rule for FY 2019

Mandatory bundle expansions (Oct. 2017)

- Hip / Femur fractures (SHFFT) added to current CJR

- Mandatory CV Bundles

New/Expanding Quality Measures

- SNF & Home Health VBP

Advancing managed care markets

- MACRA and MIPS

Advancements in Impact Act requirements

Expanding risk arrangements

Narrowing networks
Current SNF QRP requires 80% of QRP requirements for Q4 2016 must be submitted by May 15, 2017

- Net market basket increase for SNFs of 1% beginning October 2017
- SNFs that do not satisfy the reporting requirements for the FY 2018 SNF Quality Reporting Program (QRP) will have a penalty of a 2% reduction to SNF market basket percentage change for that fiscal year, after any applicable adjustments
- SNF VBP extensions & clarifications
- Survey Team Composition
- Possible Burden Reduction in the Long-Term Care Requirements
- Innovation in Medicare
Advance Notice of Proposed Rulemaking

Proposed new rate structure RUG-IV to RCS-1

- Clinical profile including co morbidities & delivery of extensive services
- NO THERAPY MINUTES
- Split PT&OT from ST services
- Cognitive status consideration
- Functional level and improvements
- PT/OT and NTA rate components per diem adjust over LOS

Changes to MDS assessment requirements for PPS
(NOTE: no changes to OBRA requirements)

Changes to Medicare “Interrupted stay policy” for SNFs

Aligns with other initiatives
SNF QRP, SNF VBP, SNFPRM with intent to drive behavior toward Triple Aim

Source: CMS proposed ANPM
## Summary of RCS-1 Case Mix Components

### Case Mix Components

<table>
<thead>
<tr>
<th>Component</th>
<th>Groups</th>
<th>Clinical Variables</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>PT/OT</td>
<td>30</td>
<td>Clinical category for admission Functional Status Cognitive status</td>
<td>Per-diem adjustment Day 1-100</td>
</tr>
<tr>
<td>SLP</td>
<td>18</td>
<td>Clinical reason or SNF admission Swallowing disorder or mechanically-altered diet. SLP related comorbidity and cognitive impairment</td>
<td></td>
</tr>
<tr>
<td>Nursing</td>
<td>43</td>
<td>Same as current Nursing RUGs in RUG IV system</td>
<td></td>
</tr>
<tr>
<td>NTA</td>
<td>6</td>
<td>Point system determined by MDS items related to dx and extensive services</td>
<td>Per-diem adjustment Day 1-3</td>
</tr>
</tbody>
</table>

### Characteristics of Hypothetical Patients

<table>
<thead>
<tr>
<th>Resident Characteristics</th>
<th>Resident A</th>
<th>Resident B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rehabilitation Received?</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Therapy Minutes</td>
<td>730</td>
<td>730</td>
</tr>
<tr>
<td>Extensive Services</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>ADL Score</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td>Clinical Category</td>
<td>Acute Neurologic</td>
<td>Major Joint Replacement</td>
</tr>
<tr>
<td>Functional Score</td>
<td>15</td>
<td>15</td>
</tr>
<tr>
<td>Cognitive Impairment</td>
<td>Moderate</td>
<td>Intact</td>
</tr>
<tr>
<td>Swallowing Disorder?</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Mechanically Altered Diet?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>SLP Comorbidity?</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Comorbidity Score</td>
<td>7 (IV Medication and DM)</td>
<td>1 (DVT)</td>
</tr>
<tr>
<td>Other Conditions</td>
<td>Dialysis</td>
<td>Septicemia</td>
</tr>
<tr>
<td>Depression?</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Rules of Participation Timeline

Three-stage implementation phase-in for new regulations

- Phase 1 November 28, 2016 – Completed
- Phase 2 November 28, 2017 – 7 Months and Counting
- Phase 3 November 28, 2019

Areas of Focus:

- Person-Centered Care
- Quality
- Alignment with HHS priorities
- Implementation of Legislation
- Comprehensive Review & Modernization
- Facility Assessment Competency-Based Approach

All DOH surveys that occur after 11/28/16 are eligible for reviews in these areas irrespective of surveyors’ guides or completed or released (expected June 2017)

New proposed rule for 2018 for skilled nursing asked for input on changes to reduces burden from this rule
Cross Continuum Areas of Focus

• Accurately align intervention of clinical care with patients’ acuity / complexity / risk score
• Internal process redesign
• Patient and caregiver health literacy
• Partnerships with quality expectations
• Advanced clinical capabilities
• Concurrent outcomes & cost analysis
• Innovative care transitions: Case Study
• Clean claims process
INTERNAL CARE ReDESIGN: Key to Success

Let go of the status quo
Accept need for change
Plan for future
Be nimble & grow

Cross continuum communication is the cornerstone for internal care redesign

Regular meetings, care pathways with primary partners including 1° care MDs

Reevaluate opportunities with existing liaisons

Risk-based care plans and service delivery

Joint QA plans and meetings
(Share metrics, scorecards & plans for improvement)

Patient & caregiver health literacy programs
(evidenced-based programs, align with hospital/SNF when available)

Early & ongoing palliative /hospice services
Identify Upstream & Downstream Referral Partnerships

- 5-Star Ratings
- Hospital Readmission Rates
- Health Care Reform Engagement – bundles, ACOs, etc.
- Ability to accept necessary insurance plans
- Overall philosophy in being part of a complete continuum; understanding the role for all post-acute care providers
- Potential to add lead generation
- Ability to add value to community market position
Opportunities in Continuum

Ability to fill gaps in a preferred provider network
Create a value offering to ACOs and MCOs
Implement/share advanced clinical capabilities, niche programs
Collect & replicate data driven outcomes
Develop new revenue streams
Rising acuity levels of seniors leads to increased focus on clinical capabilities at all stages of the continuum
Navigating Care Delivery

What services are needed?
What services do you provide?
Clinical Capabilities
What are the resident’s goals?
How can we achieve those goals collaboratively keeping in mind the Triple Aim?
Conveying Senior Living Value

- Acknowledge Senior Living Clinical Capabilities
- Understand Senior Living Potential to Support Hospital Goals
- View Senior Living as Partner

Identification & communication of clinical capabilities to health system

Demonstrate potential to partner with hospital system to achieve clinical & financial goals

Collaborate to address common challenges & share potential opportunities
Senior Living Core Competencies

**Provide a Safe, Supervisory Environment**
- Onsite clinical services
- Socialization and wellness
- Oversight of resident activity

**Provide a Low-Cost Post-Discharge Setting**
- Lower cost than any other PAC settings
- Private Pay

**Be the Geriatric Expert**
- Utilize evidence-based clinical care pathways
- Establish assessment protocols
- Knowledge of common warning signs
Advanced clinical capabilities profile
Medical & APRN coverage
Use of telemedicine
Vendor status for ancillary services; Timeliness
Internal & external care transitions process including liaison expectations
Rehab Services: SOC / Coverage / Service delivery patterns
Current partners in provision of care across the continuum (i.e.: hospice)
Integration of EMR / Data collection procedures

Selecting a Strategic Home Health Partner

Selecting a strategic home health agency (HHA) is a critical component in providing improved care coordination, greater efficiency across all settings, achieving optimal patient outcomes, reducing hospitalizations and lowering overall medical costs.

Steps to ensure you have the right partner:

1. Review the HHA quality measures on home care compare
   a. Compare those to state and national averages as well as other HHAs in the market
   b. Overall quality of patient care star rating and quality measure (QMS) ratings of 3.5 or greater
      i. How well does the HHA compare with the following QMS:
         1. Managing daily activities
         2. Managing pain and treating symptoms
         3. Treating wounds and preventing pressure
         4. Preventing harm
         5. Preventing unplanned discharges
      ii. Review patient survey results
      iii. This item should help you to narrow based on reported quality of services
   provided
2. Schedule a meeting with your potential HHA partner
   a. Prior to the meeting, have your HHA potential partner complete the Application for
      Home Health Preferred Provider List for your center
   b. Review the below listed best practices for a home health agency partnership to identify
      potential risk factors

Best Practices for a Home Health Agency Partnership

1. HHA Nurse Liaison to be present on site prior to discharge for a warm hand off of the patient
2. Start of care within 24 hours of discharge (all services within 72 hours)
3. HHA providing regular updates after the transition has occurred on the patient’s progress and
   barriers
   a. HHA Scorecard on all SNF referred patients and progress
4. Ensure care coordination items are completed
   a. Initial PCP visit is completed by day 7
   b. Medication reconciliation has occurred
   c. 6-7 days of week of coverage in the first week—on site, telephonically or by Bluetooth
      monitoring system of vital
   d. OMS has been delivered, set up and the patient/caregiver is educated on its use
   e. Community resources have been initiated and/or completed
5. Readmission reduction protocols are in place
   a. Health literacy with teach back methods are carried over from
      settings
Massachusetts 5-Star Trends

Protect or Build Your Stars

Implementation timelines for the Final Rule = Survey Stars
PBJ Accuracy and Staffing Patterns with Competencies = Staffing Stars
Quality Measures and Niche Program = Quality Stars
Recurrent QM Focus

Quality Measures
- Pressure Ulcer
- Falls with Major Injury
- Changes in Functional Status
- UTI / Sepsis
- Pain
- Medication Reconciliation

IMPACT Act
- Pressure Ulcers
- Falls with Major Injury
- Functional Status / Changes in Function
- Cognitive Status
- Medication Reconciliation

Performance Networks/P4P
- Pressure Ulcer
- Falls
- UTI / Sepsis
- Pain

THE SOLUTION:
Patient identification & robust therapy programming
Interdisciplinary Clinical Programs

Specialty Programming with Defined Cross-Continuum Care Tracks for Specific Diseases & Conditions

**ORTHOPEDICS**
- Total Joint Replacement
- Comprehensive Joint Replacements (CJR)
- Fractures

**NEUROLOGY**
- Post Cardiovascular Accident (CVA)
- Parkinson’s Disease
- Huntington’s Disease

**CARDIO-PULMONARY**
- Congestive Heart Failure (CHF)
- Myocardial Infarction (MI)
- Chronic Obstructive Pulmonary Disease (COPD)
- Pneumonia

**ENDOCRINE/METABOLIC**
- Diabetic Care
- Wound Management
- Nutritional Support

**COGNITIVE IMPAIRMENT**
- Alzheimer's & Dementia Care
- Geri-Psych/Behavioral

**COMPLEX MEDICAL**
- Oncology Care
- Neurology Care
- Pain Management
- Gastrointestinal Care
Outcome Measures
- Re-hospitalization rates by diagnosis (30 and 60 day)
- ER visits without hospitalization
- Episode length and discharges with outpatient referrals

Organizational Capability Measures
- Clinical Capabilities profile
- Care coordination measures
- Patient engagement measures
- Home Health CAHPS scores

Efficiency Measures
- Average response time to referrals
- Average LOS by payer / diagnosis

Performance Measures
- Therapy intensity / Visits per episode
- Functional Status Changes (Section GG / CARE Tool- 2017)
- 30-day cost / episode by diagnostic group

Internal Scorecards
- Quality Measures – Sepsis/UTI, Falls, Cognition, Pain, Meds, etc.
- Casper Reports
- 5-Star Ratings – listed by criteria
- Control group / peer benchmarking / hospital & national standards
## Capability Scorecards

### Van Dyk Healthcare at Montclair

#### Clinical Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Outcome Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Infections</strong></td>
<td>• Prevent provider agreements with Reedy</td>
</tr>
<tr>
<td></td>
<td>• Infections Prevention and Control</td>
</tr>
<tr>
<td><strong>Dermatology</strong></td>
<td>• Skin conditions are managed and monitored</td>
</tr>
<tr>
<td><strong>Cardiology</strong></td>
<td>• Blood pressure is regularly monitored</td>
</tr>
<tr>
<td><strong>Obstetrics</strong></td>
<td>• Gynecological exams are performed regularly</td>
</tr>
<tr>
<td><strong>Respiratory</strong></td>
<td>• Respiratory issues are managed and followed by the team</td>
</tr>
<tr>
<td><strong>Psychology</strong></td>
<td>• Mental health issues are addressed by a professional</td>
</tr>
<tr>
<td><strong>Rehabilitation</strong></td>
<td>• Physical therapy is provided to aid in recovery</td>
</tr>
</tbody>
</table>

#### Equipment

- **Dermoscopy Machine**
- **MRI Scanner**
- **CT Scan Machine**

#### Contact

Thank you for taking care of your patient and we hope they will be able to return to the facility as soon as possible. We hope you will encourage us to discuss the care and the necessary plan. Please contact:

- **Name:** [Name]
- **Position:** [Position]
- **Phone:** [Phone]

### Sample Scorecard

<table>
<thead>
<tr>
<th>Metric</th>
<th>Facility Score</th>
<th>Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>30-day all-cause hospital readmission rate</td>
<td>9.8%</td>
<td></td>
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#### Clinical Services Provided

- **Medicine**
- **Surgery**
- **Dentistry**

#### Resident Satisfaction

- **Complaints:** [Complaints]
- **Satisfaction:** [Satisfaction]
- **Recommendations:** [Recommendations]

#### Operational Capabilities

- **Average response time to hospital referral:** [Time]
- **Percentage of patients who receive follow-up from ALF after hospitalization:** [Percentage]
- **Percentage of residents receiving assistance from hospital stay:** [Percentage]
Re-Hospitalization Mitigation Focus

Nursing availability 24/7

ER diversion program

Frequent communication
  • Videoconferencing
  • Post discharge follow up calls

Risk stratified programs

30 day all cause re-hospitalizations from both hospital and SNF

Additional support services:
  • House call
  • Telehealth programs
  • Transitional therapy programs
Review and standardize clinical delivery pathways to main diagnostic groups you are currently serving
  • Coordination with service delivery patterns
  • Develop specialized pathways when indicated

Develop expanded relationships with hospitals, preferred SNFs, and Senior living providers
  • Consider all opportunities for care coordination to avoid duplications in service
    • Work to create additional referral patterns

Review & reinvent re-hospitalization mitigation strategies & pathways

Design internal & external scorecard to measure success & assess areas for improvement
  • Know your market & market expectations
Communication between therapy and nursing must exist daily to ensure highest level of care. Together they are the “Clinical Team” that determines the best plan of care for the resident. All parties must be involved in the decision making process and must always consider first what is in the resident’s best and most appropriate interest.
Results of a Collaborative Care Model: Case Studies

PAC Settings

Senior Living

Hospice/Palliative Care

Resident-Centered Care & Triple Aim

Right Care

Right Place

Right Time
Van Dyk Manor – Ridgewood, NJ

- Chosen as a Preferred Provider in ACO & BPCI networks
- 95 bed privately owned SNF
- Impact on census and workloads

**The Result: “Preferred Provider” Status**

The strategy paid off:

**Decreasing Yearly Average LOS:**

**The strategy paid off:**

**ADMISSIONS**

2012 2014 2015
Van Dyk Health Care identified unique niche opportunity to better serve post-acute patients by partnering with Valley Home Care (non-affiliated home care agency)

**Strategic Plan:**
- Best meet patients’ needs as they transition thru post acute continuum
- To create focused care transitions, clinical pathways & joint outcome measures

**Therapists follow patient from SNF to community-based HH resulting in:**
- Improved transitional communication
- Reduced redundancy of services
- Improved efficiency of start of service delivery in all settings
- Improved patient / caregiver satisfaction
- Created continuity of patient care / preserved functional gains
- Completed pre-discharge assessment in hospital or SNF before return to home
Case Study:

Florida Assisted Living Community

100 Bed AL in desirable market; 5 new AL constructions nearby

Census challenged (74% occupancy)

Recommendations:
  • Developed Clinical Care Capabilities List
  • Completed Market Analysis of Acute Care Opportunities
  • Scheduled meeting with hospitals

Upstream Partnerships with Hospitals:
  • Leverage specialty program as a model for clinical excellence and efficiency
  • Provide assistance in clinical programming & care transitions to assist w/ decreasing hospital LOS & re-hospitalization penalties

Downstream partnership with home health & community groups to excel in care transitions considering up to 90-day episode
Census increased to 92% (18% increase)

Significant increase in revenue

Re-hospitalization Rate decreased from 26% to 3.5%

Home Health Partnership with 4.5* provider

Proven functional outcomes in Rehab
COMPLIANCE STRATEGIES: Navigating the New World Order
PPN:
• Maintaining compliance with Quality Improvement Programs
• Adhering to extensive Eligibility Criteria for quality patient care
• CMS standard for Patient Choice
• Program Waivers
• Selected based on quality performance, willingness to collaborate, reputation

OIG Compliance Guidance:
• Written policy & procedures
• Designated staff allocated for day-to-day responsibility
• Training & education
• Communication lines
• Auditing
• Consist disciplinary mechanisms
• Response to compliance matters (e.g., corrective action plans & reporting to government agencies)
In Summary

Pursue Meaningful Collaborations & Choose Strategic Partners

Contact HealthPRO® Heritage with questions/feedback or to learn about our consultative services or strategic planning

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