Unlock the keys to success in the future: Clinical targets for care programming control

Kimberly McCormick RN/BSN
- 22 year Home Health Clinician
- 22 years in Home Health continuum
- 10 years Agency Administrator
- ADR rate < 1% Error Rate
- Deficiency – free Surveys/Perfect JCAHO x 2
- HHSM Associate Consultant x 5 years
- Leading Home Health Educator

MISSOURI ALLIANCE HOME CARE (MAHC)
The Affordable Care Act arrives in terms of Alternative Payment Models

Affordable Care Act

SHIFT: Volume to Value change rewires care delivery for ALL Providers
CHANGE: >80% switch from FFS – APM by 2018
Represents: Natural Evolution of PPS Model

Volume Versus Value

- 21 day SNF stays
- 60 day Home Health Episodes
- 4 days Acute stay
  - 180 HH stay?
  - Focus moved away from VOLUME
ACCOUNTABLE CARE ORGANIZATIONS

Accountable Care Organizations

An ACO is a healthcare organization characterized by a payment and care delivery model that seeks to tie provider reimbursements to quality metrics and reductions in the total cost of care for an assigned population of patients.

What if they paid us to get them better faster?

Visit volume changes – based on need/goal achievement

What if the patient only needed 1 visit?
Care Transitions Management

Care Transition refers to the movement patients make between health care settings as their condition and care needs change during the course of a chronic or acute illness; each shift from care providers and settings is defined as a care transition.
Episodic Care Delivery

The re-engineering of the acute episode derived from acuity-based expectations of patient care requirements, devoid of Provider preference, and driven by the least restrictive/costly care environment.

Episodic Care Delivery

- College GPA
- No longer a hospital patient, NH, HH
- Team Approach
  - When one team fails – all fail

POST-ACUTE BUNDLING
(Episodic Care In HH)
Post-Acute Bundling

Post-Acute Bundling is a single bundled payment for all treatment and expenses required for completing a patient’s acute episode of care.

The Silo Effect on the Care Continuum

The Silo Effect

The Silo effect refers to the lack of communication and support often found in acute care episodes. Provider types focus primarily on their own goals, often ignoring the needs of others.
Home Health Silo Effect Concerns

- Intake Accuracy/Integrity
- Inadequate SOC Response times – 24 hours?
- SOC/OASIS Accuracy – Incomplete Programming
- 60 Day Certification (versus Post-Acute)
  - 1 wk 9
- Efficiency/Productivity/Lacks In-Episode Control
- Lack of Safety-Based Frequencies?
- Disconnected Rehab Services

ACO Integration for Post-Acute Care

Post-Acute Providers seeking to participate in the ACO era must integrate ACO programming goals to counteract the legacy of silo-based care present in the PPS Care Continuum. **Clinical accuracy, staff control, and care insight** required for value concerns are paramount.
Making Sense of CCJR and VBP for the Home Health Provider

Alternative Payment Models (APM)

Alternative Payment Models (APM) are the basis of the ACA – mandated shift from the fee-for-service programming of the PPS era. By tying programs and payment to quality and value, ACA goals are achieved and the shift from volume to value begins, and will mature and refine over time.

Alternative Payment Models (APM)

Alternative Payment Models represent a new set of incentives that build on the progress of healthcare over recent years. They are slated to improve the efficiency and personalization of care programming by emphasizing care coordination and outcomes by controlling costs. Early returns form APM trials or pilot programs demo improved quality/cost results.
Value – Based Purchasing (VBP)

Comprehensive Care for Joint Replacements (CCJR)

Expected 2016 VBP/CCJR Changes

• Fiscal Results tied to care quality performance
• Increased attention to Care Intrinsics required
• Traditional Care Approaches now defunct
• Clinician – managed care WON’T WORK
  • UR program is key to success
• Focus on Wellness, Independence
• Increased Reporting, Communication
• Decreased Utilization – Decreased Payments
Expected 2016 VBP/CCJR Changes

- Management of Nursing/Rehab Volumes
- Only achieved through UR program – control!
- Safety – Based Clinical Frequencies
- Provider – Managed Scheduling/Productivity
- Programs change due to in-episode progress
- MD care management altered to APM goals
- Care volumes altered due to acuity identity
- Care delivery & value changes = STRESS

Value – Based Purchasing (VBP)

Value – Based Purchasing for Home Health

Value – Based Purchasing (VBP) will test whether incentives for better care can improve outcomes in the delivery of Home Health. The goal of VBP is to assure that ALL homecare services, regardless of the region where care is delivered, are supported by a payment system that rewards Providers who deliver the highest quality outcomes.
Value Based Purchasing in Home Health

- Pilot starts January 2016 – FLA & 8 states.
- Mandatory Alternative Payment Model
- Financial bonus funded by payment reductions to the provider groups involved
  - Front line clinicians will not achieve this success
- Performance standards are established to determine which providers receive bonuses
  - Those that do NOT meet standards = Reduction of 3-8%
  - Those that do meet standards = Increase of 3-8%
- 5 year adjustment timeline for 3%-8% by year 5

Value Based Purchasing in Home Health

- CMS projects 10% of all providers will receive payment reductions: 2.5 – 3.5% average
- 10 Process measures - 15 Outcome measures
- 4 new measures coming from OASIS, Medicare claims data, and HHCAHPS
- 50% of Medicare Fee For Service payments will be tied to quality and value by 2018
- Demands on operational, clinical and financial management challenges
- 2 new measures: Types of assistance and Prior financing

Value Based Purchasing in Home Health

- Performance and bonus payment deductions would be based on the agencies' performance in comparison to others in the state.
  - Separating large volume agencies for small volume agencies
  - From 2015 data on patients served
- States randomly selected:
  - Massachusetts, Maryland, North Carolina, Florida, Washington, Arizona, Iowa, Nebraska and Tennessee
- $380 Million in savings over 5 years
- 2017 = Retroactive bonus payments
Value Based Purchasing in Home Health

- Goals:
  - Improvement in quality of care
    - Patient centered
    - Reliable, Accessible
    - Safe
  - Improved Outcomes
    - Improved health care of the USA
    - Higher levels of quality
  - Increased efficiency
    - Reduce the cost of quality health care
  - Financial Incentives for providers to CHANGE
  - Hold providers accountable for the quality of care they provide to the Medicare beneficiaries

Value Based Purchasing – HH Focus Areas

- Move away from historical, traditional home health models
- Change is NOT led by front line clinicians
- UR program installation
- UR program reviewers / champions at the agency level = CONTROL!
- Proactive, progressive approach to efficient home care with focus on patient centeredness and quality

Value Based Purchasing – Patient Centered Care

Current home health control sits in the front seats of your clinicians’ cars and the home of your patients. Initial and deliberate energies must be paid towards shifting the focus to the patient. This focus must extend from care production and delivery to scheduling and productivity.
Utilization Review - Home Health CCJR Response

The development and delivery of home health services created from a utilization review, PPS complaint perspective. Patient centered, case managed care, modified in an ongoing manner for patient response to treatment. UR – Managed home health provides levels of clinical / fiscal outcomes not regularly seen in homecare as it creates the episode programs of the future, and survival in VBP.

Current State of Utilization Review in Home Health

- Void of OASIS accuracy through UR
- Relies heavily on front line clinicians to “get it done”
- OASIS export daily without full review, or any
- Loss of HHRG value (vs > 30%)
- Decreased outcomes (vs > 20%)
- Increased hospitalizations
- All despite current cuts, and VBP pilot

Commonly Held Home Health Beliefs

- We cannot afford a UR program
  - How can you not?
- We train on OASIS over and over and our clinicians still don’t get it right!
  - How is that working?
- The clinicians know better
  - Why have internal leadership?
- Clinician driven: Schedules
  - Missed visits
- We don’t have 5 star ratings!
  - You don’t have control through a UR program
- Patients belong to the provider number, not the clinician
- My clinicians just don’t listen
  - Because HH is the only Continuum that does not control patient centered care through a UR approach.
Benefits of Home Health UR Program in VBP

- Quality Program
  - CMS likes this!
  - Doctors like this!
  - Clinicians like this!
  - Patients love this!
- Staff retention
- Improved quality outcomes > 20 – 30%
  - Clients who maintain 5 star rating
- Reduction in re-hospitalizations
- OASIS Accuracy
- Discharge for outcomes

Benefits of Home Health UR Program in VBP

- Accurate CMW/HHRG = Accurate Payments
- Reduction in audit / denial risk
- Frequency / duration control
- Optimization (not maximization) of PPS model
- Changes legacy of clinician centered care to patient centered care
- Increase of 5-8% based on accuracy in discharge outcomes

Benefits of Home Health UR Program in VBP

- 1242: Pain
  - Pain that interferes with activity or movement
  - Usually tied to subjective scale only
  - No functional walk
- 1400: SOB
  - Interview question
  - No functional walk
  - Bedbound patients are asked, not functionally assessed.
  - Delivery of DBE
### Benefits of Home Health UR Program in VBP

- **1810: Upper Body dressing**
  - 3 part question
  - Ineffective use of response section of guidance manual
  - Interview versus functional assessment

- **1820: Lower Body dressing**
  - 3 part question
  - Ineffective use of response section of guidance model
  - Interview versus functional assessment

- **1830: Bathing**
  - 3 part question
  - Ineffective use of response section of guidance model
  - Interview versus functional assessment
  - Entire body
  - Medical restrictions

### OASIS Accuracy as it Relates to VBP

- **1840: Toilet Transfer**
  - 4 part question to/from on/off
  - Ineffective use of response section of guidance model
  - Interview versus functional assessment
  - Can't assess safety with equipment if equipment is not in the home
OASIS Accuracy as it Relates to VBP

- 1845: Toilet Hygiene
  - If ostomy: Includes cleaning
  - Ineffective use of response section of guidance model
  - Often interview versus functional assessment

OASIS Accuracy as it Relates to VBP

- 1850: Transfers
  - Use of minimal assistance or device to transfer safely
  - 1 = One or the other to perform safely
  - 2 = Requires both
  - Ineffective assessment of transfers from one level surface to another versus guidance:
    - In the bed
    - Supine
    - Up
    - Out of the bed
    - Transfer to another regular surface
  - Ineffective use of response section of guidance manual

OASIS Accuracy as it Relates to VBP

- 1860: Ambulation
  - Regardless of need of device
  - Response section of OASIS
  - 2 = Intermittent supervision
  - 3 = Continuous supervision
  - Functional walk – something for accuracy
  - Not an interview
  - Home bound status needs to present
    - Answer of 1
OASIS Accuracy as it Relates to VBP

- Sought ED Treatment without admission
  - Ineffective scripting of how to utilize agency versus ED
  - Agency call numbers not posted and reviewed every something
  - Protocols for disease process and techniques are required to lower ED visits.

Comprehensive Care for Joint Replacements (CCJR)

The CCJR model tests bundled payments for lower extremity joint replacements (MS DRG 469/470) across a broad cross-section of hospitals. The goals: better care through increased coordination, healthier patients by connecting hospitals and PAC Providers, & smarter spending by holding hospitals accountable for ALL episode costs.
First ACA Alternative Payment Mandate
CCJR slated for 1/1/16 Kick – Off
BPCI Pilot Program – MS DRG 469/470
90-Day Total Joint Replacement Bundle
Mandatory for 75 Metro Statistical Areas
Over 700+ Hospital systems nationally
Involves Hospital/MD/Patient Buy-In

Comprehensive Care for Joint Replacements

CCJR Pilot for Home Health
- Orlando
- Pensacola
- Port. St. Lucie
- Sebastian
- Tampa – St. Petersburg
- Gainesville
- Miami
- Naples

CCJR Episodic Bundling Savings Projections
CCJR Episodic Bundle Savings Projection
- Redesign improves care under decreased LOS
- First CCJR year costs CMS $23 Million
- Second CCJR year saves CMS $29 Million
- Third CCJR year saves CMS $43 Million
- 4th/5th year save $50 & $53 Million respectively
- CCJR Total 5 year savings - $153 Million
- Replicates DRG evolution during PPS era
- ALL diagnoses CMS DCs Bundled by 1/1/18

Development of a CCJR Episodic Bundle

Development of an Episodic CCJR Bundle
- 90 Day Bundle Concerns
- Patient and Family Education & Participation
- Addressing CMS Target Pricing
- Schedule for Ongoing CCJR Utilization Review
- Outpatient Management Issues
- Equipment, Care Transitions, CT Protocols
- Maturation of CCJR over time
Services and Costs included in a CCJR Episodic Bundle

Episodic CCJR Bundle Services and Costs
- Inpatient Hospital & MD Services
- LTCH, IRF, SNF, Home Health
- Outpatient Part B Services
- Laboratory, DME Costs
- Part B Drugs
- Hospice Care,
- Inpatient Psych Services

CCJR Episodic Bundling Readmission Concerns
CCJR Episodic Bundle Readmission Concerns
- Reinfection leading readmission issue
- Readmissions 50% higher – 30 day vs. 90 day
- SNF readmission rates higher than HH
- Assertive care control decreases readmits
- Silo behavior reduction a readmission issue
- PAC blowback/lack of support creates readmits
- Care Transitions, coaches, liaisons, joint camp
- Inter-team coordination decreases readmits

CCJR patterned on Model 2 469/470 BPCI Pilot Programs

JUMP
Joint Utilization Management Program
Detroit Medical Center/HHSM
Episodic Bundling Concerns

- Traditional Payer – Medicare at Risk
- BPCI Model 2 Program – DMC at Risk
- An Informed Patient – Provider - Clinicians
- BPCI Clinical Pathway Compliance
- BPCI Clinical Documentation
- Lack of UR In-episode Control – Directability
- Evidence – Based, Best Practice Care

Episodic Bundling Clinical Parameters

- Traditional 469/470 Utilization – SNF (21 days) – HH (9-14 vis)
- 2014 SNF LOS/Utilization Target – 8-11 Days @ High RUG
- 2014 HH LOS/Utilization Target – 7- 10 Days @ 6/7 rehab visits
- Clinical Program Focus - ROM, Pain, Safety, Transfers, Mobility
- DC Planning – Mimic Acute Care – Care Completion Approach
- Problems/Concerns/Modifications – Authorize with Payer (JUMP)

J.U.M.P. Partner 2014 HHC Utilization

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Example 1

Example 2

Home Health Strategic Management
1- 877- 449 - HHSM
www.homehealthstrategicmanagement.com