Pursuit of Value Driven Healthcare
Post-Acute Care Transitions
Wisconsin Focus
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Central Medical Trading Area
MiHIA supports the Central Medical Trading Area.
As defined by the State of Michigan, this area includes 14 counties:
- Arenac
- Bay
- Clare
- Genesee
- Huron
- Isabella
- Iosco
- Osceola
- Saginaw
- Sanilac
- St. Clair
- Tuscola
- More than 780,000 people live in the trading area

Confronting the Status Quo!
“Our Iceberg is Melting”
John Kotter

John Kotter 8 Steps
Establishing a Sense of Urgency
Developing a Change Vision
Empowering Broad-based Action
Never Letting Up

Creating the Guiding Coalition
Communicating the Vision for Buy-in
Generating Short-term Wins
Incorporating Changes into the Culture
Cost of US Healthcare 2013

Provider Response?

$9,255 PPPY

Exhibit 1. International Comparison of Spending on Health, 1980–2011

Average spending on health per capita (US PPP)

Total expenditures on health as percent of GDP

Note: US PPP = purchasing power parity.

Medicare Spending on Post-Acute Care, 2002-2012

Source: MedPAC, a Data Book Health Care spending and the Medicare Program June 2014
Affordable Care Act - 5 Years Old

Expand Health Coverage to Everyone
Provider Payment Reform
Reform the Healthcare Delivery System

Reform the Healthcare system - IHI Triple Aim and NQS Three Aims

The National Quality Strategy: How it Works
Trajectory to Value-Based Purchasing

It is a journey, not a fixed model of care!

Primary Care Capacity: Patient Centered Medical Home

HIT Infrastructure: EHRs and Connectivity

Operational Care Coordination: Embedded RN Coordinator and Health Plan Care Coordination

Value/Outcome Measurement: Reporting of Quality, Utilization and Patient Satisfaction Measures

Value-Based Purchasing: Reimbursement Tied to Performance on Value

Supportive Base for ACOs, PCMH Networks, Bundled Payments, Global Capitation

Source: THINC - Taconic Health Information Network and Community

Emerging Payment Reform Trends

Fee-For-Service

Bundled payments

Global budget contracts

ACOs

Volume-based reimbursement

Value-based reimbursement

Patient-Centered Primary Care Collaborative

CMS Innovations Portfolio: Testing New Models to Improve Quality

Accountable Care Organizations (ACOs)
- Medicare Shared Savings Program (Center for Medicare)
- Pioneer ACO Model
- Advance Payment ACO Model
- Comprehensive ESRD Care Initiative

Primary Care Transformation
- Comprehensive Primary Care Initiative (CPC)
- Multi-Payer Advanced Primary Care Practice (MAPP) Demonstration
- Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration
- Independence at Home Demonstration
- Graduate Nurse Education Demonstration

Bundled Payment for Care Improvement
- Model 1: Retrospective Acute Care
- Model 2: Retrospective Acute Care Episode & Post Acute
- Model 3: Retrospective Post Acute Care
- Model 4: Prospective Acute Care

Capacity to Spread Innovation
- Partnership for Patients
- Community-Based Care Transitions
- Million Hearts

Health Care Innovation Awards
- State Innovation Models Initiative
- MC Dual Eligible Beneficiaries

Initiatives Focused on the Medicaid Population
- Medicaid Emergency Psychiatric Demonstration
- Medicaid Incentives for Prevention of Chronic Disease
- Strong Start Initiative

Medicare-Medicaid Enrollees
- Financial Alignment Initiative
- Initiative to Reduce Avoidable Hospitalizations of Nursing Facility Residents
Healthcare Cost Equation

\[
\text{Health Care Costs (\$)} = (\text{Population}) \times (\text{Technology Utilization per Pop}) \times (\text{Technology Unit \$})
\]

**Inpatient Example**

100,000 people \( \times \) 100 discharges/1,000 people \( \times \) \$9,500/discharge

10,000 discharges \( \times \) \$9,500/discharge

**Inpatient Subtotal = \$95,000,000**

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**Wisconsin Medicare Demographics**

- Medicare Beneficiaries: Part A & B
- 2007 - 2013

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**Medicare Advantage Plans**

- MA Participation Rate: 2007 - 2013
- National vs. Wisconsin
Reducing Cost of Healthcare

Healthcare Cost $ Drivers

- Improve the Health Of the Population
- Reduce use of Healthcare Services
- Reduce the Cost Of Technology Provided

Determinants and Change Activities

($) = (Population) x (Utilization per Pop) x ($ per Utilization)

Determinants of Health
- Engaged Community
- Healthy Choices
- Treatment Compliance
- Personal Accountability
- Access and Insurance
- Reduce # Uninsured
- Access to Providers

Determinants
- Clinical Need
- Provider Preference
- Evidence Based Medicine
- Culture
- Insurance Structure
- Insured/Uninsured
- Poor Care/Good Care
- Unknowns

Determinants
- Clinical Need
- Competition
- CMS New Tech Process
- Research
- Health Policy
- Poor Structure
- Poor Care Quality/Safety
- Labor Market
- Insurance Plan Structure
- Social Economic Environment

Determinants and Change Activities

($) = (Population) x (Utilization per Pop) x ($ per Utilization)

Change Activities
- Use of Lower Cost Tech
- Consolidation (i.e. Lab Testing)
- Controlled Tech Growth
- Regionalization of High Tech
- Medical Error Reduction
- Improved System Efficiency
- Improved Quality (Error Reduction)
- Developed Integrated Systems
- Capitation

Change Activities
- Applied Evidence Based PCP
- Effective Use of Care
- Treatment Compliance
- Reduce # Uninsured
- Access to Providers
- Health Education

Change Activities
- Applied Evidence Based PCP
- Reduce Provider Variance
- Medical Home Coordination
- Increased Payer Controls
- Transparency Reporting
- Decision Support Systems
- Informed Engaged Patients

Change Activities
- Applied Evidence Based PCP
- Effective Use of Care
- Treatment Compliance
- Reduce # Uninsured
- Access to Providers
- Health Education
## Triple Aim Relationship

\[(S) = (\text{Population}) \times (\text{Utilization per Pop}) \times (\$ per Utilization)\]

- **Aim 1:** Improving Pop Health
  - Use of Lower Cost Tech
  - Consolidation (i.e. Lab Testing)
- **Aim 2:** Reducing Cost per Capita
  - Controlled Tech Growth
  - Regionalization of High Tech
- **Aim 3:** Experience of Care Runs Through All Three
  - Medical Error Reduction
  - Improved System Efficiency
  - Improved Quality (Error Reduction)
  - Developed Integrated Systems
  - Capitation

### County Health Ranking Weights

The County Health Rankings & Roadmaps program is a collaboration between the Robert Wood Johnson Foundation and University of Wisconsin Population Health Institute.

Areas Hospitals Typically Offer Health Education

- Clinical Care 20%
- Social Economic Factors 40%
- Health Behavior 30%
- Physical Environment 10%

### Health Ranking Weights Alignment

- **Clinical Care 20%**
- **Social Economic Factors 40%**
- **Health Behavior 30%**
- **Physical Environment 10%**
Healthcare Provider Role

New Story - Value Equation

Value = Cost/Quality

Price/Cost ($) Quality & Satisfaction

Third Party Insurer Role

Population Change
Access to Providers
Medical Home - Coordination
Engaged Community
Healthy Choices

Improved Utilization
Medical Home-Coordination
Increased Payor Controls
Applied Decision Support
Informing Engaged Patients

Physician Pay for Performance
Quality
Compliance
Utilization
Cost

Hospital Pay for Performance
Quality
Outcomes
Penalties
Cost
Other Payment Programs

- Population Change
  - Medical Home - Coordination
  - Access and Insurance
  - Reduce # Uninsured
  - Access to Providers
  - Engaged Community
  - Healthy Choices

- Improved Utilization

- Technology Cost $ Use of Lower Cost Tech
  - Controlled Tech Growth
  - Regionalization of High Tech

PQRS Penalty Programs

Bundled Payments (Hip & Knee)
  - Voluntary
  - BPCI 1-4
  - BPCI 2-3

Post Acute Nursing Home

($) = (Population) x (Utilization per Pop) x ($ per Utilization)

- Population Change
- Improved Utilization

Restorative/Rehabilitation Care

Healthy Subpopulation

Extended Care – Primary Elder Care

End of Life Care

Cost of LTC/Rehab

Changes in Population, by Age Group

- Millions of People
  - Population Age 65 or Older
  - Relative to the Population Ages 20 to 64

- Number of People Age 65 or Older, by Age Group
  - Millions of People
  - Ages 20 to 64
  - Ages 65 to 74
  - 65 or Older
Causes of Projected Growth in Federal Spending for Social Security and Major Health Care Programs

- Percentage of Projected Growth Through 2019
  - Aging of the Population: 55%
  - Growth in Spending per Capita on Health Care: 24%
  - Expansion of Federal Health Care Programs: 21%

Wisconsin SNF Covered Stays

- Medicare FFS SNF Covered Stays per 1,000 Beneficiaries
  - Wisconsin
  - National

Wisconsin SNF Stays per 1000 Beneficiaries by County

- Rural vs. Non-Rural
Rural Community Post-acute Days are Dominated by care in Free Standing SNFs

Source: NCPHRHC analysis of CMS Hospital Cost Report Information System, 6-30-10

State Surveyor Role

($) = (Population) x (Utilization per Pop) x ($ per Utilization)
Aim of Post Acute Care
Complete Treatment to Achieve Maximum Attainable Health

Unplanned Readmission is a Failure to Achieve the Aim, Care Plan

AMDA – The Society for Post-Acute and Long-Term Care Medicine Care Transitions Guide

Hospital Readmissions, Medication Errors, Adverse Events Transfers from nursing facilities constitute 8.5% of all Medicare admissions to acute-care hospitals.

About 40% of these hospitalizations occur within 90 days of nursing facility admission, 84% percent of these patients are discharged from the hospital back to their original care setting.

Jencks et al3 recently 2004 estimate that close to one fifth of all Medicare beneficiaries discharged from the hospital were readmitted within 30 days, 90% of these readmissions were unplanned, and that the cost to Medicare of unplanned rehospitalizations amounted to $17.4 billion.

Patients with heart failure accounted for 26.9% of all readmissions within 30 days; patients with pneumonia, 20.9%.
In FY 2011, nursing homes transferred one quarter of their Medicare residents to hospitals for inpatient admissions, and Medicare spent $14.3 billion on these hospitalizations.

Nursing home residents went to hospitals for a wide range of conditions, with septicemia the most common. Annual rates of Medicare resident hospitalizations varied widely across nursing homes.

Nursing homes with the following characteristics had the highest annual rates of resident hospitalizations: homes located in Arkansas, Louisiana, Mississippi, or Oklahoma and homes with one, two, or three stars in the CMS Five-Star Quality Rating System.

"Develop a quality measure that describes nursing home resident hospitalization rates and instruct State survey agencies to review the proposed quality measure as part of the survey and certification process."
Downward Trend in Wisconsin Medicare FFS Readmissions

Wisconsin County Medicare FFS Readmission Rates
SNF Stay Potentially Avoidable Conditions

- Electrolyte imbalance
- Respiratory illnesses,
- Urinary tract / kidney infections
- Anticoagulant complications
- Adverse drug reactions
- Cellulitis / wound infection
- Blood pressure management
- Congestive heart failure
- Sepsis
- Hypoglycemia / diabetic complications
- Fractures / musculoskeletal injuries
- Acute delirium
- Pressure ulcers


Post Acute Continuation of Care

- Aim of Post Acute Care
  - Complete Treatment to Achieve Maximum Attainable Health

- Bundled Payments will Cover Full Continuum

CMS - BPCI 2-3
Wisconsin has some CMS BPCI projects

SNF - Value Equation

- Value = function of (Price, Quality, Satisfaction, Safety, Pop Health)

Price/Cost ($)  Pop Health, Safety Quality, Satisfaction
What Should You Include on Your Dashboard?

- SNF Value Products
- Quality
  - Five Star
  - Readmission Rates
  - Patient Safety
  - LOS
  - Employee influenza immunization rate
- Rehabilitation/Care Transition Success
- Local Access to Family Support System
- Support of High Risk Patients
- Maintaining/Improving Health of Residents

SNF Value Products - Continued

- Discharge Planning Process
- Change in Condition Alert Process and Method for Intervention
- Satisfaction Patient/Family/Employee/Medical Staff
- Wanderer protection system
- Cost/Price
- LTC-PCMH Capabilities
SNF Post Acute Care Processes

Evaluation and Acceptance
  • Physician Acceptance and plan input
  • Readmission Risk Assessment
  • High Risk Capability
  • 24/7 Capability

Medication Reconciliation

Quality Metrics (Star rating, LOS, infection rate, readmission, functional assessment, employee influenza immunization rate, etc.)

Participation in Acute Care Protocol Support

SNF Post Acute Care Processes

Electronic Record Capability

Telehealth Capability

Integration of hospital providers/case workers

Discharge Planning Process

Networking Desire/Capability

Ed’s Questions

What causes readmissions?

What causes transfers to emergency room?

What do you see as the PAC SNF responsibility?

What is the Acute Care Provider Responsibility?
Contact Information

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