Post-Acute Care

Good-bye Volume; Hello Value

presented by

Irving L. Stackpole

Irving Stackpole

- *Over 45 years' experience in US and international healthcare*
- *Clinician, statistician and marketer*
- *Multiple national & international awards*
- *Interviewed in The Financial Times, Forbes*
- *Lecturer at Northeastern University, Cambridge, and INCAE*
- *Author, speaker & consultant*

Learning Objectives

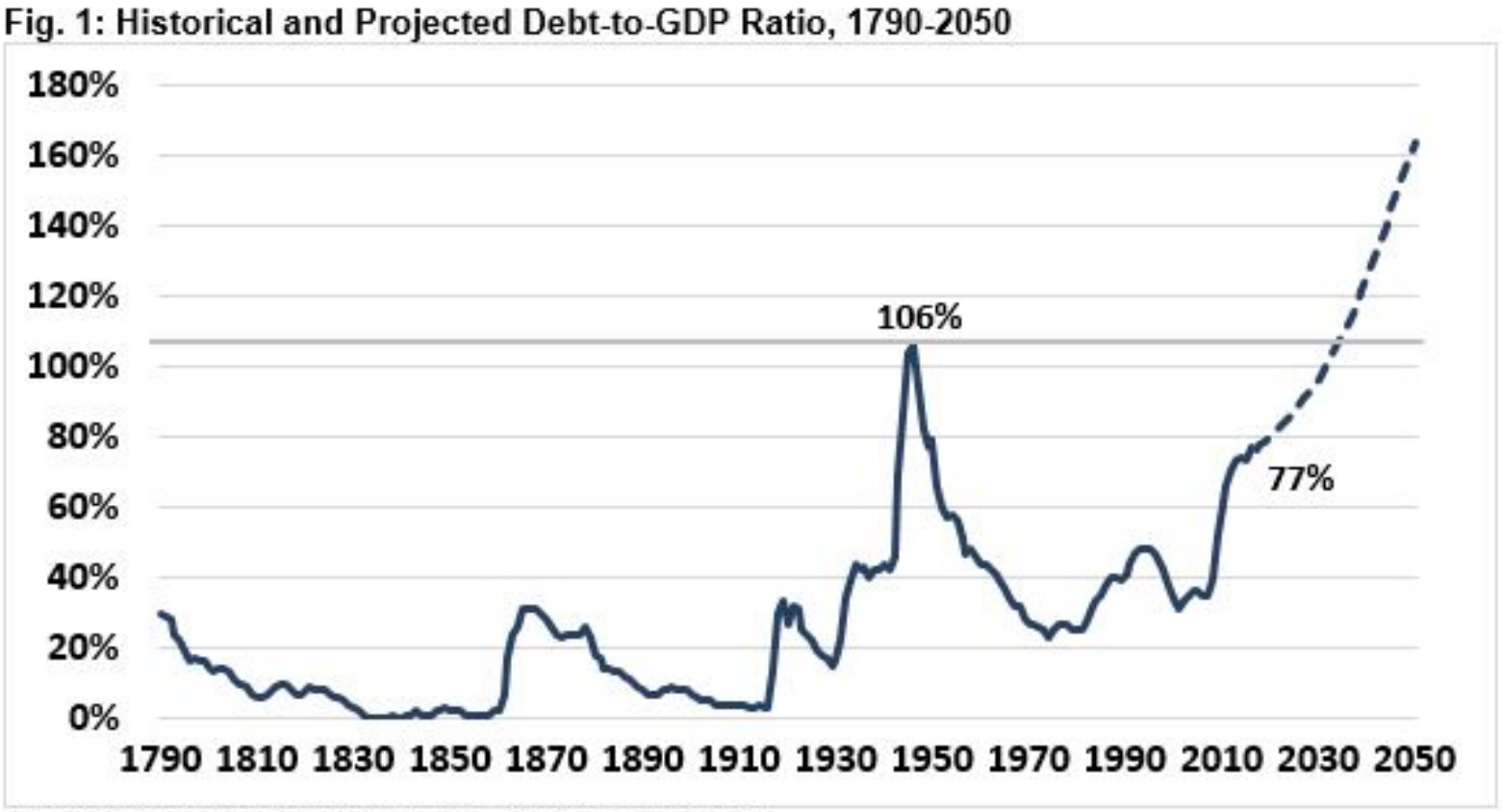
- Understand the shift from “volume” to value based payment
- Learn how to manage new relationships between and among discharging hospitals and post-acute providers
- Explore a proven process to build strategic partnerships and cross continuum collaborations with competitive providers in your market.

Factors driving the shift from Volume to Value

- Pressure in Society - “just in time dollars”
- Rising attention by CMS to PAC
- New CMS Survey Protocol
  - Facility Assessment and QAPI
  - Mandated data analysis to prove effective and efficient resource use (VALUE)

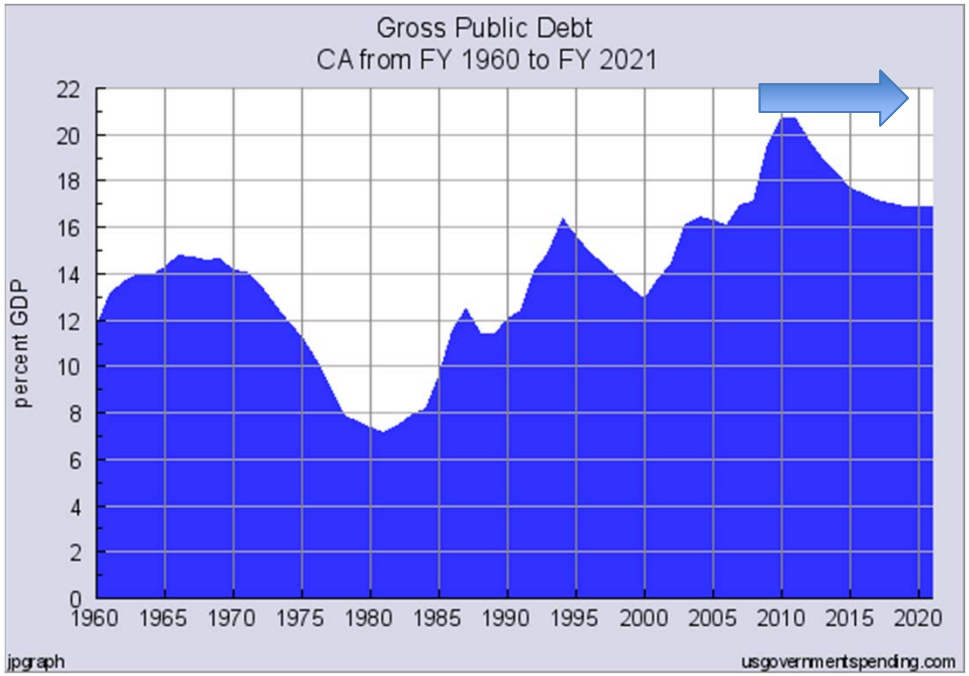
Pressure for Aging Services

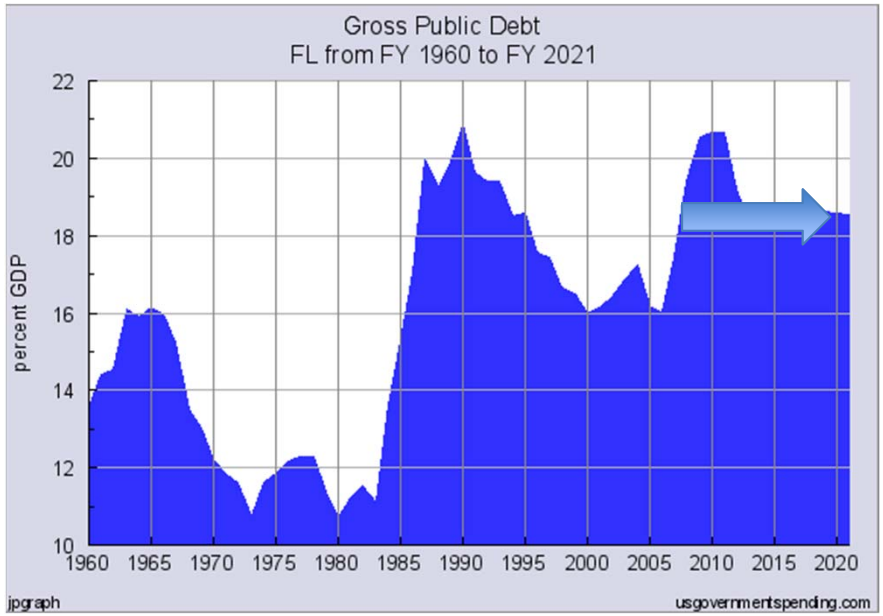
- Federal Debt as Percent GDP

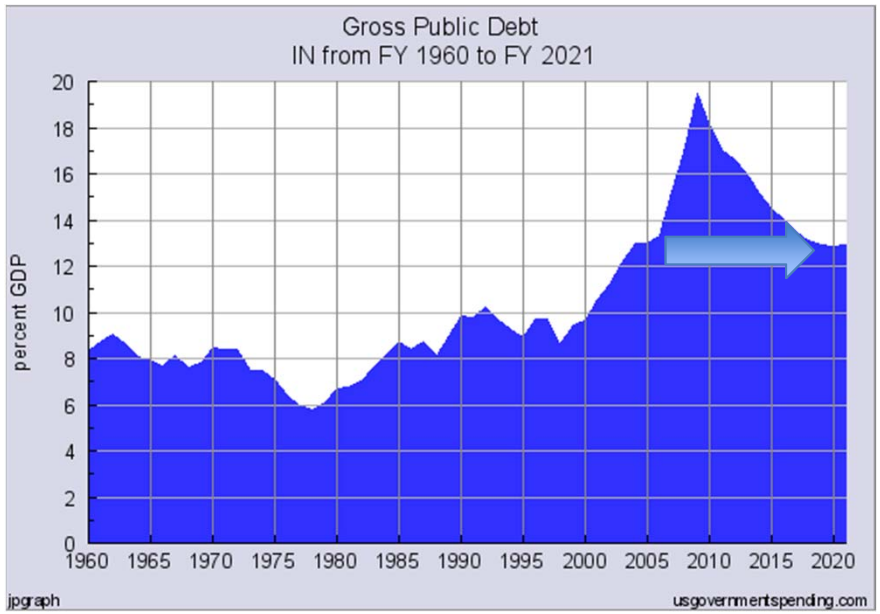


Source: https://en.wikipedia.org/wiki/National_debt_of_the_United_States#/media/File:51129-land-summaryfigure1(1).png

State Debt as Percent State GDP – Are the States the source of solution?

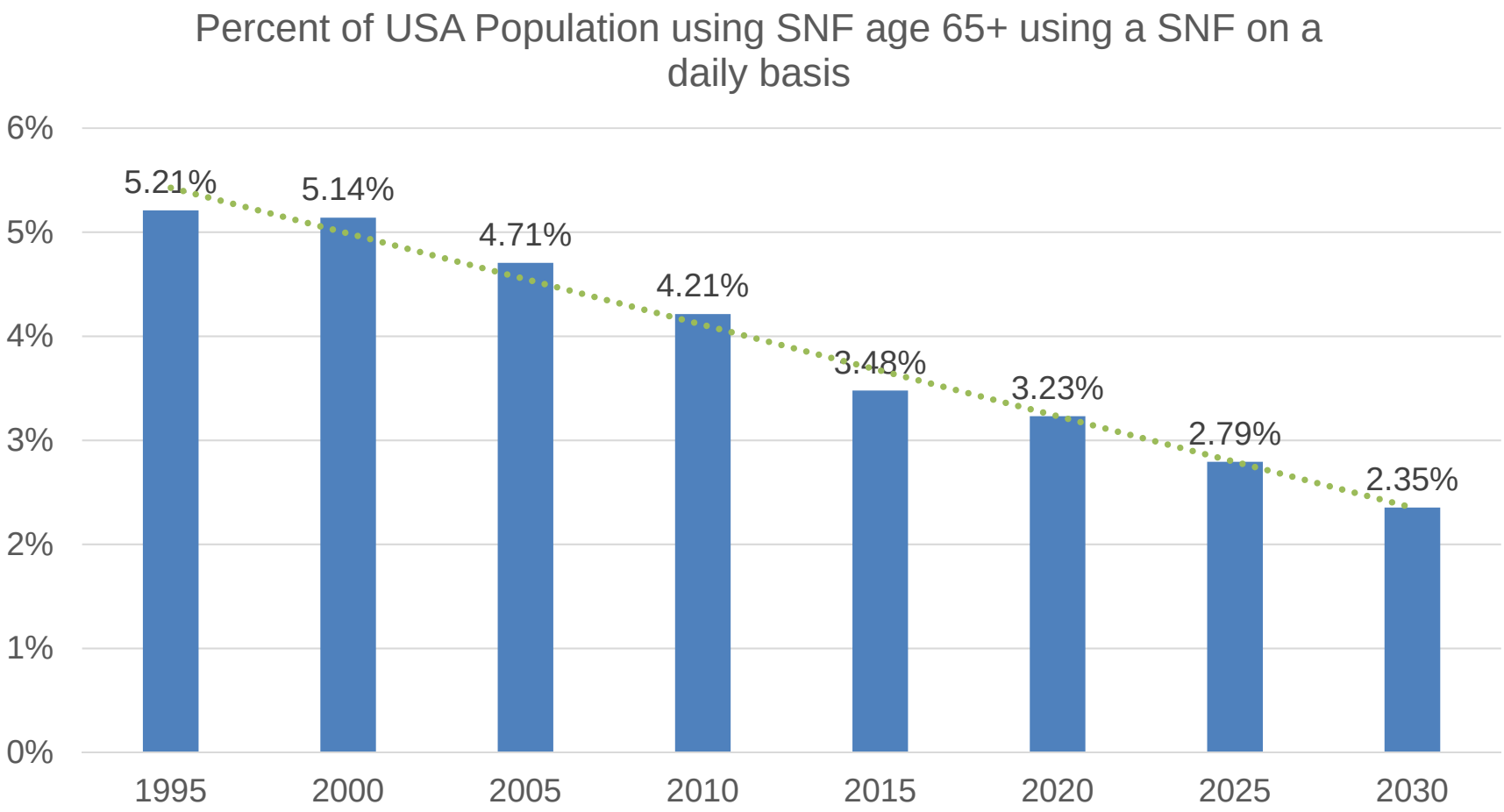




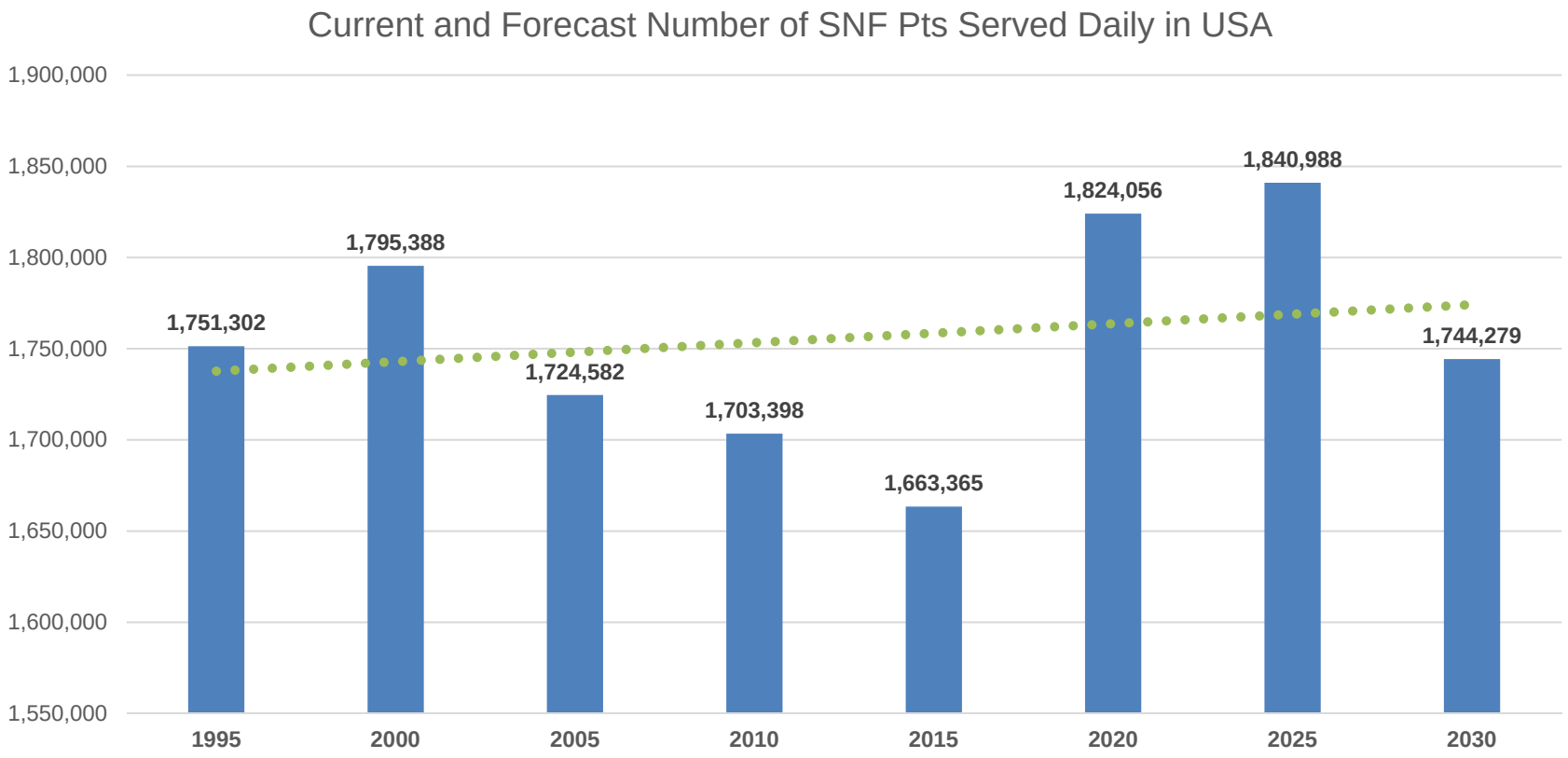


Source: http://www.usgovernmentspending.com/spending_chart_1960_2017ILp_13s1li011lcn_H0t

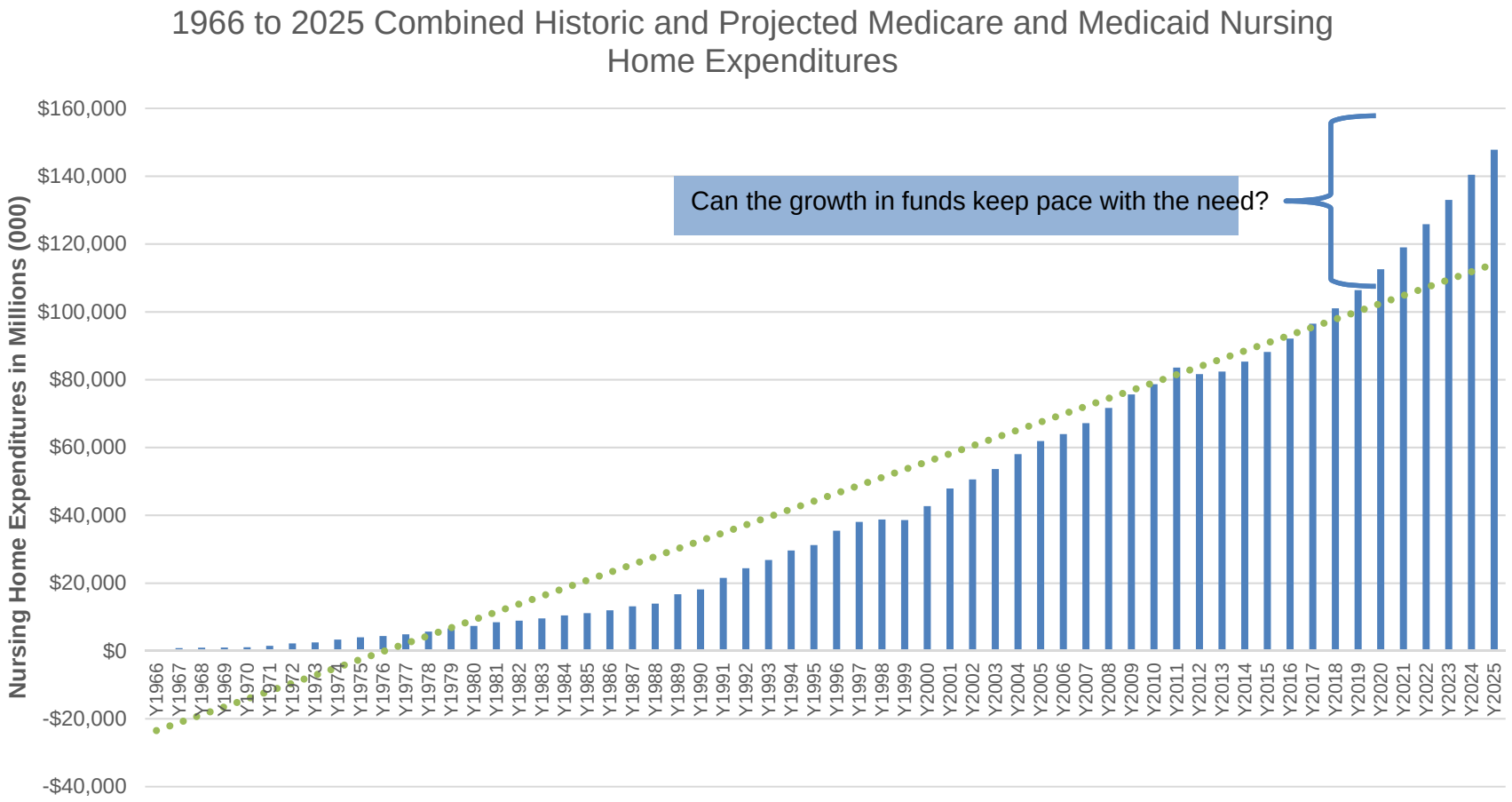
The Percent of Population 65+ Using / Needing Skilled Nursing Services



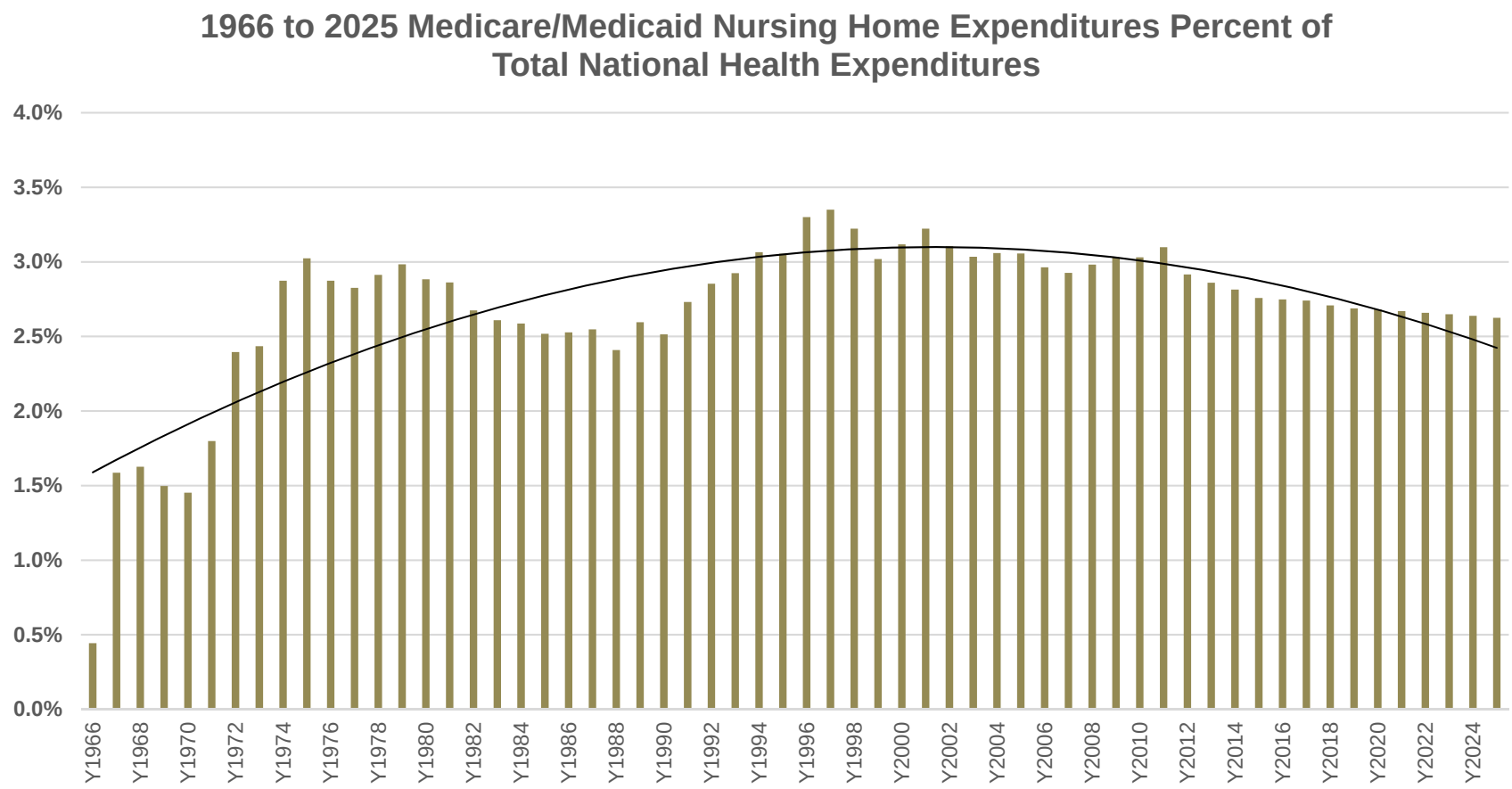
USA Historic / Current / Projected People in SNFs



Medicare and Medicaid Nursing Home Expenditures

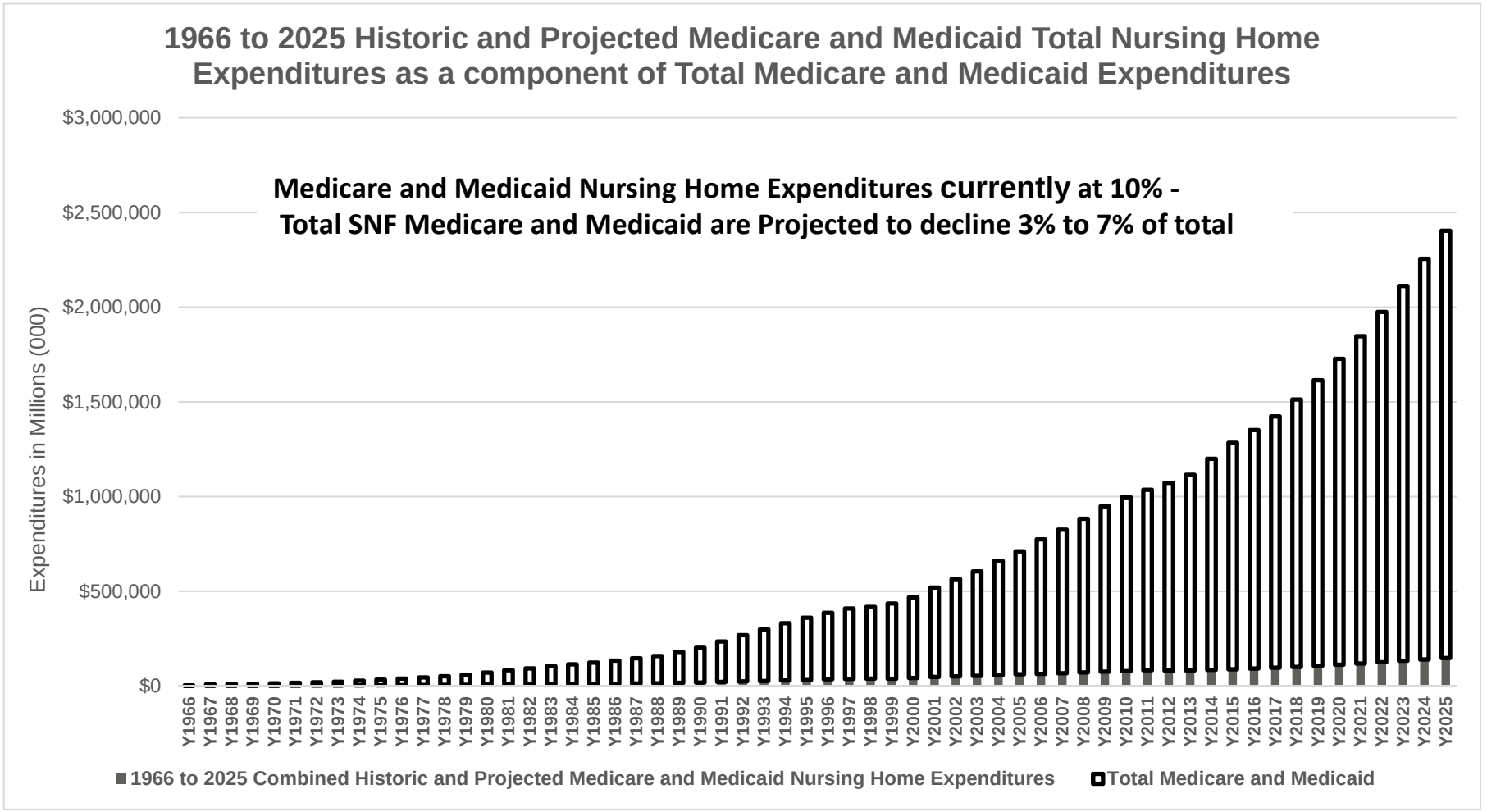


Nursing Home Care % of Health Expenditures



Nursing Home Care is now and projected to be 2.6% of US Health Expenditures

Restraining SNF Revenue Growth: the role for ALFs?



Turbulence in action

- Navigating change
- Balance in growth and value
- Race for Value
- Measurement is easy outside of the river

MSPB –PAC SNF Payment FY-18

Measures Mapped to IMPACT Act Domains for SNF QRP-Proposed Measures (FY 2017 SNF PPS Published NPRM)

Domain	NQF ID	Measure Title	Reporting and Payment Timelines	Confidential Feedback Reports & Public Reporting
Resource Use and other Measures	Not Submitted for Endorsement	• Total Estimated Medicare Spending Per Beneficiary (MSPB)-PAC SNF QRP • Discharge to Community-PAC SNF QRP • Potentially Preventable 30-Day Post-Discharge Readmission Measure for SNF QRP	Claims-based data will be used for payment adjustments for fiscal year (FY) 2018 payment adjustment and subsequent years	One year of claims-based data will be used to inform confidential feedback reports beginning with CY 2016 and public reporting beginning with CY 2017
Medication Reconciliation	Not Submitted for Endorsement	Drug Regimen Review Conducted with Follow-Up for Identified Issues-Post Acute Care SNF QRP	Initial Reporting October–December 2018 for fiscal year (FY) 2020 payment adjustment followed by CY reporting for that of subsequent FYs	Performance data will inform confidential feedback reports one year after the specified application date of assessment based measures. Public reporting must begin NLT two years after the specified application date of such measures

MSPB becomes VBP

SNFs will be ranked and compared in a similar way

Value of Care: National Distribution of Hospital Results on the Mortality (Death) and Payment Measures for Heart Failure Patients.

Worse mortality & lower payment **10 hospitals**	Worse mortality & average payment **68 hospitals**	Worse mortality & higher payment **11 hospitals**
Average mortality & lower payment **355 hospitals**	Average mortality & average payment **2563 hospitals**	Average mortality & higher payment **521 hospitals** **LONG BEACH MEMORIAL MEDICAL CENTER**
Better mortality & lower payment **12 hospitals**	Better mortality & average payment **71 hospitals**	Better mortality & higher payment **85 hospitals**

Value – Three Principles

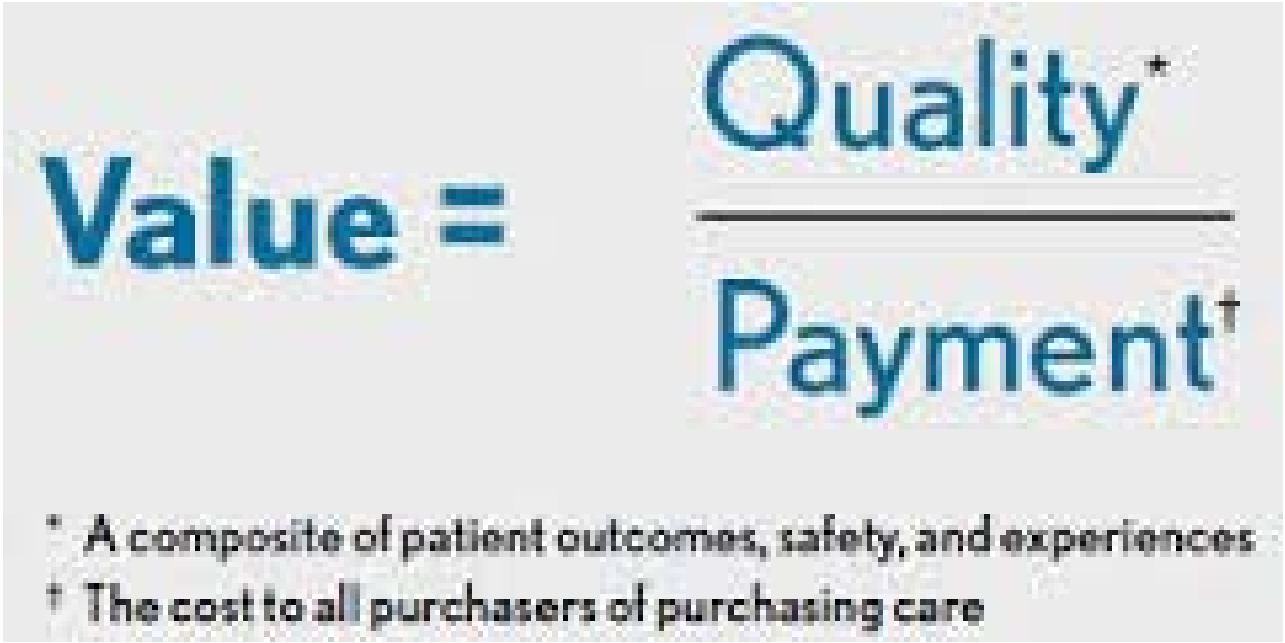
- First Principle
  - Current Post Acute Care System has great variance in costs and outcomes
    - This is a key indicator of inefficiency AKA “waste”
- Second Principle
  - Fee for Services in Post Acute Care – the more you do the more you get paid - regardless of benefit
    - Are incentives aligned with need or are they misdirected?
- Third Principle
  - ***Simplify*** to meet Triple Aim
    - The current system is overly complex and lacks integration
    - Too many care givers, none has responsibility for coordination and full patient benefit

How to increase your value?
Create clinically integrated care and organized paths!

- Clinical integration denotes a **minimum level of coordination and alignment of goals** among providers caring for a population
- In clinically integrated environments, providers:
  - **share** clinical data,
  - **agree** on plans of care, and
  - **collaborate** to achieve favorable patient-centered outcomes
- You can **foster care coordination** among individual providers of care, as well as share data and track service use and outcomes to **measure progress**
- **Technology** can help better manage, communicate and use data

Volume to Value

- Volume - Fee for Service
- Value



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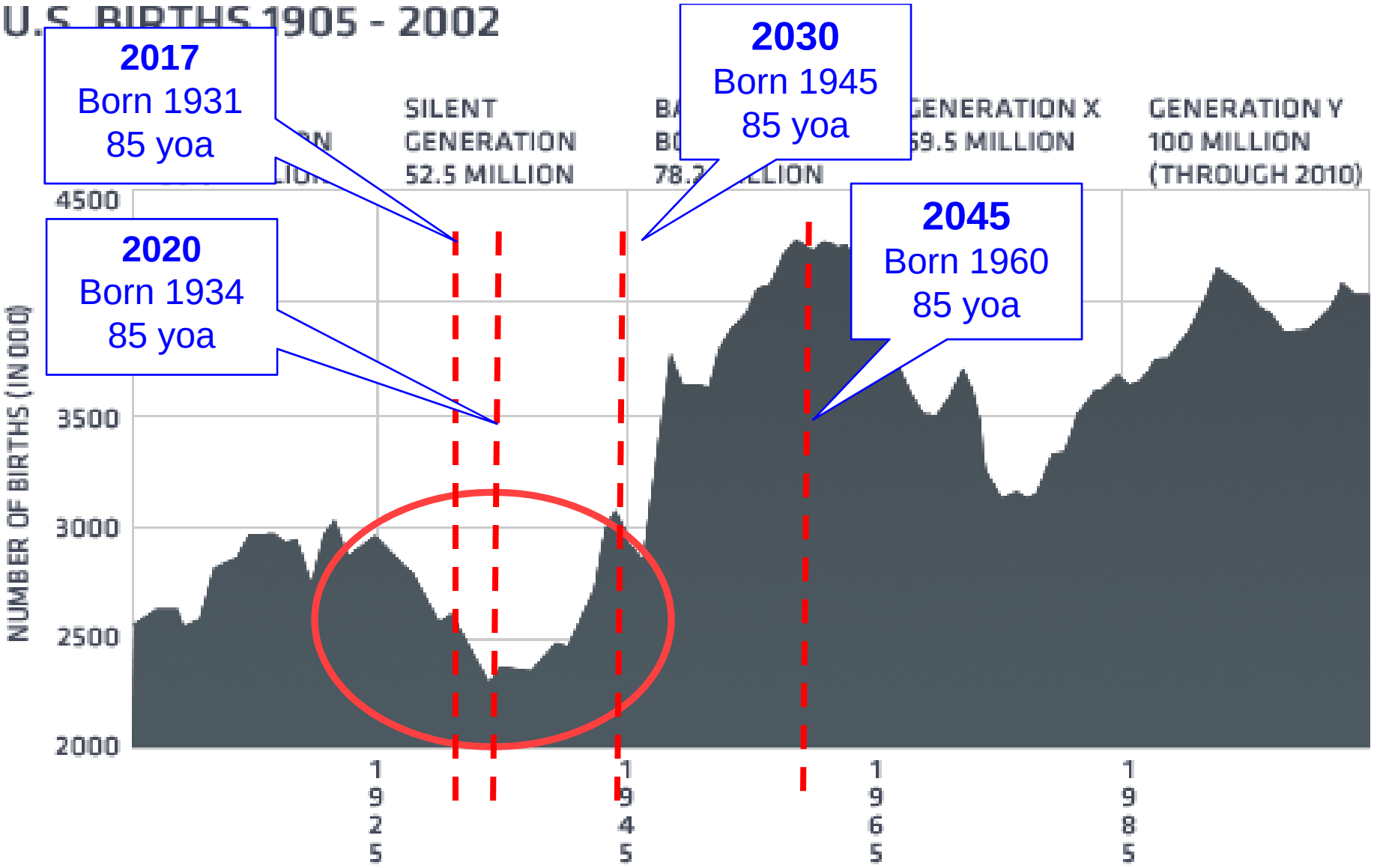
Volume or Value?

"Paper or plastic?"

The Challenges / WHY?

- *Volume – Value Shift*
  - *High Value Providers thrive*
- *Low occupancy*
- *Declining payments*



G.I GENERATION: 1905-1924 56.6 MILLION
SILENT GENERATION: 1925-1944 52.5 MILLION
BABY BOOMERS: 1945-1964 78.2 MILLION
GENERATION X: 1965-1984 69.5 MILLION

Three Principles – *REMEMBER!*

- *First Principle*
  - *Decrease variance & ↑ efficiency*
- *Second Principle*
  - *Align incentives for best outcomes*
- *Third Principle*
  - *Simplify, integrated care & ↓ complexity*

New Rules

1. *Defend, protect & fortify*
   - *Manage to Loyalty*
2. *Increase Productivity / Efficiency*
3. *Innovate*
4. *Differentiate*

- *The Theme - <u>prove</u> value*

“Take your partner by the hand…”

- ***Steps to the dance…***
- *Leadership*
- *Trust*
- *Shared experiences*
- *Early wins*
- *Inclusive*
- *Data, data, data*

Efficiency

Technical, Productive, Allocative

- Technical
  - Maximum improvement from resources
- Productive
  - Best health outcome for given costs or reduction in cost for the same outcome
- Allocative
  - Best outcomes for society

Focus for Clinical Integration

- *Focus e.g., quality improvement,*
- *Care coordination - SNF, HHA & PAC referrals,*
- *Favor efficient providers*
- *Target high-risk individuals & populations*
  - *disease management*
- *COLLABORATION*

What reduces value?

- ***Fragmentation***
  - *Services are delivered across an increasing array of distinct and often competing providers and entities, each with different objectives, obligations, and capabilities (Cebul et al., 2008).*
  - *Providers practicing within the same geographic area, sometimes caring for the same patients, often work independently from and not communicating with one another (Bodenheimer, 2008; Shih et al., 2008).*
  - *As a fragmented health care delivery system we are not equipped to manage the continuum of health care for an aging population with complex needs.*

Drive Value
– How can we respond?

Short Cut – New Rules

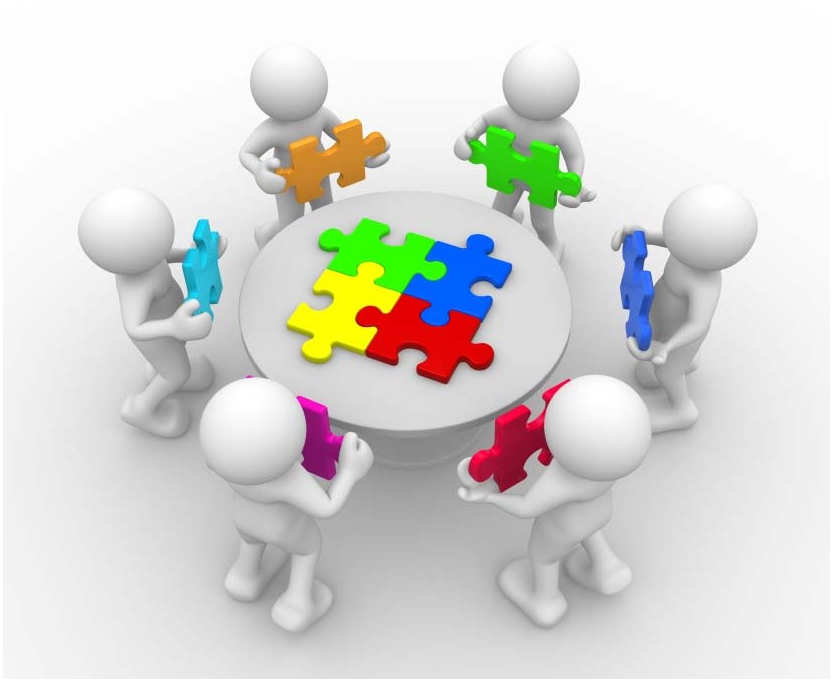
- *Defend, protect & fortify*
- *Increase Productivity / Efficiency*
- *Innovate*
- *Differentiate*
- ***Engage v. Bunker***
- ***COLLABORATION***

Where do we start

- *How can disparate actors move effectively from vision to the implementation of cross-continuum collaboration?*
- *When no one actor has all the answers or the authority, the usual committee of working group isn't adequate to the task.*

“Take your partner by the hand…”

- ***Steps to the dance…***
- *Leadership*
- *Trust*
- *Shared experiences*
- *Early wins*
- *Inclusive*
- *Data, data, data*
- *Focus on end-users*



Leadership

- *Leadership*
  - *Visibility*
  - *Support*
  - *Focus &*
  - *Endurance*
  - *Leadership – measures*

Trust

- *One-on-One*
  - *Reliable*
  - *Transparent*
  - *Personal*

Shared Experiences

- *Integration between / among*
  - *“Walk a mile in my shoes…”*
  - *Work-a-Day / Work-a-Week*
  - *Functional v. management*
    - *–Trust, personal*
    - *–Early “wins”, durable*

Early Wins

- *Focus on 15 – 30 day victories*
  - *↓ delay to start of home care by 12 hours*

  OR
  - *Eliminating readmissions*
- *Which is more likely to have “early win”?*

Inclusive

- *Staff the initiative “inclusively”*
- *NOT the usual position-based staff*
  - *Who is likely to have the insight*
  - *Who handles the phone / text / email*

Data, data, data

- *Measure EVERYTHING*
  - *Qualitative*
  - *Quantitative*
- *Buy Excel tutorials for EVERYONE*

The end user

Efficiency

Technical, Productive, Allocative

- Technical

–Maximum improvement from resources

- Productive

–Best health outcome for given costs or reduction in cost for the same outcome

- Allocative

–Best outcomes for society

Realities

- *Occupancies are poor*
  - *The age qualified markets are declining*
  - *Increased options / choices*
  - *Negative perception*
  - *The economy*
  - *The role of “Intermediaries”*
- *The need for change is URGENT*
- *“Soft” skills are needed*

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Facts of Life

- *The age qualified market is shrinking*
- *Continued pressure on payments*
- *Continued pressure on utilization*
- ***Efficiencies & productivity are the keys to effective differentiation***
- ***Collaboration is the "new frontier"***


QUESTIONS???

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Irving Stackpole

Stackpole & Associates, Inc.

1-617-739-5900, Ext. 11

1-617-719-9530

istackpole@StackpoleAssociates.com