EXPANDING THE POSSIBILITIES
Embracing Healthcare Reform: Developing Specialty Services in a VBP Environment

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Aegis Therapies and Golden Living
About Us

• Integrated healthcare system dedicated to advancing practice throughout the post-acute care continuum through innovative evidenced-based services

  – **Established Divisions**: Aegis Therapies | Aegis Acute Rehab (Specialty) | AseraCare Hospice | Golden LivingCenters & Communities | 360 Healthcare Staffing | Ceres Purchasing Solutions

  – **Newest Divisions**: Salude TCU (Specialty) | Non-Profit Clinical Research Institute
About Us

- Therapeutics, Wellness, Nursing, Medicine, Hospice, & Pharmacy,
- CCRC, SNF, ILF/ALF, HH, and OP
- > 1000 locations throughout the USA
- Touch lives of > 62K patients/clients daily
- Outreach/Education: Sponsored degree programs with RMUoHP & Concord College
Value-Based Purchasing and Accountable Care Organizations

Limited Dollars for Growing Medicare Population
CMS’s Vision for America

• “Patient-centered, high quality care delivered efficiently.”
  • Value-Based Purchasing
    • Provides incentives
    • Fosters joint clinical and financial accountability
Value-Based Purchasing

CMS’s Goals for Value-Based Purchasing

- Financial Viability
- Payment Incentives
- Joint Accountability
- Patient Experience of Care
- Effectiveness
- Ensuring Access
- Safety and Transparency
- Smooth Transitions
- Electronic Health Records

Responsibilities of Medicare ACOs

- As required by the Affordable Care Act of 2010, the final rule requires an ACO to define processes to:
  
  - Promote evidence-based medicine
  - Promote patient engagement (Consumer/Caregiver Activation)
  - Improve Patient Satisfaction with Health Care Providers
  - Report on quality and cost measures
  - Coordinate care throughout the continuum, such as through the use of telehealth, electronic portals, remote patient monitoring and other such enabling electronic technologies.
ACO-Measuring Quality Improvement

1. Patient/caregiver experience of care
2. Care coordination
3. Patient safety
4. Preventative health (Wellness)
   • Diabetes
   • Heart failure
   • Coronary artery disease
   • Hypertension
   • Chronic obstructive pulmonary disorder
5. At-risk population/frail elderly health
   • Falls: screening for fall risk
   • Osteoporosis management in women who had a fracture
   • Monthly INR for beneficiaries on Warfarin

Wellness through passive participation alone is insufficient. Education based on principles of adult learning are essential to “activation.”
ACO expectations of PAC Providers

• IT infrastructure (HIE and EMR) to share clinical information in a two way fashion
• Stronger medical care support to accept higher acuity patients that would have used LTACH’s and IRFs - SPECIALISTS
  – Geriatricians, Internal Medicine MD’s, NPs, RTs
• Close coordination with hospitals and HH agencies to reduce avoidable readmissions
• Clinical pathways to better sequence the timing and delivery of services
Excellence in clinical care, providing the right care in the right place at the right time, resulting in:

- Lower re-hospitalizations
- Seamless transitions of care
- Improve ability to teach and train patients on self care needs for the discharge environment
- Improved clinical outcomes
- Coordinated communication among providers
ACO’s choice of PAC Partners in RFP?

- SNF Surveys and Length of Stay Data
- Patient Satisfaction and Beneficiary Engagement
- Tenure, experience and expertise of Facility Staff
- Capacity to serve specialty patient populations
- IT Integration and capabilities
- Relationships with Key Hospitals, Medical Groups and Geography covered
- Evidenced-based services and outcomes
Still with us?! 

- Describe 3 services/criteria that ACOs look for in a RFP when establishing their PAC provider network.
  
  A. Low hospital readmission rates; Beneficiary Activation through activity classes and groups; Integrated Home and Outpatient Services
  
  B. High patient satisfaction, Use of Evidenced-Based Practice, Unit with Hospitalist Chief of Staff and Licensed Clinicians
  
  C. Shorter LOS by DRG; Beneficiary Activation through activity and educational classes & 1:1 sessions; Unit with Hospitalist Chief of Staff and Specialty Practitioners
ACO & VBP: Implications

Post-Acute Care Providers
Clinical Milestones Across Continuum

Example: TSA Rehab with Tissue Deficient Milestones

- Historically uncoordinated leading to duplication and less than optimal outcomes.
Features and Benefits of Specialty Services

Units and Programs

“God is in the Details.” – Ludwig Mies van der Rohe (1886–1969)
Terminology Soup: Devil in Detail?

• Many providers claim “specialty programs” or “..units”
• Most post-acute settings do not actually have them
• Important to define and develop on recognized criterion
• Avoid using the terms loosely – consumers WILL ask for proof!

“| The 2\textsuperscript{nd} floor is our specialty orthopedic unit – because that’s were we admit most our patients with joint replacements. |
| ‘I am board certified in neurologic care’ |

“We offer a go to lunch at noon program”

“She completed the certificate program in cardiac care”

“We need to promote our Neuro Program – our RN on 3 and OT are good with strokes”
Definition of a “Program”

• A brief outline (preferably in writing) of the order to be followed, the features to be presented, and the persons participating

• A plan or system under which action may be taken toward a goal

• A sequence of coded instructions that can be inserted into a process or technique for achieving a result

Merriam-Webster Dictionary
Definition of a “Unit” & “Specialty”

Medical Definition of UNIT
• An area in a medical facility and especially a hospital that is specially staffed and equipped to provide a particular type of care <an intensive care unit>

Medical Definition of SPECIALTY
• Something (as a branch of medicine) in which one specializes

Merriam-Webster Dictionary
Board Definitions of a “Specialty”

American Board of Medical Specialties
• Nationally recognized standards for education, knowledge, experience and skills... **certification goes above and beyond basic medical licensure.**

American Board of Nursing Specialties
• Formal recognition of the specialized knowledge... **[certification] reflects achievement of a standard beyond licensure.**

American Board of Physical Therapy Specialties
• Recognition... [of] **advanced** clinical knowledge, experience, and skills.

Certification vs. Certificate Program
• Certification: credentialed (nationally recognized)
• Certificate: (not nationally recognized)

NOTE: “Specialty” DOES NOT = Equipment
General vs. Specialty Practice

**General**
- Heterogeneous Diagnostic Groups
- Comingled Beds/Units
- General Providers
- Standard Clinical Competencies
- General Training
- Logical Reasoning Mandatory
- Regulated General Standards
- General Support Services
- General Quality Audits
- Comparable Outcomes

**Specialty**
- Homogeneous Diagnostic Groups
- Dedicated Beds/Units
- Dedicated Providers
- Advanced Clinical Competencies
- Specialized Certification
- EBP Mandatory
- Regulated Controlled Standards
- Dedicated Support Services
- Practice-Specific Quality Audits
- Best Possible Outcomes

NOTE: “General” DOES NOT = Inferior
Designing Specialty Services

Eight (8) Key Features and Benefits

1. Dedicated specialization (unit or program) and staff
2. Patient-Centered Care Model
   • Evidence-Based
   • Multidimensional e.g. Service Types
3. Regulated Standards
   • Brand Standards e.g. Operational Management and Quality
   • Practice Standards e.g. Reasoning Processes and Interventions
4. Continuity of Care Services
   • Outpatient
   • Preoperative (Pre-habilitation)
   • Wellness and Complimentary Medicine
5. Advanced Clinical Competencies
   • Certification/Re-certification
6. Advanced Technologies e.g. patient/provider portals
7. Advanced Outcomes e.g. uses valid and reliable outcome measures e.g. SF-36
8. Quarterly Appraisals e.g. Specific and Sensitive to service standards
Patient Centered Care

Evidence-Based and Multi-dimensional

• Several models exist
• Select model that is sustainable and consistent with mission and values
• At least these four attributes
  – "Whole-person" care.
  – Coordination and communication
  – Patient support and empowerment
  – Ready access
Establishing Standards

**Evidence-Based**

- Grounded in science vs. best guess “only”
  - *e.g. focus group with board certified specialist if no evidence available*
- Scientific method or equivocal rigor
  - Market analysis *e.g. Buxton Group (customer analytics)*
  - Review of available literature
- Formal focus groups
  - Profiled consumers
  - Referral sources
- Brand standards consistent w/market analysis
- Practice standards consistent w/evidence
  - Patient Management – all disciplines
Continuity of Care

Right Care, Right Place, Right Time

- Access to care*
- Seamless transitions to OP, HH, Wellness*
  - Outpatient
  - Preoperative (Pre-habilitation)
  - Wellness and Complimentary Medicine
- Clinical Milestones across care continuum
- Rapid Recovery

*Also a patient-centered care dimension (Pickard)
Advanced Technologies

Efficient AND Effective Integration, Communication, Administration

- Patient/Provider Portals for seamless communication
  - e.g. eTracker, MyCare, MatrixCare
- Tele-medicine and Tele-health
  - e.g. cost effective care management
- Clinical modalities
  - e.g. electrical stimulation, body-worn inertial sensors

Synchronized, wireless sensors

In a clinic

Community Level Monitoring
Health Information Technology/Exchange

Caregiver patient dashboard...

Patient/family dashboard...

Nursing Care

Update from Cameron Davos, Registered Nurse - 12/7/2012 at 8:31 AM

Quisque adipiscing, libero vel placerat lacinia, eros massa mattis turpis, ut venenatis justo
risus eget nulla. Pulvinar tempor eros ut lorem elementum dignissim. Nam vitae dui in orci
vehicula porttitor.
Simple and Secure Telemedicine

Courtesy of Vsee

iPad
(iPhone in production)
Advanced Outcomes

Superior Performance

• Valid and reliable outcome measures
  • e.g. Minimal Data Set and SF-36
• Delivery model that consistently yields
  • Optimal outcomes
  • Durable outcomes
• Establish % ≥ norm
  • e.g. 20% ≥ norm
  • Shorter LOS
  • ICF Gains
    • Functional Impairments
    • Activity Limitations
    • Participation Restriction
Key Point

The primary objective of Specialty Practice Model is to achieve **optimal outcomes and reduce cost**.
Hmm..were you listening?!

• Describe 3 essential elements of designing specialty units and programs to meet the demands of value-based purchasing and use an evidence-based approach to identify populations in need of these services.

A. Dedicated specialization, State-Required Clinical Competency, Regulated Standards
B. Dedicated specialization, Advanced Clinical Competency, Regulated Standards
C. Dedicated specialization, Standard Technology, Appraisals (QAPI)
Specialty Services

To Meet the VBP & ACO Demand
Specialty Services Value Proposition

For Patients

- Patient-centered standards
- Advanced nursing and rehabilitation
- Dedicated MD for higher level of physician to patient care
- Dedicated staff for optimal experience and outcomes
- Continuity of care services
- Concierge service model with care and quality-based amenities
Specialty Services Value Proposition

For Hospitals/Partners

- Elevated practice standards for seamless care transitions
- Elevated practice standards for reduced hospital readmissions
- Shared-risk for reduce penalties
- Shared-risk for increase performance payments
- Low cost alternative for bundled payments and quality outcomes
- Enhanced physician and patient satisfaction
- Coordinated follow-up visits for seamless post surgery care
- Meets specialized populations with limited options (CMS 60/40 rule)
Specialty Services Value Proposition

For Physicians

- Physician-specific clinical milestones and order sets for reduced complications and consistent outcomes
- Care coordination - seamless transitions
- Physician follow-up visits
- Advanced competency levels for optimal clinical outcomes
- Advanced service levels improve patient satisfaction
Specialty Services Value Proposition

For Payers

• Low cost alternative for bundled payments and quality outcomes
• Managed care case rate at lower cost than IRF
• Continuity of care – seamless transitions
• Shorter length of stay – rapid recovery
• **Durable** outcomes – reduced length of stay
• Advanced quality standards reduce rate of re-hospitalization
• Advanced practice standards maximize care efficacy
• Advanced technologies maximize care efficiency
Evidence: Scientific

“The deepest sin against the human mind is to believe things without evidence.” – Thomas H. Huxley 1825-1895
Rea et al, 2011

- **Design:** Retrospective study
- **Sample:** 115,540 patients (4.6% specialized)
- **Purpose:** Specialized practice improve colorectal
  - **Intervention:** colorectal resections from 2001 to 2007 in specialized or general practice (non-specialized).
  - **Comparison:** General practice
- **Outcomes:** Cost, length of stay, and mortality; risk adjustments for demographics, comorbidities, acuity of admissions, disposition at discharge, payer surgeon volume.
Rea et al, 2011

Multivariate Analysis:

- **Mortality:** Lower risk 0.72 (CI 0.57-0.90)
- **Length of Stay:** decreased absolute days difference in days .23 (CI 0.11-0.49)
- **Costs:** absolute cost difference $420 less (CI $238 more to $1079 less)
Results: Specialization yielded statistically and clinically significant differences.

Intervention: Significant ↓ mortality (p=0.0044), ↓ length of stay (p= 0.0022), ↓ in cost (p=0.211). Non-significant cost at 75% cutoff, but relationship existed between lower hospitalization cost – cost of hospitalization ↓ with ↑ specialization

Conclusion: Specialization lead to reduction in mortality, hospital days, cost for inpatient colorectal care.
Evidence: Empirical

“If we knew what it was we were doing, it would not be called research, would it?” Albert Einstein 1879-1955
Created as a response to the 2004 CMS 75% rule impacting a percentage of certain diagnostic groupings admitted to Inpatient Rehab Facilities (IRF’s). After modification by CMS the ruling ended in a 60/40 ruling.

Example: 60% Rule limits IRF hospitals from admitting many orthopedic patients with a single hip or knee replacement unless:
- The patient is over 85 years old.
- Had a body mass index (BMI) over 50, or
- They are having bilateral hip or knee surgery.

The ruling forced 40-50% of the patients on the IRF to other venues of care.
## Service Line Orthopedics; Service Type Units

### Service Types
- **Specialty Units:** Specialty Service with dedicated unit and staff
- **Specialty Programs:** Specialty Service without dedicated unit (OP, HH)

### Kinetix: Service Lines

<table>
<thead>
<tr>
<th>Specialization</th>
<th>Target DRG (not all inclusive)</th>
<th>Availability</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Kinetix Orthopedic</strong></td>
<td>• Elective Joint Surgeries</td>
<td>Now</td>
</tr>
<tr>
<td></td>
<td>• Trauma</td>
<td></td>
</tr>
<tr>
<td><strong>2. Kinetix Neurologic</strong></td>
<td>• Stroke</td>
<td>Under Development</td>
</tr>
<tr>
<td></td>
<td>• Brain Injury</td>
<td></td>
</tr>
<tr>
<td><strong>3. Kinetix Cardiopulmonary</strong></td>
<td>• Coronary Bypass</td>
<td>Under Development</td>
</tr>
<tr>
<td></td>
<td>• COPD</td>
<td></td>
</tr>
<tr>
<td><strong>4. Kinetix Metabolic</strong></td>
<td>• Diabetic Conditions</td>
<td>Under Development</td>
</tr>
<tr>
<td></td>
<td>• All Wounds</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Amputation</td>
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</tbody>
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Service Line **Orthopedics; Service Type Units**

- Branded specialty unit in a SNF
  - Orthopedic specialty
    - Dedicated Program Director
    - Dedicated Patient Transition Representative (PTR)
    - Dedicated, part-time, contract Medical Director
    - Orthopedically certified nurses and therapists
  - Separate dedicated wing
    - Separate entrance
    - Separate therapy room
    - No co-mingling with long term care population
  - Concierge service model
    - Private rooms
    - Hotel like atmosphere
    - Special dining options
    - TV, Internet
  - An attractive high outcome, low cost alternative to hospital units and traditional sub-acute programs in SNFs for payers
Patient Profile: Target patient for Specialty Orthopedics

- 50-80 years old
- Dx knee, hip, spine, shoulder surgery or multi trauma
- Can’t D/C home due to medical complexity
- Experiences an average LOS 10-14 days
- In SNFs, inpatient rehabilitation units, and IRFs
- MCR A, MCR Medicare, private insurance, and worker's compensation
- ≥ 80% chance D/C home
Each prospective Kinetix location must pass 6 key tests before approval

Initial Buxton Market Assessment Score >140
DRG Analysis supports beds @ 10% share
Detailed Buxton Assessment supports location
In-market interviews validate referrals
Mystery Shopping yields few surprises
Talent Assessment validates SNF team readiness
Revenue to SNF

- Reimbursement for Therapy and residency of ~$595 PPD, increasing 2% per year
- Averages $2.00 per therapy minute for specialty units, a premium managed rate

Management Fee/↑ Rate
- covers the cost of the advanced non-therapy personnel, overhead
- Assumed to increase 2% per year

Charge per Therapy Minute
- covers the cost of advanced therapy personnel and contributes to bottom-line
- similar to the rate structure used in our typical Therapy contracts
- priced in the range of $1.23 to $1.29 per minute delivered
- Assumed to increase 2% per year

Who’s responsible??
Literally ALL team members… clinical staff plays a more direct and influential part.
Financial Impact from unit for a single SNF

The consolidated impact on SNF of a Specialty Orthopedics in a single SNF is significant, regardless of the scenario:

- In scenario I (filling unoccupied beds) the specialty unit generates a combined EBITDA contribution of $900,000 by year 2
- In scenario II (filling Medicaid beds) the EBITDA contribution climbs to $1,070,000 by year 2 since Medicaid beds generate a loss to SNFs, on average.
Specialty Units Superior Outcomes

10K General patients and 91 Specialty Orthopedic patients. Patients on Specialty unit achieved better outcomes, shorter LOS, and returned home more often.
No dosing off now!

- Translate research findings related to developing specialty services for accountable care organizations and other value-based-purchasing payment programs into practice. Which center would be ideal for specialty unit?

A. CCRC w/Buxton score of 160, DRG analysis supports beds @15% share, Hospital closing neuro-unit on mystery shopping

B. SNF w/Buxton score of 120, DRG analysis supports beds @5% share, Hospital opening neuro-unit on mystery shopping

C. CCRC w/Buxton score of 175 DRG analysis supports beds @10% share, Hospital opening neuro-unit on mystery shopping
Barriers

- Seek “Top of License” Staff
- Physical plant (appeal)
- Physical plant (space)
- Low census ↓ demand
- Low census ↓ awareness

Best Practices

- Targeted Selection
- Refurbish (vs. rebuild)
- Low census wing/ALF
- Formal Market Analysis
- Dedicated Transition Rep
Questions?

make the difference.
share the difference.
be the difference.

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