How to be a Strategic Partner with Acute Care Systems and Payers

Jim Newbrough, CEO Menorah Park
Carol Irvine, Abramson Center for Jewish Life
Lou Woolf, CEO Hebrew Senior Life
How to be a Strategic Partner with Acute Care Systems and Payers

Why Do They Want (or need) to Partner with Post-Acute Care?
Shifting Care to Lower Cost Setting

Care Continuum

Hospital
ALOS: 5.4 days
Average Episode: $9,460

LTAC
ALOS: 26.6 days
Average Episode: $38,600

IRF
ALOS: 13.1 days
Average Episode: $18,000

SNF
ALOS: 27.1 days
Average Episode: $11,000

Home Health
PPS: 13.2 visits
Average Episode: $3,000

Hospice
ALOS: 60 Days
Average Episode: $8,700

Shift to Appropriate Lower Cost Setting

Cost Savings Range between $7,000- $35,000 Per Continuing Care Episode

Medicare Patients Use Multiple Post-Acute Settings

Medicare FFS Hospital Discharges → 41.4% to PAC

1st Discharge Setting
- SNF 19.5%
- Home Health 16.8%
- Acute Rehab 3.2%
- LTACH 1.1%

2nd Discharge Setting
- 42.9%
- 4.2%
- 64.3%
- 60.2%

Post Acute Care (PAC) by the Numbers

FACTS

- Over-utilization of SNF days
- 25% of SNF admits could go home
- Amount saved by Medicare annually if patients utilize the appropriate PAC setting
- The rate at which Medicare spending for SNF, LTC, and Home Health grew annually from 2001 - 2012

*SOURCE: NaviHealth*
How Do Post Acute Care Providers Succeed in a Value-Based World?

• Quality – this is a given, baseline
• Vertical Integration and partnerships
• Enhancement of Cross-Continuum capabilities
• Alignment with H&HS and Health Plans
• Understanding when and how to take risk (and reward)
# Models for Partnership

<table>
<thead>
<tr>
<th>Joint Quality Improvement</th>
<th>Strategic Contracts</th>
<th>Asset Operation</th>
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</thead>
<tbody>
<tr>
<td>• Information exchange</td>
<td>• Pay for performance, bundles, total cost</td>
<td>• Staffing contracts (e.g. contract therapy services)</td>
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<tr>
<td>• Joint training</td>
<td>• Under-reimbursed service purchasing (e.g. telehealth, heart failure education, care transition services.</td>
<td>• Joint ventures</td>
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<tr>
<td>• Quality tracking</td>
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<td>• Managed services agreements</td>
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<tr>
<td>• Preferred provider</td>
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<td>• Asset acquisition</td>
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<tr>
<td>• Affiliation agreements</td>
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Source: Advisory Board Post Acute Collaborative 2017
Menorah Park

Excellence in Caring
About Menorah Park

• Integrated Senior Living Community in Ohio serving over 1000 clients/day on single campus.
• Not for profit home, largest stand-alone nursing facility in the State with 355 dually licensed (MA/MC) beds.
• 1 Independent living residence with 193 units
• 2 Assisted living residences with combined 260 units
• Home Health, Hospice, Ambulance, Adult Day Care
• Outpatient land and water-based therapy program.
• Center 4 Brain Health and Dementia Care Program
• $80 million in annual revenue.

Excellence in Caring
What H&HS Focus On

• Through-put issues
  • ED is crowded
  • Observation status
  • Discharges
• Readmission penalties
  • Reported by physician
• Reducing overall cost of care
  • Shorter lengths of stay
• Meaningful Use Dollars
  • 10% Summary of Care
• Preparing for Risk = Value
What You Should Know Before You Meet with H&HS Leaders

**Clinical Quality Metrics**

1. Adverse Event Rate
2. CMS Star Rating
3. Patient Satisfaction

Source: Advisory Board Post Acute Collaborative 2017
What You Should Know Before You Meet with H&HS Leaders

**Efficiency Metrics**

1. Readmission Rate
2. Average Length of Stay
3. Average Time to Admission
4. Average Time to Initial Physician Visit

Source: Advisory Board Post Acute Collaborative 2017
What You Should Know Before You Meet with H&HS Leaders

**Alignment Metrics**

1. Clinical Capabilities and Specialty Lines
2. Current Referral Volume
3. Technology Capabilities

Source: Advisory Board Post Acute Collaborative 2017
Be Transparent About Your Needs

- Admissions are good, but they take time.
- Shorter LOS means less reimbursement.
- Balance good / bad business.
- Share in the risk, share in the reward ($$).
- Want to be more than a preferred provider. Want to be **THE** Provider.
- Co-Brand if possible.
- Ask them to invest in new programs.
Case Study

Menorah Park CardioPulmonary Rehab Program

Excellence in Caring
Case Study

Menorah Park CardioPulmonary Rehab Program

• Joint committee formed in November 2015
  • 12-15 individuals from both UH and Menorah Park
• Goal – to establish an 8-12 bed Post-Acute Cardiopulmonary Rehabilitation Program on the campus at Menorah Park.
• Develop a tailored rehabilitation program for individuals with acute or chronic cardiac and pulmonary conditions.
• Modeled after Jewish Home in NYC and NYU Medical.
• Program would be a “bridge” between acute care stay and discharge to home.
Case Study

UH Service Provision included:

- Cardiologist and Pulmonologist dedicated to program.
- Creation of care protocols – acute to home health
- Staff training in care pathways
- Coordination team to oversee the program

Menorah Park to provide:

- Room renovation with new rehab cardio equipment
- Installation of telemetry monitoring equipment
- Dedicated cardiac nurse
- Development of a kosher cardiac diet.
Case Study

Menorah Park CardioPulmonary Rehab Program

**Unique features of this program:**

- Joint care pathways between hospital and SNF
- Joint staff training (home health, SNF, Rehab, Hospital Staff)
- Dedicated Cardiologist, Pulmonologist, RN Program Manager
- Rehab telemetry monitoring equipment
- Bridges gap between hospital, SNF and home health.
Case Study

Menorah Park CardioPulmonary Rehab Program

Program Results to Date:

- Since August 2016, admitted 95 patients
- Low rehospitalization rate = 7%
- High patient satisfaction scores
- Increased referrals to home health program.
- Earlier identification for Palliative Care
- Monthly meetings to discuss program results.
Case Study

Menorah Park CardioPulmonary Rehab Program

Benefits to Menorah Park:

• Increased overall referrals from UH to sub-acute
• Developing other niche programs to include neuro-stroke, neuro-psych, ED intercept.
• Built strong relationship with Cardiologist and Pulmonologist.
• Increased referrals to other programs (LAC).
Case Study

Menorah Park CardioPulmonary Rehab Program

What could we have done different:

- Asked UH to help with infrastructure costs.
- Set KPI goals initially and monitored each month
  - Set quality goals, not operations goals.
- Cardiologist should have been better positioned geographically.
- Should have brought UH Homecare to the table at the time of development.
Strategic Partnering with Acute Care Systems and Payers
Abramson Senior Care

Comprehensive Chronic Care Management Across Settings

Home and Community Solutions

- Home Care Services
  Medicare Certified and Private Duty; Care Innovations Home Monitoring
- Hospice & Palliative Care Services
  End-of-Life Care
- Geriatric Care Management and Primary Care
  House Calls Home-based
- Medical Adult Day Care
  NE Philadelphia

Facility-Based Solutions

- Residential Care and Assisted Living
  North Wales
- Transitional Care Units
  North Wales and Lankenau Hospital
- Dialysis
- Concierge Medicine and SNFist Services
  Main Line
- Healthy Brain and Memory Clinic
  Main Line

Partnerships with Community Agencies

Maintaining or Returning Patients “Home”

Right Place, Right Time, Right Cost

Abramson Care Advisors and Care Transitions Program
Top 10%: Our Sweet Spot

- **Top 1%**: Dominant chronic
- **Top 5%**: Severe significant multiple chronic conditions
- **Middle 14%**: Multiple chronic or severe chronic
- **Middle 30%**: Minor chronic
- **Bottom 50%**: Healthy

![Average monthly cost per risk tier](chart.png)

- Mean
Today’s Focus: TCU Strategies for Partnering with Acute Care Systems and Payers

Two Part TCU Strategy

- Distinguish as Best in Class: Quality and Total Episode Cost
- Access to TCU and Senior Services throughout Philadelphia and Integration with Key Health Systems
Best in Class: Quality and Total Episode Cost

- Already met usual quality indicators: facility, large private rooms, amenities, separate gym for TCU, 24/7 medical management, staffing, 5-Stars, admissions from the ER, etc.
- Current focus: the Abramson Approach and Total Episode Cost
Best in Class: The Abramson Approach and Total Episode Cost

- Reduced ALOS in TCU
- Standardized Evidence-Based Care Pathways
- Research-Based Person-Centered Care Instrument and Implementation
- Lowest Regional Rehospitalization Rate
- Road to Recovery
Results Showing Best in Class TCU

**Reduced TCU ALOS**
- **18.0** days (2017) vs. PA **21** days

**Evidence-Based Care Pathways**
- CHF protocol with Jefferson Health System
- Wound protocol via physician and certified wound care RN
- UTI protocol from Infectious Disease Society of America

**Lowest Rehospitalization Rate in Region**
- **15.5%** vs PA **20.3%**
Road to Recovery

- QIO Initiative that targets 12 days post-SNF
- Discharge survey for goals at home
- Built around lifestyle choices to reduce rehospitalizations
- Results: 1.56% rehospitalizations vs. 6% baseline
Partnership with Health Systems and Payers: Phase 1 and Phase 2

### Phase 1

- Top provider in narrow networks; for example:
  - **Jefferson Health**: Monthly meetings; sharing of quality metrics; sharing educational materials and communication tools
  - **DVACO**: Quarterly provider meetings and education; sharing of report card/quality metrics; utilizing their preferred providers for HHA referrals

### Phase 2

- **Access and Integration**
- Abramson-owned TCU within Lankenau Medical Center, part of Main Line Health
  - Supported by robust Abramson home care, hospice, Geriatric Care Management in Main Line
  - Concierge medicine and outpatient Healthy Brain and Memory Center on campus of Bryn Mawr Hospital, Main Line Health System
Phase 2: Access and Integration of Abramson Services with Health System

Step 1
Management Contract for 22-bed TCU in Lankenau Medical Center

Step 2
Ownership Transfer of TCU and Space Lease/Purchased Services/Affiliation Agreement with Lankenau Hospital

Step 3
Renovate (50/50 split costs), Add 13 Beds, Wrap-Around Abramson Post-TCU Services
Access and Integration in the Future

- **Access:** TCU, home care, Geriatric care management in two major geographic areas of Philadelphia; expanding geographic presence elsewhere
- **Integration:** Abramson manages post-acute care (TCU, home care) for Lankenau Medical Center
- We have a replicable TCU ownership and integration model for other hospitals and health systems
Hebrew SeniorLife and Strategic Partnering with the Health System
The Massachusetts Healthcare Landscape and Funding Environment are Changing

- **MA health care organizations** are long-time, committed participants in value-based healthcare, and the ACO model.

- **MassHealth represents ~ 40% of the Commonwealth’s Budget.** Governor Baker has established reducing that % as a priority - placing increased pressure on government programs. Massachusetts is moving to a MassHealth ACO model.

- **The merger wave continues with Massachusetts hospitals and doctors,** threatening to widen the payment gap between providers, increase health care prices, and further consolidate and “professionalize” post-acute management and referral decision-making.

- **Closures are occurring across SNFs and LTACs.**
Hebrew SeniorLife – At A Glance

- 113 year old organization

- 2,600 employees serving 3000+ seniors across 8 campuses and communities, and in-homes
  - 1,500 units of senior living (independent and assisted)
  - 775 beds of long term chronic care, sub-acute, and rehab care

- $223 million in projected FY18 annual revenue

- Medical staff with 40 physicians and nurse practitioners

- Affiliated with Harvard Medical School
  - Largest aging research institute in a clinical care setting
  - 700 - 900 clinical professionals trained annually

- Boston Globe Top Employer – last two years
HEALTH CARE
Hebrew Rehabilitation Center, Boston and in the Adelson Field Health Center at NewBridge on the Charles, Dedham
• Long-term chronic care
• Post-acute care
• Outpatient services
Hebrew SeniorLife Community Health Services
• Primary and specialty medical care
• In-home care
• Hospice care
• Adult day health

RESEARCH
Institute for Aging Research

TEACHING
Education and training programs for the next generation of geriatric professionals

SENIOR LIVING COMMUNITIES

SUPPORTIVE LIVING COMMUNITIES
Center Communities of Brookline
• Feinberg Cohen Residences
• Danesh Family Residences
• Goldman Family Residences
Simon C. Fireman Community, Randolph
Jack Satter House, Revere

CONTINUING CARE RETIREMENT COMMUNITIES
Orchard Cove, Canton
NewBridge on the Charles, Dedham on the Adelson Campus

ASSISTED LIVING COMMUNITIES
NewBridge on the Charles, Dedham
• Satter Assisted Living Residences
• Slifka Memory Support Assisted Living Residences
What are our Aims?

Measurably improved quality of life

Health
- Mobility
- Mental health
- Cognition
- Comfort

Personal satisfaction
- Autonomy
- Empowerment
- Respect
- Security

Cost effectiveness
- Lower out-of-pocket costs
- Higher ROI for society
HSL Strategic Partnering Initiatives

- Preferred Provider Relationships
  - Quarterly Meetings: Metrics, SWOT
  - Tailored Objectives & Metrics
    - Physician Groups
    - Hospitals
    - Specialty Hospitals
    - Health Systems

- Total Cost Management
  - Post-Acute Patient Progression (LOS)
  - Post-Acute cost per day
  - Discharge Disposition
  - Post Discharge Rehab & Home Care
  - Rehospitalization

- Conversion Rate Optimization

- Clinical Pathways (Spine & Joints)
HSL Strategic Partnering Initiatives

- Patient Tracking System
- Open Medical Staff / ACO Attending Physician
- Collaborative Lean / Six Sigma Care Transitions Improvement
- Information Management / Access to Data
- Medicare 3-Day SNF Waiver (Reduce Anchor Admissions)
- Pulmonary LTAC Focus
- Other Long Stay Patients
- Specialized Population Health Management (Dementia Patients)
- ACO Membership
- Bundled Payments
Being viewed as Part of the Solution: Visibility/Participation

- Engage in your community’s Health Care and Social Services Reform Process
  - Optimize your seat at the table and be viewed as part of the solution
  - Focus on Community & System Needs, Not Yours. “Help Me Help You”
- HSL Engagement with Associations
  - Massachusetts (& American) Hospital Association: Boards & Committees (CCC)
  - LeadingAge: Massachusetts (& National) Boards and Committees
  - Home Care Alliance of Massachusetts Board
  - Massachusetts Assisted Living Association
Being Viewed as Part of the Solution
Visibility/Participation

- HSL Engagement with Massachusetts Government entities
  - Health Policy Commission
  - MassHealth Accountable Care Task Forces
  - Board of Registration of Nursing Home Administrators
  - Executive Offices of Health and Human Services and Elder Affairs
  - Governor’s Office
  - MassHousing and Department of Housing and Urban Development
  - Senate and House Health Care Bill development (Visits and Testify)
Supportive Housing
“*A Day in The Life*”

8:00AM: Resident starts her morning with a Tai Chi Class

9:15AM: Meets with Wellness Coach: Discusses goal to attend and dance at granddaughter’s wedding in 6 months

10:00AM: Has Well-Check with Nurse Practitioner who eliminates medication due to improved health

10:45AM: Amends File of Life with updated family contact

11:00AM: Is greeted by Front Desk Receptionist who asks about her grandson’s graduation

11:15AM: Is asked by Facilities Technician how she likes her new tub cut

11:45AM: Is reminded to take her medications before lunch

12:00PM: Enjoys a nutritious meal with other residents

1:30PM: Works with Physical Therapist on balance in the Fitness Center

2:00PM: Social Worker updates daughter on mom’s improved sense of well-being

3:30PM: Enjoys visit with Depression Care Manager who supports her increased community involvement

4:00PM: Learns from local high school students how to connect with family on Skype

6:45PM: Listens to local symphony orchestra’s live performance of Shahrazad

8:30PM: Receives call from daughter asking how her day was and wishing her goodnight

Integrated, High Quality, Resident-Centered Living
**R3: Right Care, Right Place, Right Time:** Effectively Integrating Senior Care and Housing

**Our vision** is to create a replicable, scalable, and sustainable model of housing with supportive services to enable seniors to live independently as long as possible, receiving the right care in the right place at the right time, while reducing health care costs for this growing population.

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<tr>
<th><strong>Goals</strong></th>
<th>Create a platform for housing and healthcare collaboration and measure effectiveness</th>
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<tr>
<td><strong>Wellness Teams</strong></td>
<td>Wellness Coordinator and Wellness Nurse</td>
</tr>
<tr>
<td><strong>Partners</strong></td>
<td>Payers, hospitals, ASAPs, emergency service providers, mental health, housing</td>
</tr>
<tr>
<td><strong>Timing</strong></td>
<td>6-month preparation period, 18-month implementation</td>
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R3 Initiative: Total Funding, Scope, & Evaluation

Health Policy Commission * MassHousing * DHCD *

Combined Funding Sources of $1M

* Enterprise
* Beacon Communities
* WinnCompanies

HSL CCB Danesh * HSL CCB Cohen *
HSL CCB Goldman * Winn – TVAB *

7 Senior Housing Sites
1,100 Residents
400 Enrollees

* HSL - Fireman
* MRE – Unquity House
* MRE – Winter Valley

UMass Boston * LeadingAge Collaboration *

Evaluation / Research

* Pre/Post & Control Group
* Impact Analysis
Alzheimer’s Center of Excellence Vision

Care navigation/management/planning **across settings**

**Prevention**
- Prevention registries
- Prevention strategies

**Diagnosis**
- Clinical assessment tools
- Imaging
- Genetic testing
- Clinical biomarkers

**Treatment**
- Medication for memory loss
- Treatments for behavior, sleep
- Alternative therapies
- Clinical trials

**Support**
- Residential
- Caregiving
- Safety
- Financial planning/protection
- Family/community education
- Transportation
- Legal counseling

Research (best practices, guidelines, policy development)
Consulting, training, education
Technology (e.g., sensors, smart home, GPS, assistive technology, brain training)
QUESTIONS AND DISCUSSION