Session #T19
Nursing Home to Post-Acute Care
Change, Transition, Success

Dr. Terry Sullivan, Chief Medical Officer
COMS Interactive, LLC
Contact: tsullivan@comsllc.com

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Presentation Objectives

- Identify Critical Factors Impacting Post-Acute Providers.
- Present Strategic Initiative Options for Post-Acute Organizations.
- Communicate How to Better Manage Clinical Outcomes to Promote Continuous Quality Improvement.

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The Opportunity
Provided by HealthCare Reform

- Medicare Managed Care
- Dual Eligible Managed Care
- Accountable Care Organizations (ACOs)
- Bundled Payment Structure
- Value-Based Purchasing
- Hospital Readmission Penalties

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Leadership Is Key to Winning
In the Post-Acute Care Environment

Definition of Leadership

Leadership is a process whereby an individual positively influences a group of individuals to achieve a common goal or goals.

Evolving Post-Acute Care Model

- "Managing" Care vs. "Providing" Care
- "Proactive" Care vs. "Reactive" Care
- "Resident" vs. "Patient"

Hospital Readmission Penalties
The Upside for Post-Acute Care Providers

- Improved care for residents.
- Immediate returns for the facility.
- Facility is well positioned for Managed Care networks, Hospital networks, and ACOs.
  - Kaiser Model
  - Sharp System
  - State examples: Florida, Ohio, Pennsylvania

Hospital Readmission Penalties
Exponential Reduction in Reimbursement

Disease State Penalties								
CMS Penalty	Heart Attack	CHF	Pneumonia	COPD	Disease 5	Disease 6	Disease 7	Disease 8
1% 2013	$125K per Hospital →							
2% 2014	$250K-$500K per Hospital →							
3% 2015	$500K-$1M per Hospital →							

This chart does not completely account for the fact that CMS intends to increase the RTH review period from 30 days to 60 days in 2015.

SNFs Face Readmission Penalties
Similar to Hospitals

- **Affordable Care Act** - Mandated payment reductions for Hospitals with high rates of readmission.
- **SN**Fs - U.S. Department HHS 2014 Budget proposes payment reductions to SNFs for preventable readmissions.
- **Medicare Patients** - Proposal cites analysis that nearly 14% of patients discharged from a Hospital to a SNF are readmitted with conditions that could potentially have been avoided.
- **Payment Reduction** - Proposal recommends reducing payments up to 3% for SNFs with high rates of preventable RTH.
- **Proposed Penalties** - Effective in 2017, with an estimated $2.2B savings in 10 years.

Source: ALFA http://www.alfa.org/News/3102/Nursing-Homes-May-Face-Readmission-Penalties-Similar-to-Hospitals

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Healthcare System Evolution
Five Year Projections

Phases	Providers	Consequences
Phase 1 – Traditional EMR (Govt $)	Not Organized 50% Employed	Fear, Decreased Spend, Economy
Phase 2 – Current EHR/IT - Communicate But Not Rules-Based	Organized Vertically in Silos	Decrease Waste Low Hanging Saving Money
Phase 3 – Future System Integ. and Management Rules-Based Applications (COMS Daylight IQ®)	Integrated Networks	Profit, Risk, Management, Competition

Think Virtual Kaiser !

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SNFs Face Increased Competition
Across the Continuum

- Hospital-Based SNFs - Critical Access
- Transitional Units
- High Acuity Clinics
- Medical Home
- Assisted Living
- Home Health Care
- Home Care by Family
- Telemedicine

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Assisted Living Sample

Physician Medical Model - Go Where the Patients Are!

Medicare Beneficiaries

- 5% in Assisted Living Facilities.
- Cost of $80K per year (basic Medicare $1,000/year).
- Represents 40% of total spend.

Physician Medical Model Results

- 80% of costs are associated with Hospitals, SNFs, Emergency Rooms.
- 20% of costs are associated with outpatient, Assisted Living, Rehab Therapy and prescriptions.
- Program decreases admissions for Hospitals (83%), SNFs (75%) and Emergency Rooms (73%).
- Summary: $26K total spend savings.

The Winning Formula

Implement Standard Clinical Processes

- Guided, disease-specific evaluations/assessments and interventions.
- Supervisory review and real-time QA.
- Outcomes measurement and continuous process improvement.
- Technology ensures compliance.

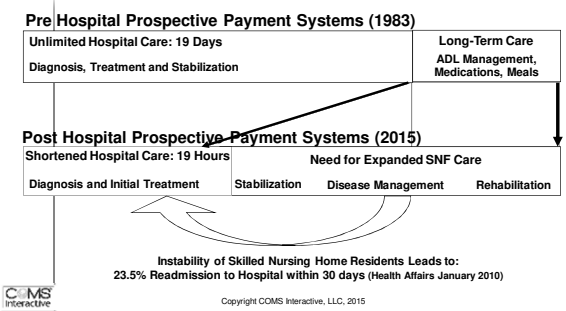
Close the "Back Door"

- Reduce re-hospitalization.
- Reduce mortality.

Open the "Front Door"

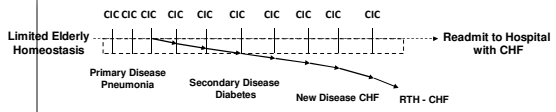
- Market improved performance/outcomes to key referral sources.
- Drive census and increase annual skilled revenue.

The Winning Post–Acute Care Model



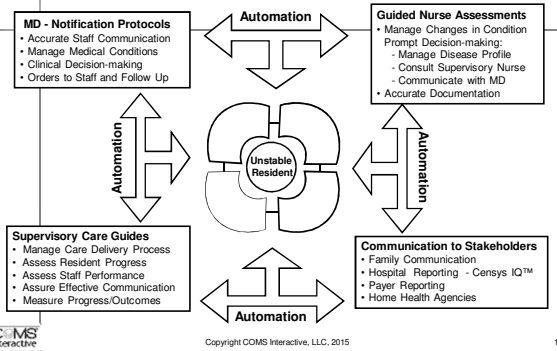
Recently Hospitalized Residents
Are Clinically Unstable

Unmanaged Changes in Condition

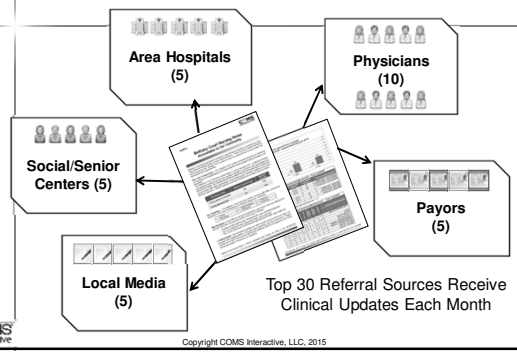


Key Details:
- Interplay of resident diseases/hospitalization produces resident instability, which manifests as daily changes in condition (CIC).
- Unmanaged CICs lead to readmission to the Hospital.
- Changes in condition are related to primary, secondary and new diseases.

Automation Optimizes Care Management



Demonstrate Improved Outcomes



Top 30 Referral Sources Receive Clinical Updates Each Month

Connecting Clinical/Financial Outcomes
Snapshot of California Territories

- Sample Number of Skilled Residents: 40,432.
- Return to Hospital Rates: 23.5% to 10.8% (13%, 5,256 ppl).
- Premature Mortality Rates: 5.9% to 2.1% (3.8%, 1,536 ppl).
- Savings to CMS: $38.9M (40,432 x 13% x $7.4K[1]/RTH).
- Revenue to Facilities: $44M (5,256 ppl x 14 days x $598/day).
- COMS Marketing Outcomes can increase Medicare census by 2-4 beds per facility per year.

[1]Source: The New England Journal of Medicine.

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