Value-Based Purchasing 101
New England Alliance
January 12, 2017

We C.A.R.E. About Care

- Compliance
- Audit & Analysis
- Reimbursement & Regulatory
- Education & Efficiency

Harmony University
The Provider Unit of Harmony Healthcare International (HHI), Inc.

www.harmony-healthcare.com
Value-Based Purchasing 101
Matt McGarvey, MBA, VP of Business Development
Harmony Healthcare International (HHI)
We C.A.R.E. About Care

About Matt
As Vice President of Business Development for Harmony Healthcare International (HHI), a nationally recognized premier Healthcare Consulting firm specializing in C.A.R.E. (Compliance, Audits and Analysis, Reimbursement and Regulatory, Education and Efficiency), Matt is responsible for growing and maintaining customer relationships, having added new relationships in 20 different states including New York, Connecticut, Vermont, Pennsylvania, California and more. Matt is passionate about improving the delivery of healthcare and specializes in the areas of 3rd party reimbursement, compliance, revenue cycle, electronic medical record software, and managed care.

Follow me! @mattymcgaaavey

Disclosure
- Disclosures: The planners and presenters of this educational activity have no relationship with commercial entities or conflicts of interest to disclose
- Planners:
  - Elisa Bovee, MS, OTR/L
  - Diane Buckley, BSN, RN, RAC-CT
  - Kris Mastrangelo, OTR/L, LNHA, MBA
  - Matt McGarvey, MBA
- Presenters:
  - Elisa Bovee, MS, OTR/L
  - Matt McGarvey, MBA
Learning Objectives

• The learner will be able to identify the key strategies to prepare the SNF for the Value-Based Purchasing reimbursement system
• The learner will describe two strategies to proactively negotiate payment contracts for managed care and hospitals
• The learner will state three clinical and operational strategies to excel in an episodic reimbursement system

Today’s Topic

You have the undivided attention of a room full of people...

and you go with a slideshow of words?

Today’s Topic

DEATH BY POWERPOINT
Today’s Agenda

1. Impact of the Election
2. Definitions: Value-Based Purchasing System
3. Impact of VBP on Clinical and Financial Operations
4. Re-hospitalizations
5. Clinically Anticipated Stay
6. Payment Models
7. Therapy Operations
8. Quality Measures/Five-Star Rating
9. Managed Care Contracts
10. Partnering with your Partners

Impact of the Election

- Certainly the result of the election was surprising
- Strong likelihood that Republicans will control the federal government for the next 4 years (only need to defend 8 Senate seats in 2018)
- Expect new Administration to be business-friendly and looking to reduce regulations
- Congressman Tom Price has been nominated to Chair the Department of Health and Human Services
  - has been an outspoken critic of the Affordable Care Act
  - Also has aggressively opposed additional post acute bundles
Impact of the Election

• We might not have anything to talk about today....

Impact of the Election

• AHCA sees an opportunity to seek relief from regulatory requirements, aggressive tactics of survey teams, IJs and CMPs for relatively minor infractions

Impact of the Election

• Among the issues AHCA will be advocating for:
  – Clean Medicare Payment Rule for FY 2018
  – Relief related to delivery of therapy
  – Recognizing Observation stays as counting for the 3-day stay
  – Survey / Regulatory/ CMP relief
  – Stop Additional Bundles
  – Repeal of the Requirements of Participation (RoP)
  – Repeal of the employer mandate (return to mini-med plans)
Impact of the Election

- Sounds good so far.............

Impact of the Election

- Riskiest area by far is Medicaid
  - Republicans have wanted to fundamentally change Medicaid
  - With complete control now at hand, Medicaid reform is now possible
  - Could come in the form of Block Grants
  - This could put Post-Acute Care at risk
  - States with Governors who support LTC are likely to do be in better position than others

Definitions:
Value-Based Purchasing
Key Definitions

- **Bundled payment**: Known as episode-based payment, case rate, evidence-based case rate, package pricing. Reimbursement of health care providers on the basis of expected costs.
- **Bundled Payments for Care Improvement (BPCI)**: Made up of four models of care that link payments for multiple services beneficiaries receive during an episode of care. Organizations enter into payment arrangements that include financial and performance accountability for episodes of care.
- **CCJR**: Comprehensive Care for Joint Replacement. Part A and Part B payment model which acute care hospitals in certain selected geographic areas will receive retrospective bundled payments for episodes of care. All related care within 90 days from admission is included in the episode.

Key Definitions

- **DRG**: Diagnosis related group. Used to classify patients by diagnosis, average length of hospital stay and therapy received.
- **Episode**: All services provided to a patient with a medical problem within a specific period of time across a continuum of care in an integrated system.

IMPACT Act

- **Improving Medicare Post Acute Care Transformation Act of 2014 (IMPACT Act)**: puts in place new and streamlined quality measures for nursing homes, home health agencies, and other post-acute care providers participating in Medicare.
- **Expand and strengthen Medicare’s widely-used 5-Star Quality Rating System for Nursing Homes, also known as Nursing Home Compare**.
IMPACT Act

- Bipartisan bill passed on September 18, 2014 and signed into law by President Obama on October 6, 2014

IMPACT Act Intent

- Quality care provision will now be directly linked to financial success
- Quality versus Quantity of Care

IMPACT Act Intent

- Strengthens patient rights
- Improves communication
- Focuses on patient well-being
Impact of Value-Based Purchasing on Clinical and Financial Operations

SNF Industry Concerns About Value-Based Purchasing

- Being left out in the cold – excluded from the network by acute-care organizations who are trying to narrow their networks:
  - Post-acute providers are striking deals with hospital systems and payors to become part of preferred networks, realizing the narrow network trend can work to their favor as CMS provides incentives for quality improvements across the network
- Pressure to reduce re-hospitalizations

SNF Industry Concerns About Value-Based Purchasing

- Pressure to reduce costs
- Payment Reform seems to be in direct conflict with admitting more medically complex patients
- More and more admissions and discharges
- If it’s anything like managed care……….
Traditional SNF Payment Arrangements

• Medicaid:
  – Most of our volume
  – Payment doesn’t cover costs
  – Goes a long way toward paying the bills
  – Provides regular cash flow
• Private Pay & Medicare Part A:
  – Provides profit margin
  – Depends on volume
  – The more volume, the better
  – Fill the beds!

Traditional SNF Payment Arrangements

• MedPAC’s observation include:
  – Increase in SNF admissions by 3.2%
  – Decrease in LOS of 4% between 2013 and 2015
  – Payments driven by the amount of therapy delivered, not patient characteristics
• Among MedPAC’s recommendations:
  – More bundles
  – Eliminate future PPS updates

New Arrangements Under Payment Reform

• ACOs were a precursor to a quality-based/risk sharing reimbursement system
• Bundled Payment for Care Improvement (BCPI) programs such as Comprehensive Care for Joint Replacement (CCJR) are the second wave
• Payments by the episode (Episodic Care) are the future
Essence of Value-Based Purchasing

- Measure
- Report
- Reward

Value-Based Purchasing

- Measure:
  - Gauge performance by showing if care is:
    - Safe
    - Timely
    - Efficient
    - Effective
    - Equitable
    - Patient-Centered

- Report
  - The performance measure needs to be transparent and public for purchasers, payers and consumers to make informed decisions
Value-Based Purchasing

- Reward
  - When provider is successful in meeting the performance measure, they are rewarded with:
    - Improved reputations because of the public reporting
    - Enhanced payments
    - Increased market share

VBP in Skilled Nursing Facilities

Measure
(SNF RM) Skilled Nursing Facility Re-admission Measure:

1. Re-hospitalizations during a 30 day window from admission to the SNF during and after the SNF stay (if discharged home prior to 30 days)
2. The current National Average for hospital readmissions is 21.1%
3. The Better of Achievement Score (Ranking) or Improvement Score
   - The Achievement Score based on SNF’s ranking on their rate
   - Performance period based on Calendar Year (Jan 2017 to Dec 2017)
4. The Improvement score based on SNFs improvement over 2 years
5. Compares re-hospitalization rates Calendar Year 2015 to Calendar Year 2017

VBP in Skilled Nursing Facilities

- CMS proposed "potentially preventable re-hospitalization" measures
- Counts re-hospitalizations with a diagnosis on hospital claims that is considered potentially preventable
  - Including COPD, CHF, etc.
VBP in Skilled Nursing Facilities

• Report
  – Provide confidential feedback reports quarterly via QIES (Quality Improvement and Evaluation System) system starting October 2016
  – Information will be public in 2018
  – This measurement will be different than the Five-Star

VBP in Skilled Nursing Facilities

Reward
• The government is using a "withhold approach"
• The amount of money impacted is 2% of total Medicare Revenue. This amount will be "withheld" and given back to the facility if they meet the measure.
• If your hospital readmission rate is above 20% hospital readmission level, there is a high likelihood you will lose the 2%
• The 2% withhold of SNF Part A payments is effective October 1, 2018 (based on performance calendar year 2017)

Potential Impact of VBP

<table>
<thead>
<tr>
<th>Month</th>
<th>Part A Revenue</th>
<th>Therapy Portion</th>
<th>Therapy % of Total Revenue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jul 16</td>
<td>$706,485.33</td>
<td>$325,289.73</td>
<td>46.0%</td>
</tr>
<tr>
<td>Aug 16</td>
<td>$810,775.57</td>
<td>$374,662.53</td>
<td>46.2%</td>
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<tr>
<td>Sep 16</td>
<td>$843,726.14</td>
<td>$383,283.38</td>
<td>45.4%</td>
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<td>$781,475.96</td>
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<td>$856,416.72</td>
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Nursing and Rehab
Revenue Analysis 2016 & 2017

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Estimated Timeline for SNF VBP Implementation

Oct 2015

Oct 2016

Oct 2017

Oct 2018

Oct 2019

Re-hospitalizations

CMS SNF RM Measure

- Includes only Medicare FFS Part A Beneficiaries:
  - Used data from Part A Medicare Claims
- All cause readmission
- Counts re-hospitalizations during 30 day window from admission to the SNF:
  - During & after SNF stay (if discharged home prior to 30 days)
- Excludes:
  - Elective admits
  - Observations stays
- Risk adjusted:
  - (Actual + Predicted) x National average
SNF Re-hospitalization Rates

• Takeaway #1 -- Know your Re-hospitalization rate compared to the national average

SNF Re-hospitalization Rates

National Average
21.1%

SNF Readmissions Program

• Included in the Protecting Access to Medicare Act of 2014 signed into law on April 1, 2014
• Establishes 2% withhold from which 50-70% will be used as an incentive pool for bonus payments to providers who perform well on 30-day readmissions
**SNF Re-hospitalizations**

**Value-Based Purchasing**

- This program establishes a hospital readmissions reduction program for these providers, encouraging SNFs to address potentially avoidable readmissions by establishing an incentive pool for high performers.
- The program is budgeted to save Medicare $2 billion over the next 10 years.

**Value-Based Purchasing**

- In order to fund the incentive payment pool, CMS will withhold 2% of SNF Medicare payments starting October 1, 2018.
- CMS will redistribute 50-70% of the withheld payments back into the profession by way of incentive payments to SNFs.
- CMS will retain the remaining 30-50% of funds as programmatic savings to Medicare.
- The program also requires the Secretary to publicly report the performance on the readmission measure for each SNF on Nursing Home Compare beginning on October 1, 2017.
Clinically Anticipated Stay

- Understanding Clinically Anticipated Stay (CAS) has always been a bit of a moving target
- In order to succeed under Value-Based Purchasing, we must understand CAS by Diagnosis!
- It is a MUST in order to achieve financial & clinical success
- Takeaway #2 – Start collection your CAS by diagnosis

Top 10 Questions to Ask About Data

1. Why are you collecting the data?
2. What type of data is collected?
3. How is data collected?
4. How is data normalized?
5. What does the data mean?
6. How is data presented?
7. How is the data beneficial?
8. How are you going to use the data?
9. Are you going to be transparent with your data?
10. What was your starting point data?
Performance By Diagnosis

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>% Patients</th>
<th>CAS</th>
<th>Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>PNA</td>
<td>8.0%</td>
<td>19.8</td>
<td>Days</td>
</tr>
<tr>
<td>CHF</td>
<td>5.7%</td>
<td>20.0</td>
<td>Days</td>
</tr>
<tr>
<td>UTI</td>
<td>5.5%</td>
<td>20.2</td>
<td>Days</td>
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Percent Patients & CAS By Diagnosis

• Top 3 Diagnoses

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Home CAS By Categories

• Top 3 Categories

<table>
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<tr>
<th>Categories</th>
<th>% Patients</th>
<th>CAS</th>
<th>Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orthopedic</td>
<td>22.0%</td>
<td>16.3</td>
<td>Days</td>
</tr>
<tr>
<td>Respiratory</td>
<td>16.2%</td>
<td>19.2</td>
<td>Days</td>
</tr>
<tr>
<td>Cardiac</td>
<td>11.1%</td>
<td>19.5</td>
<td>Days</td>
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</table>
Home CAS By Diagnosis

- Top 3 Diagnoses

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<td>PNA</td>
<td>8.4%</td>
<td>19.2 Days</td>
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<td>5.7%</td>
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Re-hospitalization CAS By Diagnosis

- Top 3 Diagnoses

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<td>6.6%</td>
<td>11.8 Days</td>
</tr>
<tr>
<td>UTI</td>
<td>5.9%</td>
<td>12.4 Days</td>
</tr>
<tr>
<td>CHF</td>
<td>5.7%</td>
<td>14.1 Days</td>
</tr>
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Payment Models
Payment Models

• Today’s Model:
  – Paid by the RUG by the day
  – The more “resources” used, the higher the payment
• Bundled Payment Model:
  – Lump sum payment by condition/diagnosis
  – Regardless of Clinically Anticipated Stay
  – Measure thy outcomes!

Takeaway #3 – Its time to work double time on Clinical Reimbursement. Accurate and appropriate reimbursement in the PPS / RUGS System. Prepare for VBP simultaneously

What Do Episodic Payments Look Like?
What Do Episodic Payments Look Like?

- Establishment of a bundled payment for an episode of care (i.e., by diagnosis)
- It becomes a de facto “Target Price”
- Hospitals have done it for years
- Financial success will come from 2 areas:
  - Know the relationship between clinical outcomes and target price
  - Reduce readmissions
  - Deliver clinically appropriate care in order to produce successful discharges

Payment Models

- What Constitutes a “Good” Bundle?
- Need to Know Three Critical Statistics:
  1. CAS by Diagnosis
  2. Average Medicare Rate
  3. Outcomes by diagnosis/re-hospitalization Rate
- Recent article in McKnights showed that from 2008 – 2015 payments for CCIR episodes saved 20% or $5,500 per beneficiary. Almost half for the join itself.

Payment Model

- Example #1:
  - Facility A is has an average Medicare Rate of $500 per day. A COPD CHF patient typically stays 25 days, receiving an RU level of therapy with 9/10 successful discharges to the community.
  - If the referring hospital wants to pay you $15,000, is that a good bundle?
Payment Model

• Example #2:
  – Facility A is has an average Medicare Rate of $450 per day. A Pneumonia patient typically stays 20 days, receiving an RU level of therapy with 8/10 successful discharges to the community.
  – If the referring hospital wants to pay you $5,500, is that a good bundle?

Payment Models

• Now you have a starting point!
• Until you know this information, you run the risk of being out-negotiated!
Takeaway #4 – Look long and hard at therapy operations

Future of Therapy

Therapy Reimbursement to be linked to improvement
Treatment Environment Considerations

- Containing costs:
  - Expenditures appropriate
  - Predictable
- Consider: What are the costs of the individual components of care?
  - What are the costs of the episode across the continuum of care?
  - Which clinical processes have the greatest cost variation?
- Reducing this variation will improve the cost structure

Value-Based Treatment Goals

- Avoid surgeries
- Heal wounds faster
- Prevent adverse medical events
- Successful and sustained discharge
- Reducing pain to avoid interruption of task completion and sleep

Treatment Environment

- Individual sessions?
- Groups
- Concurrent
- Co-Treatment
- Student Programs
- Rehab Aides
- Clinical Practice Acts
- State Regulations still supersede
Therapy for Quality Measures

- Interdisciplinary Team to focus on:
  - Falls reduction
  - Preventing and improving Pressure Ulcers
  - Prevent re-hospitalization
- Are you part of the team?
- How can we help?
- Are we providing therapy in a Silo?

Discharge Planning

- What are the patient’s individualized clinical goals?
- What are the patient’s individualized physical/functional goals?
- What are barriers to safe discharge home?
  - What are we doing about it!!
- Work together as a team
- Develop and use Rehabilitation programs

Rehabilitation Program Development

- Interdisciplinary Discharge Planning
- Identify and Care Plan barriers to achieving clinical, rehab and Discharge goals
- Communicate patient changes to prevent adverse events
- Clinical Program Development:
  - Interdisciplinary Team
  - Nursing and Rehab Program liaisons
Program Development

• The goals are:
  – To provide quality care
  – To ensure that all patients that have the potential to benefit from skilled therapy intervention receive access to services
  – To support the facility in meeting all regulatory requirements
  – Improve patient outcomes

Program Development

• Educate nursing on appropriate patient referrals
• Therapy to initiate routine review of key facility reports to address resident needs in a timely fashion (e.g., falls, weight loss, skin, etc.):
  – Quality Measures
  – Risk Reports
• Utilize the MDS

Patient Identification

• 30-day window of wellness, annual, and significant change in status screens:
  – Screening determines only if an Evaluation is warranted. No recommendations should be made without an evaluation.
  – Previous therapy service dates or documentation for most recent services or reviews
  – ADL flow sheets for previous three months
  – Review nursing documentation and MDS to identify any red flag areas (falls, skin issues, positioning issues, incontinence, pain, feeding issues)
  – MD orders for 1-2 months for med/diet change orders and recent acute diagnosis that may indicate a therapy evaluation is needed
Program Development Systems for Resident Identification

- 24-hour report review
- Nursing referral checklist for Care Plan meetings
- Effective communication at daily stand-up and weekly Medicare meeting
- Develop specialty programs and perform monthly or quarterly rounds
- Interview direct care staff for patients with a functional decline in mobility, ADLs or communicating
- Review patients at RISK for skin issues, weight, pain, behavior, restraint, incontinence and fall risks
- Review Quality Measure data

Program Development

- Create a Clinical Leader Program partnering rehab and nursing staff for program development
- Lunch and Learn program in-servicing
- Create STOP Program: See, Tell, Observe and Referral Program

Under-dosed Strength Training

- Don't prescribe under-dosed strength training programs for older adults. Instead, match the frequency, intensity and duration of exercise to the individual's abilities and goals.
- Improved strength in older adults is associated with improved health, quality of life and functional capacity, and with a reduced risk of falls. Older adults are often prescribed low dose exercise and physical activity that are physiologically inadequate to increase gains in muscle strength.
- Failure to establish accurate baseline levels of strength limits the adequacy of the strength training dosage and progression, and thus limits the benefits of the training. A carefully developed and Individualized strength training program may have significant health benefits for older adults.
- APTA
Bed Rest for DVT?

• Don’t recommend bed rest following diagnosis of acute deep vein thrombosis (DVT) after the initiation of anticoagulation therapy, unless significant medical concerns are present
• Given the clinical benefits and lack of evidence indicating harmful effects of ambulation and activity, both are recommended following achievement of anticoagulation goals unless there are overriding medical indications
• Patients can be harmed by prolonged bed rest that is not medically necessary
• APTA

Program Development Specialty Programs

• Pain management
• Seating and positioning
• Contracture management
• Wound care
• Dementia rounds
• Dementia intervention (mobility, communication, safety and behavior)
• Dining rounds
• Activity rounds
• Therapy Integration with RNA
• Continence Program
• Rehab Dining
• Dysphagia Management (Altered consistencies)
• Fall and Balance Program
• Comprehensive use of modalities and other treatment areas

Pain Management Program Development

• Clinical Partnership:
  – Nurse Clinical Leader: Pain Management Specialist
  – Rehab Clinic Leader: Modalities and Manual Therapy
• MDS Section J
• Strategies for identifying patients with pain:
  – Review patients weekly during RISK meeting to identify current pain management program and review pain assessment to identify changes
  – Review MD orders of scheduled versus PRN pain medication
Pain Management Program Development

• Examples of Reason for Referral:
  – Patient has had increased pain which prevents patient from performing functional tasks
  – Patient requires more assistance from caregivers due to pain
  – Patient referred by nursing to receive OT services due to patient’s increased pain in R shoulder, causing patient to have moderate assist with toileting skills and transfer

Pain Management Program Development

• Treatment activities:
  – Patient tolerate modalities: E-stim, diathermy, ultrasound, hot pack, etc., to decrease pain and increase joint flexibility
  – Soft tissues massage, joint mobilization, relaxation techniques

Program Development Wound Management Program

• Clinical Partnership:
  – Clinical Nurse Leader: Skin Integrity Specialist and Dietician
  – Clinical Rehab Leader: Wound Specialist include Modality use
• MDS Section M
Program Development Wound Management Program

• Strategies for identifying skin integrity issues:
  – Identify at RISK meeting active skin integrity issues, nutritional decline, impaired sensation, incontinence, prior wound history
  – During Positioning Rounds discuss potential skin issues and Wound Care rounds discuss current treatments for skin integrity issues
  – Regular communication and educate Rehab’s roles with Wound Care Specialty team
  – Review Norton pressure ulcer risk or Braden Scale for change and risks (High Risk)

Program Development Wound Management Program

• Examples of Reason for Referral:
  – Patient has had a Stage III coccyx wound treated by skilled nursing for past 30 days and presents with increase pain and inability to remain OOB
  – Patient has increased complaints of pain to left heel which nursing reports is red, boggy, and difficult for patient to transfer from bed to wheelchair

Program Development Wound Management Program

• Evaluations should portray clinical necessity for skilled therapy intervention:
  – Etiology of wound, type of prior treatment by medical team, stage of wound, description of wound including length, width, depth and grid drawing are a few examples
Program Development  
Wound Management Program

• Example of Goals:
  – Patient will decrease size of wound by .1cm with increase in granulation tissue to promote healing to coccyx area
  – Patient will be able to reposition self in wheelchair with Min assist to provide pressure relief and increase circulation to promote wound healing to coccyx:
    • Always include a functional goal to support

Program Development  
Wound Management Program

• Treatment Activities:
  – Reflect the skilled plan of treatment, including specific frequency of the modality. For example: Electrical Stimulation for a chronic stage III and IV pressure ulcer, arterial ulcer, diabetic ulcer and venous stasis ulcer not demonstrating measureable signs of healing after 30 days of conventional care, as part of a therapy Plan of Care.

Program Development  
Contracture Management Program

• Clinical Partnership:
  – Clinical Nurse Leader: Restorative Nurse Programmer
  – Clinical Rehab Leader: Contracture Management Specialist
  • MDS Section G (ROM)
Program Development
Contracture Management Program

• Strategies for identifying contracture risk:
  – Daily stand up, 24-hour report regarding increase pain, joint stiffness, muscle spasms, tonal changes for example
  – Patient currently on splinting program, regularly assess appropriate use and necessity for splint
  – Interview staff to identify patients who have new or increase limitations of movement that are affecting function
  – Review MDS (Section G04000) to identify change in range of motion

• Reason for Referral:
  – Patient refusing to wear resting hand splint, reports pain with wear and redness noted after 2 hours of wear time
  – Patient has increased tone to left elbow and direct care staff report patient has increased pain and difficulty with donning shirts

• Examples of Goals:
  – Patient will increase left elbow extension by 10 degrees and have min complaints of pain in prep for orthotic fit and prevent further contracture
  – Patient will tolerate R resting hand splint x 4 hours without signs or symptoms of pain or irritation in order to Independently grasp and hold object during meals
Program Development
Cognitive Dementia Program

• Clinical Partnership:
  – Clinical Nurse and Therapist (OT/SLP):
    Dementia Specialist, Activities Department, Dementia Programmer

• Strategies for Identifying Cognitive Program:
  – Interview staff and families to identify change in resident’s condition such as: Answers questions inappropriately. Needs assistance finding room (was able to find previously). Forgets eating meals/ refuses, stating they have already eaten. Taking food from others tray. Disoriented – needs constant reminders about person, place, time. Difficulty communicating needs and wants.
  – MDS Section C

• Reason for Referral:
  – Patient has had decreased ability to follow directions
  – Patient unable to complete self-care task, as is demonstrating frustration when presented with multiple steps task of washing, grooming and dressing
Program Development
Cognitive Dementia Program

• Example Goals:
  – Patient will complete upper body dressing with visual cue card to instruct one step at a time with min assistance
  – Patient will answer basic questions regarding care needs given a printed cue of 4 choices with 90% accuracy

Program Development
Dining Rounds

• Clinical Partnership:
  – Clinical Nurse Leader: Hands on deck nursing staff
  – Dietary Specialist: Dietician and Dietary Manager
  – Clinical Therapist Leader: SLP or OT with interest in feeding and Dysphagia treatment

• Strategies to Identify Dining Program:
  – Perform regularly scheduled Dining Rounds to identify patients who are at risk for weight loss, have difficulty feeding self, abnormal positioning at meals. Patients who have difficulty swallowing with signs and symptoms of Dysphagia including: Food pocketing, choking/coughing, drooling, taking longer time to finish meals, recurrent or slow resolving respiratory issues.
Program Development
Dining Rounds

• Strategies to identify Dining Program:
  – Increased visibility of the therapy professionals during meal times
  – Screen those with alternate diet and use of adaptive equipment to identify if still relevant for current use
  – MDS Section K and G

Program Development
Dining Rounds

• Reason for Referral:
  – Patient has had 10-pound weight loss in the past 3 months and has little interest in eating
  – Patient noted to have increase drooling and storing food in cheeks while eating regular diet with thick liquids
  – Patient has increased spillage of food and beverages while self-feeding

Program Development
Dining Rounds

• Examples of Goals:
  – Patient will use rocker knife with non-affective hand to cut up meat with standby assistance
  – Patient will alternate solid and liquids with 90% accuracy to promote safe swallow with a pureed diet with min verbal cues
  – Patient will establish good carryover of clock method to identify food items on tabletop to increase self-feeding skills to minimal assist
Program Development Dining Rounds

• Treatment Activities:
  – Visual and perceptual retraining exercises to determine ability to identify objects during meal
  – Use of adaptive equipment to decrease spillage and increase ability to self feed

Program Development Falls and Balance

• Clinical Partnership:
  – Clinical Nurse Leader: Direct Care Nursing Staff
  – Clinical Rehab Leader: PT and OT
• MDS Section J (Falls) and G (Balance)

Program Development Falls and Balance

• Reason for Referral:
  – Fall
  – Patient has unsteady gait while ambulating from room to dining room and has had 2 episodes of loss of balance in the past week
  – Patient able to ambulate 35 feet with rolling walker with min assist x 1, however requiring increase verbal cues for safety
  – Patient requires verbal cues for hand placement to push up to stand and unable to bear weight onto left leg due to sore on heel
Program Development
Falls and Balance

• Assessment Tools to consider:
  – Tinneti’s Test, Berg Test, Functional Reach test,
    Chair Stand test, and 6-Minute Walk test

• Prior Level of Function:
  – Patient was able to ambulate 100 feet with rolling
    walker with supervision for safety
  – Patient required mod A x 1 to roll to left side to get
    from side-lying to edge of bed

Program Development
Falls and Balance

• Clinical Partnership:
  – Clinical Nurse Leader: Risk Manager, Safety/
    Quality Assurance Nurse
  – Clinical Rehab Leader: Falls and Balance Specialist

Program Development
Falls and Balance

• Strategies to implement a Falls and Balance Program:
  – Review Risk Meeting note and review falls reports and
data
  – Daily Risk Meeting note and review falls reports and data
  – Interview staff to identify who requires more assistance,
    who requires frequent redirecting on transfer and
    mobility. Identify patients that have increase difficulty
    with bearing weight, transferring, ambulating, has
    changes in vision, or altered muscle tone.
Program Development
Falls and Balance

• Examples of Goals:
  – Patient will decrease left knee pain to 2/10 and build gross LE strength to 4/5 to focus on stand pivot transfers
  – Patient will increase static standing for 3 minutes with ability to right self with min assist in order to perform standing ADL tasks
  – Patient will ambulate 75 feet with CTG with rolling walker with minimal SOB on exertion and >90% O2 saturation on 1L via nasal cannula

Program Development
Falls and Balance

• Treatment Activities:
  – PREs, Strengthening and balance programming, analyze gait patterns over various surfaces, ongoing graded cueing to improve deviation in weight shift during swing phase of gait. Functional reach activities and obstacle course or walk test programming.

Five-Star Rating &
Quality Measures
Sweet 16 Quality Measures
Short-Stay

1. Improvements in Function (Short-Stay)- New
2. Successful Community Discharge (Short-Stay)- New
3. Re-Hospitalized Following Nursing Home Admission (Short-Stay)- New
4. Outpatient Emergency Room Visits (Short-Stay)- New
5. New or Worsening Pressure Ulcers (Short-Stay)
6. New Antipsychotic Medications (Short-Stay)
7. Moderate to Severe Pain (Short-Stay)

Sweet 16 Quality Measures
Long-Stay

8. Residents Whose Ability to Move Independently Worsened (Long-Stay)- New
9. Moderate to Severe Pain (Long-Stay)
10. High Risk Pressure Ulcers (Long-Stay)
11. Antipsychotic Medications (Long-Stay)
12. Injurious Falls (Long-Stay)
13. Urinary Tract Infection (Long-Stay)
14. Catheter (Long-Stay)
15. Physical Restraints (Long-Stay)
16. ADL Decline (Long-Stay)

New Quality Measures

• Three of the new measures are on Medicare claims and include events that occur after discharge from the SNF:
  1. Re-hospitalization
  2. Emergency Room Use
  3. Discharge to Community
Data Preview

- Data will be available for SNFs to preview before it is posted on Nursing Home Compare
- Rates on the 6 measures can be previewed on QIES (Quality Improvement and Evaluation System)

Quality Measures

- Takeaway #5 – Start looking at Quality Measures more often
  - Used to be a once-a-quarter thing, now every week is not too often

Analyze Your Data
### Five-Star July 2016

**July 2016 through January 2017**

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### Five-Star Composite Rating Calculator

#### 2016

- **Health Inspection Stars**
  - 1
- **Staffing Stars**
  - 1
- **Quality Measure Stars**
  - 1

#### 2016

- **Facility Five Star**
  - 5

### Five-Star Composite Rating Calculator

#### 2016

- **Score**
  - 5

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Quality Measures/Five-Star

• Takeaway #6 - “What do I do if my Five-Star rating is below average?”
  1. Survey star carries the most weight
  2. Quality Measure star is most dynamic
  3. Focus on your strengths during conversations with partners & negotiations
  4. Launch a QAPI program for continuous lasting results

Quality Measures/Five-Star

• Wait a minute... What about Geography??

Managed Care Contracting
Managed Care Contracting

1. Do your homework
2. Know the players in your geographic area
3. Will they be good business partners?
4. Identify those with whom you want to contract?
5. Begin to establish a relationship
6. Use your data as a your strongest negotiating tool

Successful Managed Care Contracting

Thanks to compromise they were moving closer.

Tools for Successful Managed Care Contracting

• Takeaway #7 – Sharpen your negotiating tools
Managed Care Contracting

• Put yourself in their shoes: What do they want in a partner?
• Low cost
• High quality
• Successful outcomes
• If that is YOU, then TELL THEM!
• SING YOUR PRAISES!!

Managed Care Contracting

• Low Cost:
  – One night in the hospital costs them more than a week in a SNF. Don’t let anyone tell you otherwise.
• High Quality:
  – Five-Star Rating and MDS-Based QMs
• Successful Outcomes:
  – Outcomes based Quality Measures (above average successful discharges, below average re-hospitalizations)
Managed Care Contracting

• Negotiating the Plan:
  – Payment rates & terms: Levels, RUGs, or Bundles??
  – Exclusions
  – Consolidated Billing: Out of the ordinary billing rules?
  – Concurrent Clinical Review
  – Rules of Traditional Medicare (Prior Level of Function/Highest State of Well Being)

Managed Care Contracting

• Recently saw some examples of some very poor Managed Care billing practices
  – Poor ICD-10 Diagnosis coding
  – Ancillaries (Lab, Pharmacy, Radiology) missing
  – Concurrent review processes with very poor vernacular

Managed Care Contracting

• Vocabulary and vernacular in speaking with medical reviewers:
  – “Skilled Observation and Assessment”
  – “Ensuring Medical Safety”
  – “Promoting Recovery”
  – “Stable” -- Don’t Say it!!!!!!

• Appeal Rights:
  – What are your appeal rights?
  – Know them in advance
Partnering with Your Partners

Looking for Solutions?

– We have been living in a Medicare world where it’s all about volume
– Now we are transitioning into a world of preferred post-acute providers where hospitals are narrowing their networks to high performing SNF providers
– Define what makes you successful
– WORK DOUBLE-TIME!
– Must work on both simultaneously
What is on the Minds of the Hospital Systems?

- Reducing readmissions are Numero-Un in their world
- The best way for them to gain control over reducing readmission rates is to narrow their networks
- It’s too difficult to manage if hospitals are discharging to 100 different SNFs
- If in that network are high performers (Five-Star and QMs), readmissions are more likely to be reduced

What if Hospitals and Physicians Want to Bypass the SNFs?

GOOD QUESTION
What if Hospitals and Physicians Want to Bypass the SNFs?

- We have to expect that outcomes will eventually catch up to them
- QUALITY and OUTCOMES!
- We know it really isn’t as cost effective as one would lead you to believe
- Transition Nurses in facilities will play a vital role in order to deal with shorter LOS
- Sing your praises! Show them your outcomes and quality. Sell your strengths.

How to Succeed in VBP

- Develop effective, quality, utilization, risk and infection management programs
- Implement reliable performance improvement tools and measures
- Implement effective admission, discharge and transfer protocols
- Improve performance in reducing conditions and complications that will lead to readmissions
- Build solid relationships…. DO NOT wait!

Key References

- IMPACT Act
- Final Rule FY 2016
- Final Rule FY 2017
Harmony Healthcare International (HHI)

Would you like a...

Free Five-Star Analysis

Contact
Matt McGarvey
518.477.0608
mmcgarvey@harmony-healthcare.com

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Thank You