



HOME CARE AND THE CONTINUUM:

How Home Care and Acute Care Can Work Together



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AGENDA

- Reform
- Speaking the Language
- ACO Measures
- Making the Connection
- Developing the Relationship
 - F&A
 - Goals
 - Operational Considerations
- The Future of Change



WHY HEALTH CARE IS CHANGING



REFORM

PPACA, as we all know, included a number of new health care payment models including ACOs, bundled payments and others. The goal of these models are to provide for savings while also reducing costs. They are part of a trend that is driving Medicare to a quality-based payment model.

These changes impact all health care providers and the trick will be to get out of our silos and work together!

REFORM

P4P and quality are the focus of these efforts. Acute care providers have been working on this for awhile.

Acute care providers are beginning to take notice of Post Acute Care Providers including Rehabs, SNF's and Home Health recognizing.

They now recognize they will NEED us!

REFORM

On January 26, 2015, Secretary Burwell announced HHS goal of having at least 50% of Medicare's payments be based on quality, not quantity, by 2018.

REFORM

This effort has included a push towards more integration along the continuum. CMS understands that if everyone works together, patient care improves and costs go down.

Health systems are getting the message of the value of home health clearer than ever before.



REFORM

- **Medpac** has suggested that the need for coordination from acute to post acute is so strong that Acute care providers and ACOs should be given greater leeway to “steer” patients.
- CMS has sought comments on this option.
- They understand that the ACO (and other acute care providers) may be penalized as a result of post-acute care provided to discharged patients. Therefore, acute care providers ought to have more of a say.

REFORM

- This is leading providers across the acute/post-acute spectrum to begin looking at ways to work together to address:
 - Outcomes
 - Readmissions
 - Care coordination

REFORM

While both Acute Care and Post Acute Care providers understand they are the key to each other's success.....

- PROBLEM: Acute care providers and home care providers are unfamiliar with each other.
 - Home care – does not understand acute care goals and how homecare can help to address these goals.
 - Acute care – does not understand what home care can do to help achieve these goals.

HOME CARE

What we know now.....

- Home Health:
 - Paid lump sum – adjusted – for each 60 days of care
 - Reimbursement declining – efficiency is key
 - Labor intensive: employees visiting the patient's home
 - Confined to home
 - Disabled, chronic, post-operative



HOME CARE

- Hospice:
 - Paid per diem amount
 - Hospice provider responsible for all services, supplies, pharmaceuticals related to palliation
 - Terminally ill patients – six months
 - Election of hospice
 - Forego curative care related to terminal illness
 - Growth in industry leading to increased scrutiny

HOME CARE

- Private Duty/Home Care:
 - Paid for by patient/patient's family/Medicaid Waiver
 - Non-skilled – aide services, no nursing, no therapy
 - Assist patients with ADLs, IADLs so client can remain in home

HOME CARE

- Home care is very decentralized. Limited administrative overhead/few physical assets. Caregiving staff scheduled from office, but infrequently in office- requires different management skills
- Significant expense in labor, travel, etc.
- Very different model from acute care and even other aspects of long-term care



ACUTE CARE

Hospitals:

Paid per DRG- Average 3% margin IF they manage well -
High risk for losses and Penalties for Re-Admissions

Managed Care - Average 18% Margin

They don't clearly understand that home health prefers
Medicare and most lose on Managed Care!

▪ SPEAKING THE SAME LANGUAGE

- Hospital decision makers may not understand the how home care is paid and all the issues. Anticipate the need to be thoroughly and repeatedly educated.
- Homecare providers need education as well but don't rely on them to educate you – Do your homework!
- You need to understand what hospitals and other acute care providers are looking for from homecare.
- You need to speak their language and their language is data.

▪ SPEAKING THE SAME LANGUAGE

- Hospital administrators do not speak our language...
- Terms such as SOC, LUPA, PEP, are completely foreign terms
- They do not understand the importance of
 - Visits per episode
 - LUPA Rates
 - Case Weight Mix
 - Recert Rates
 - ETC!

Be prepared to demonstrate data related to the significance of these measures and where you stand compared to benchmarks.

▪ SPEAKING THE SAME LANGUAGE

- With the move to value based purchasing, P4P, etc., there are a number of different models.
- We will look at the ACO measures as an example to illustrate how homecare can impact acute care scoring.
- By briefly reviewing these, we can develop some ideas as to how home care can help acute care achieve its goals.
- This allows us to speak the same language.

▪ SPEAKING THE SAME LANGUAGE

- CMS chooses the ACO measures from five “domains”:
 1. Patient/caregiver experiences
 2. Care coordination
 3. Patient safety
 4. Preventive health
 5. At-risk/frail/elderly health
- CMS modifies them each year.

■ SPEAKING THE SAME LANGUAGE

Domain	Number of Individual Measures	Total Measures for Scoring Purposes
Patient/Caregiver Experience	8	8 individual survey module measures, includes CAHPS
Care Coordination/Patient Safety	10	10 measures (compressed two categories)
Preventive Health	8	8 measures
At-Risk Population	7	7 measures. Homecare connection: Diabetes, Hypertension, Ischemic Vascular Disease, Heart Failure, Coronary Artery Disease, Depression
Total in All Domains	33	

■ SPEAKING THE SAME LANGUAGE

- Home care providers have experience in MOST of these areas and can assist acute care providers with these areas.
- We have to show them our value and how we can assist them

Some of the metrics a home care provider can address:



ACO CAHPS MEASURES

Domain	Measure
Patient/Caregiver Experience	CAHPS: Timely Care, Appointments
	CAHPS: How Well Your Providers Communicate
	CAHPS: Patient's Rating of Provider
	CAHPS: Health Promotion and Education
	CAHPS: Shared Decision-Making

ACO CAHPS MEASURES

- Home health and hospice providers are already familiar with the CAHPS survey process.
- The survey questions that HHA patients are asked address a number of the same issues as the ACO CAHPS survey.
- Demonstrate your outcomes compared to benchmarks and tie it back to the patient overall experience which impacts the health system.

ACO CARE COORDINATION MEASURES

Domain	Measure
Care Coordination/Patient Safety	Risk standardized all condition readmission
	Ambulatory sensitive condition admissions: COPD and asthma
	All cause unplanned admissions for diabetic patients
	All cause unplanned admissions for patients with multiple chronic conditions
	Documentation of current medications in record
	Screening for future fall risk

ACO CARE COORDINATION MEASURES

- HHAs and hospices serve many COPD, diabetic and chronic patients. How they handle those patients directly impacts hospital readmissions.
- Some HHAs have specialty diabetic care, COPD, CHF and similar programs.
- Demonstrate standardized best practices and results.



■ ACO CARE COORDINATION MEASURES

- HHA and hospice are specifically required to coordinate with other providers. Communicate updates/changes of orders to physicians.
- 60-day summaries with re-certification.
- Demonstrate how your processes will marry their regulations and practices to improve efficiencies, reduce cost, and better coordinate care.

■ ACO CARE COORDINATION MEASURES

- Private duty providers in patients' homes also monitor and can report changes.
- These reports can allow other providers, HHA, physician, etc., to intervene earlier, thus avoiding admissions.
- Demonstrate that you have the processes in place to be effective.

ACO CARE COORDINATION MEASURES

- Agencies are required to perform, and are surveyed on, medication reconciliation.
- Agencies also perform fall risk assessments as part of the OASIS admissions assessment.
- Show the data! Be prepared to demonstrate your ability to reduce their overall risk.



ACO CARE COORDINATION MEASURES

Domain	Measure
Preventive Health	Influenza immunization
	Pneumonia vaccination in older adults
	Screening for high blood pressure
	Screening for clinical depression
At-Risk Population: Diabetes	Hemoglobin A1c poor control



PREVENTIVE HEALTH/ AT-RISK POPULATION MEASURES

- Many agencies provide influenza and pneumococcal vaccines to their patients. This indicator has overall low benchmarks – What can you do to provide better coordination with the system to get the information needed and have better overall results.
- Demonstrate your preventive health measures both on patient outcomes and community activities for preventive health.



PREVENTIVE HEALTH/ AT-RISK POPULATION MEASURES

- Many agencies have developed programs to improve diabetic patient care and other chronic care programs.
- Define your programs and outcomes to address Diabetes and other at-risk populations.
- Don't assume they know what you do – Many times we take for granted, the great things we do everyday. We have to define it for them!



▪ MAKING THE CONNECTION

- Caring for patients at home is cheaper, if they are appropriate for home care.
- This means properly identifying and moving patients can lead to cost savings.
- Find ways to identify health system statistics –
 - Overall discharges to home health - compared to benchmark
 - Discharges to long term care, rehab or SNF's compared to benchmark

If you show them **their** data, and how referring more patients to home health (as appropriate) will reduce cost – They will be IMPRESSED.

▪ MAKING THE CONNECTION

- Although home care can help acute care providers to reduce costs and improve outcomes, it is important to know how to identify acute care providers whom you could assist.
- Hospitals – Don't limit yourself to just one
- Rehab Facilities
- Long Term Care Facilities
- Everyone is looking to align with partners throughout the continuum.
- Need to consider not just outcomes, but institutional culture. Culture is important, because you will need to be able to work with your partner. DO NOT UNDERESTIMATE!

■ MAKING THE CONNECTION

- When approaching an acute care provider, you need to be able to make your case in terms they know and understand.
- Don't assume they understand because they are nodding or even repeating back to you!



■ MAKING THE CONNECTION

You will want to show how utilizing your agency can lead to cost savings.

You will want to show how utilizing your agency will result in improved outcomes for them.

Show them with DATA!

■ MAKING THE CONNECTION

1. Demonstrating savings can be done in two ways:
 - Compare home health costs to in-patient costs. Can you show how appropriately timed discharges can reduce Medicare/Medicaid spending?
 - Find out what their average cost per day is – Calculate saving by .5 day LOS and 1 day LOS
 - Is there an overutilization of home health/hospice by competitors? How many providers are they using?
 - Is there an overall under utilization of home health?
 - Is there an over/under utilization of SNF/LTAC?

■ MAKING THE CONNECTION

How do you show cost savings?

- Reduced ER utilization?
- Reduced hospital admissions?
- Shorter hospital stays?

■ MAKING THE CONNECTION

Important point: Hospitals/ACOs get nervous when they hear providers talking about reducing admissions – they get paid for admitting patients. Some agencies have received “push back” when discussing reducing admissions.

- It is important to show the whole picture and use terms such as avoidable hospitalizations or 30-day readmissions – Again – Our terminology is the same but the meaning can be interpreted very differently!

■ MAKING THE CONNECTION

2. Making the case for Quality.

- Acute care will want to evaluate a home care provider's outcomes – CAUTION – We need to demonstrate what data is important for them, how to interpret and how it impacts them -
 - Outcomes Data (OBQI, CAHPS, etc.)
 - ER usage
 - Re-admission rate
 - HHCAHPS results
 - Average recertification rate/length of stay
 - Cost per visit

■ MAKING THE CONNECTION

OBQI: You may have to explain OBQI to acute care provider.

You will also have to explain OASIS, the OBQI benchmarks, etc.

Show how this data relates to ACO or similar metrics.

Show how your scores relate to local and national benchmarks.

■ MAKING THE CONNECTION

- Don't let them rely on CMS data alone.
Highlight your strengths and teach them about the other important indicator that drive home health success!
- Case weight mix and what that means – Do your patients have a higher acuity than most and you still have great outcomes?
- Cost per visit – and why that is important – Hospitals are looking for the most efficient lowest cost provider.
- Visits per episode – compared to benchmark.
- Demonstrate your capacity – How your service area aligns with their population.

■ MAKING THE CONNECTION

- You should also explain:
 - Specialty programs
 - Patient census
 - Common diagnoses
 - Infrastructure
 - **IT capacity** – important to ACO data collection, etc.



■ MAKING THE CONNECTION

- The Acute care provider is trying to:
 - Identify agencies that collect and use data in a manner that can work with acute care provider
 - Identify agency or agencies whose outcomes and quality data can improve acute care's performance
 - Identify savings

■ MAKING THE CONNECTION

- Providers that cannot “speak the language” cannot help them and will not be considered.
- Providers whose data shows poor performance cannot help them and will not be considered.

■ DEVELOPING THE RELATIONSHIP

- Identifying providers that can help you achieve these goals is important.
- However, once you have identified these providers, you need to determine how to work with them.



DEVELOPING THE RELATIONSHIP

- This requires careful consideration for a number of reasons:
 - Fraud and Abuse Risk
 - Business Goals
 - Operational Goals/Issues

DEVELOPING THE RELATIONSHIP F&A RISK

- Fraud and Abuse issues must be considered carefully because acute care/home care relationships involve a relationship between providers who can refer patients to each other.

DEVELOPING THE RELATIONSHIP BUSINESS CONSIDERATIONS

- Each party needs to be clear at the beginning what the goals are.
- Goals should be related to patient care and quality, NOT VOLUME OF REFERRALS.



DEVELOPING THE RELATIONSHIP BUSINESS CONSIDERATIONS

- The parties' goals will influence whether the parties pursue:
 - Sale/Acquisition
 - Ownership JV
 - Contractual JV
 - Preferred Provider Arrangement

DEVELOPING THE RELATIONSHIP BUSINESS CONSIDERATIONS

- Sale/Acquisition – homecare provider sells agency to acute care provider.
- Ownership JV – acute care provider becomes part owner.
 - Current entity? New Entity?
- Contractual JV – homecare manages provider owned by acute care provider.
- Preferred provider agreement – homecare provider agrees to certain terms related to quality, outcomes, etc. and is then designated as “preferred” to patients.

DEVELOPING THE RELATIONSHIP OPERATIONAL CONSIDERATIONS

Picking a JV vehicle involves considering a number of issues including:

1. Who wants control?
2. Acute care provider’s risk profile.
3. Each entity’s long term strategy.
4. Speed with which the parties want to move forward.
5. Need for immediate Medicare reimbursement.

DEVELOPING THE RELATIONSHIP OPERATIONAL CONSIDERATIONS

Acquisition/Ownership JV and the acute care provider's risk profile. Need to be clear partner understands:

1. Medicare liability and assuming provider number.
2. Employee liability and successor employer issues.
3. Contracts that are needed for operation.

DEVELOPING THE RELATIONSHIP OPERATIONAL CONSIDERATIONS

Clearly discuss options and specific goals related to the provider number. Acute care provider may want an "ownership JV", but may intend to create a new entity and enroll it as a new provider.

They may ultimately want something else: pay agency to provide case management, etc.

DEVELOPING THE RELATIONSHIP OPERATIONAL CONSIDERATIONS

If the parties determine to move forward with a joint venture of some form, need to consider a number of day to day operational matters.

It is extremely important to discuss those matters and decide *before* moving forward. Having those discussions after the JV has started is too late.

DEVELOPING THE RELATIONSHIP OPERATIONAL CONSIDERATIONS

- Each structure impacts how the parties handle a number of aspects of the relationship. For example, aspects of controls/decision-making:
 - Preferred provider/Contractual JV – contractual agreement on outcomes
 - Ownership JV/Acquisition – Board involvement in operations/setting goals

DEVELOPING THE RELATIONSHIP OPERATIONAL CONSIDERATIONS

- To be successful, parties must address not just business goals, but operational issues:
 - Decision-making
 - Communications
 - Monitoring
 - Compliance
 - Other aspects of the relationship

DEVELOPING THE RELATIONSHIP OPERATIONAL CONSIDERATIONS

- Home care operations are very different and must be considered.
- This may impact thinking on controls and who is in control and/or at what level.



DEVELOPING THE RELATIONSHIP OPERATIONAL CONSIDERATIONS

The operational differences are very important and must be clearly, and repeatedly, explained.

Need to be sure that all parties understand what each side is proposing. Do not want to spend six months on a project and then discover the parties were not on the same page. Be certain to avoid home care lingo and clearly define terms – don't assume you are speaking the same language and are on the same page.

DEVELOPING THE RELATIONSHIP OPERATIONAL CONSIDERATIONS

- Communications:
 - If the parties have clearly defined lines of communication on operational/clinical issues, this can improve outcomes

DEVELOPING THE RELATIONSHIP OPERATIONAL CONSIDERATIONS

- Communications examples:
 - Discharge planning – prompt notification/delivery of paperwork
 - Point of contact – resolve discharge issues
 - Education – ensuring acute care staff understand what home care can do and what it cannot do

DEVELOPING THE RELATIONSHIP OPERATIONAL CONSIDERATIONS

- Monitoring:
 - Need to have standards to use to measure effectiveness of collaboration- They need to understand what is important to measure home health success such as:
 - LUPA rates, Recert rates, Visits per episode, Timely Initiation of Care
 - **NOT FINANCIAL!!!! –Should not be a measure of referrals or share of Medicare business!!!**



DEVELOPING THE RELATIONSHIP OPERATIONAL CONSIDERATIONS

- Compliance:
 - Initiating a relationship has Fraud and Abuse concerns, but those do not go away once the relationship is initiated. Need to be vigilant.
 - Realize that other home care providers will object and may complain.
 - Be prepared and diligently focus on patient care and quality.

DEVELOPING THE RELATIONSHIP OPERATIONAL CONSIDERATIONS

- Other issues:
 - Exit strategy – what happens if partners want to go their separate ways?
 - Deadlock
 - Changing leadership

DEVELOPING THE RELATIONSHIP OPERATIONAL CONSIDERATIONS

ACO participation.

This is another option in some areas. You may be invited to participate in an ACO.

DEVELOPING THE RELATIONSHIP OPERATIONAL CONSIDERATIONS

ACO Participation Considerations:

1. Shared savings opportunity?
2. Membership/Management fee?
3. Policies and procedures which you must follow?
4. Involvement in ACO governance?
5. Participate in multiple ACOs?



THE FUTURE OF CHANGE



▣ WHERE ARE WE GOING?

- As these new models grow and expand, acute care and post-acute care will continue to integrate more closely.
- As reform continues to drive change, acute care and home care will continue to look at ways to work together.

▣ WHERE ARE WE GOING?

- Integration along the continuum appears to be the future of health care, but that does not mean providers can simply ignore the traditional risks of partnering with referral sources.
- Change is coming, but we need to be prepared to properly navigate it.

▣ WHERE ARE WE GOING?

- Need to consider appropriate partners.
- Need to consider compliance in partnerships.
- Need to consider how partnerships help to achieve overall goals.





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