The Health System of the Future: Becoming a Preferred Provider in the Narrow Network

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Josh Luke, PhD., FACHE

- **Hospital CEO**
  - Memorial Hospital of Gardena
  - Western Medical Center Anaheim
  - Anaheim General Hospital

- **VP, Post Acute at Torrance Memorial Health System**
  - Home Health and Hospice oversight
  - Developed award winning Post Acute Network

- **CEO for HealthSouth Las Vegas Rehab Hospital**

- **SNF Administrator/ALF Executive Director**
  - Home Kindred
  - Windsor/SNF Management
  - California Friends Homes
Presentation Objectives

• The delivery model of the future: “Discharge Home”
• Post Acute to do list
• Innovations to consider

It's time to innovate and transform!

Let’s get off the starting line and skate to where the puck will be!
1998........It was a very good year
1998......Led to Career Change
Grandma Belva
March 1920 – July 2002

Congestive Heart Failure
The Summer of 2002

Home $0
Hemet Valley Medical Center $48,000
LTACH $52,000
Nursing Home $12,000
Home with Home Health $4,000
* Hemet Valley Medical Center $36,000
Nursing Home $18,000
Assisted Living with Home Health $4,000
* Hemet Valley Medical Center $42,000
Nursing Home $24,000
* Hemet Valley Medical Center $58,000

* Readmission $298,000
The ACA is a Mandate
We Must coordinate care

- The goal is to find a better way for individuals to age and heal at home.
- The truth is that my job is not to teach you how to prevent re-admissions, it's to teach you to prevent...Admissions.
- Welcome to the world of...

**ADMISSION PREVENTION**
What does this mean for you?

- Hospitals = Last resort
- SNF = Second to last resort; increase capability to handle med surg level patients
- Home health = Networks will be narrowed
- Patients will be directed to lower levels of care and care paid privately (ALF, home care, remote monitoring)
Winning!

• So who is winning?
  • Home Care
  • Private duty nursing
  • Assisted living

• Who can position for success?
  • Health systems designed so that hospital is truly the last resort
  • SNF’s who are willing to push for shorter LOS
The US Supreme Court concluded:

“Patients in an acute hospital have the right to be discharged to the least restrictive environment when the care team determines that community placement is appropriate and the patient does not oppose to the transfer.”

“Continued institutionalization of patients who may be placed in less restrictive environments often constitutes discrimination based on disability.”
The US Supreme Court concluded:

- Operationally, this means that both physicians and hospital case managers must first rule-out the least restrictive environment as a safe discharge before considering institutionalizing a patient for post acute services.”

- What do you think CMS would say about this? MSPB?
Transitional Care, Wellness & Revenue Streams

Everyone is being incentivized to avoid the hospital

- Direct to SNF transfers from the ED
- Remote monitoring at home and in SNF
- Home visits
- Expansion of Home Health to Ambulatory case managers
My Visit with MedPAC

- Quota based physician model
- The future of specialty hospitals
- Slow to grow Home Health due to fraud
3 Midnight Rule

- So what about the three midnight rule?
- IMPACT requires that MEDPAC make a recommendation on changing the 3 midnight rule by June 30, 2016
- What would happen if they changed it now?
Obama Alaska

Hypothetical New City

Health System of the Future

- Home
- Doctors office
- Wellness clinic/gym
- OP/Ancillary Services
- Assisted Living
- SNF
- Hospital
Obama Alaska

The System of Old – The Fee-For-Service Free-for-All

Hospital

- Home
- Doctors office
- Wellness clinic/gym
- OP/Ancillary Services
- Assisted Living
- SNF

Insert Hospital Here!
Story Time
Once Upon a time…

Hospital Bed Capacity

Old Hospital = 290 beds

The Fee For Service Free-for-All Era

New Hospital = 249 beds

Post ACA Era
Seven Reasons to Coordinate Care

1. ACO’s (MSSP incentive)
2. Bundled Payment Initiatives
3. Value based Initiatives
4. Readmission Penalties
5. MSPB
6. RAC Audits
7. 2016 (30%) and 2018 (50%) of Medicare dollars to CC

Only one of these has been impactful enough to get hospitals to react to date!
The transformation of the acute hospital: the C-suite must take action

Coordinating Care for Improved Outcomes

- Hospitals must act like health systems
- Health systems must act like managed care organization
- Thus, the hospital must act like a managed care organization as well
Declining Inpatient Admissions & Revenue

Modern Healthcare January 5, 2015

“Hospital Admissions Still Declining”

- Secret to running a hospital during “Fee For Service Free for All” was three simple steps
  - Contracts
  - Physician relations
  - Inpatient specialty programs

- CEO or CFO request for information
  - 40% from bottom line
SNF Providers: Are You Ready for the New Normal?

What if, on December 31, 2014 you received a notification from CMS advising you that…
SNF Avoidance & Duals

**Bad News**
- Pre-authorizations
- Shorter LOS
- Reduced reimbursement

**Good News**
- Narrow networks for those committed to quality
- Its inevitable that the three midnight requirement go away if managed care can approve a direct from home to SNF admissions
Here Comes Reason #7 to Coordinate Care

Improving Medicare Post-Acute Transformation Act of 2014

*IMPACT* Act of 2014 takes a crucial step toward the modernization of Medicare payments to *post-acute* care (PAC) providers

Who wins? Maybe no one: It appears to be more documentation to prove medical necessity
Post Acute Expectations

1. POLST
2. SBAR
3. Stop and Watch
4. Return to Acute Log (Emergency Dept)
5. Return to ED Root Cause Analysis
6. Predictive software/electronic quality data *

*Only tactic requiring investment; small price to pay to be preferred provider*
The Super SNF

• Stop looking at competitors within the SNF industry for the answers and start innovating

• Hospital based SNF’s within a mile of your facility get paid $800-$1100 a day for SNF patients; why don’t you?
As part of our efforts to provide transparency and accountability to our community, Marlora is pleased to provide you this month’s report card reflecting patient satisfaction and hospital readmission statistics.

**HOSPITAL READMISSIONS (RTH) DETAIL**

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<td>Other Dx</td>
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**FEBRUARY OVERALL HOSPITAL READMISSION RATE**

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<tr>
<td>RTH %</td>
<td>2.2%</td>
<td>21.4%</td>
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(1) Reflects clinical data 2/1/14-2/28/14; (2) Source: medicare.gov. Hospital Outcomes of Care Measures; (3) Source: Rehospitalization from Skilled Nursing Facilities, Mor, Integrator, et al, Health Affairs, Jan 2010
Four examples of Value-Added Innovation

Connectivity and Care Planning

• Risk Stratification in acute and post acute connectivity
  • *Software such as RightCare Solutions (UPenn) identifies & connects*
  • *Vree Health population management resource software*

• Care Management
  • Community Integration Model

• Home Based Transition programs
  • Home Instead transition program
  • Care Centrix HomeStar: Home Health management

• Predictive software (Coms Interactive and Medline) in SNF’s:

*These are all MSPB solutions as well.*
Key Action Items

• Outreach to your referral partners consistently
  • On the 15th of each month: Share the tools above!

• Innovate and Differentiate
  • Readmission Tool Kits

• Providers MUST Become Certified to Stand Out
  • Certified Readmission Prevention Professional program
My Legacy: *Going Purple for My Mom*

**Values**

- Passion
- Empathy
- Fight
- Use your gifts
- Legacy
Go Purple to fight Alzheimer’s Disease!
NRPC has donated $2,000 already in 2015!

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