Getting and Building an Effective Health System Partnership

Maximizing Your Agency’s Engagement Strategies

Larry Baker, Baker Home Care Financial Consulting, LLC
Andrew Eaves, a.m.eavesConsulting, LLC
Kate Mercier, MSPT, COS-C, VP of Operational Excellence, BVNA

Brockton Visiting Nurse Association
How we are Going to Do This

- Educational concepts
- Case study
- Take your questions throughout
Our Story

- How BVNA identified an opportunity to form a preferred provider relationship with Signature Healthcare
Overview of BVNA, SHC & Marketplace

• Brockton Visiting Nurse Association
  o Independent, non-profit, 110 years in Brockton
  o Average daily census of 800+
  o 100 clinicians/175 employees
  o Service 30+ towns
  o $16MM revenue

• Signature Healthcare
  o Brockton Hospital, Signature Medical Group, Signature Foundation, Brockton Hospital School of Nursing
  o Clinical affiliation with Beth Israel Deaconess Medical Center
  o 550 affiliated physicians and other direct care providers, 150 employed physicians and a total of 2,200 associates
  o Multiple practice locations
Goals for Today

1. Identify partnership opportunities
   - System vs. non-system
2. Get a seat at the table to make your proposal
3. Construct the most effective approach for your target partner
4. Manage the relationship
5. Measure the performance and value of the relationship
Why a Partnership?

1. Enhanced quality of care
2. Improved collaboration
3. Solidify referral volume
4. Increase market share and/or new lines of business
5. Monetize the evolving payment structure
Where do You Start?
Overview of the Evolving Healthcare Environment

Emerging payment models

- Bundles
- Gain sharing
- Risk sharing
- ACO
Success is tied to value as defined by the customer

- Traditional Metrics
  - STAR
  - Clinical outcomes
  - Patient experience
- Innovative Metrics
  - Disease-specific
  - TME Management
Overview of the Evolving Healthcare Environment

Health system partnerships include more than just hospitals

- SNFs
- Physicians
  - Developing continuums and community health initiatives
Overview of the Evolving Healthcare Environment

Changing role of home care

- We can leverage our skill set in new ways
- Be involved in setting the agenda
Evaluating Your Agency & Marketplace

SWOT Analysis

- Strengths
- Weaknesses
- Opportunities
- Threats
Evaluating Your Agency & Marketplace

Market Analysis
- Competitors
- Customers
- Trends
- Market Share
Evaluating Your Agency & Marketplace

Develop a profile of both you and potential partner

- Relationships
- Programs
- Payment models/payors
- Brand and positioning
- Geographic scope
Formulate Your Strategy

- Do you know what you want to achieve?
  - New business growth?
  - Sustain existing business?
  - Or both???
Getting a Seat at the Table

• What’s your network? Who can open the door?
• Leverage existing relationships
• Create the pitch
• Set and suggest the agenda
Creating the Pitch

1. Reference your connection
2. Demonstrate knowledge of an issue that is compelling to them
3. Reference the opportunity to help them find a solution
4. Request a meeting to discuss or brainstorm
Our First Agenda

Cross Continuum Collaboration
Initial Planning Session

January 27, 2014

Agenda

I. Introduction:

II. Purpose: How we can better partner with each other to address the opportunities and challenges we face?

III. Goal: Develop collaborative programs and processes to engage patients, offer best practice services to the geographic area that we mutually cover and achieve the Triple AIM in a financially sustainable way

IV. State of Affairs: Industry, Organization, Programs

V. Group Discussions: Challenges, Opportunities, Synergies

VI. Next Steps: Establish Plans/Committees
Constructing the most effective approach for your target partner

- Determine what’s in it for them
  - Clinical Coordination of Care
  - Financial
  - Reduced Re-Hospitalizations
  - Other
- Demonstrate that you have the data
  - Knowledge of market share data
  - Demonstrating your quality
  - Know your financial data
- Target the presentation to your audience
1. Healthcare Industry Influences
   - Environmental factors
   - Triple Aim
   - Shift from volume to value-based payments
   - New payment models
   - Need for coordinating care across settings
2. Home Care’s Strengths in a Post-Acute Care Strategy

- Evidence-based practices
- Low cost provider
- Medication reconciliation
- Personalized teaching & coaching
- Home safety evals
- Coordinate community resources
- Eyes and ears in the home
Innovative approaches to the use of post-acute care could be key to improving patient care at a lower cost.

A recent study showed that patients with similar clinical and demographic characteristics are receiving post-acute care in various settings.

Example:
Comparing average payments across first post acute settings, it is clear that home health is the most cost-effective. For example, the average first setting Medicare payments for MS-DRG 470 (major joint replacement) are:

<table>
<thead>
<tr>
<th>Setting</th>
<th>Average Payment</th>
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<tr>
<td>Home Health</td>
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<td>Skilled Nursing Facilities</td>
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<tr>
<td>LTCH</td>
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</tbody>
</table>

http://www.ahhqi.org/research/efficient-care
3. Home Care’s Strengths in a Population Health Strategy

- Chronic care management
- Specialty programs, such as HF, Diabetes, COPD
- Use of technology, such as telehealth
- Coordination of non-medical resources
Studies show that as the number of chronic conditions increases so do hospitalizations. Medicare beneficiaries with multiple chronic illnesses account for the MAJORITY of all hospital readmissions.

Figure 2.7  Distribution of Medicare FFS Beneficiaries by Number of Chronic Conditions and Total Medicare Hospital Readmissions: 2010

DATA HIGHLIGHTS:

There were 1.9 million Medicare hospital readmissions in 2010. Medicare beneficiaries with two or more chronic conditions accounted for almost all (98%) of these readmissions.

Beneficiaries with 6 or more chronic conditions accounted for a disproportionate share of these readmissions, with the 14% of these beneficiaries accounting for 70% of all Medicare readmissions.
4. Home Care’s Reimbursement Doesn’t Support Innovation
   - Home care economics
   - Recent changes
Current home care reality:
• Medicare has a positive margin
• Medicaid has a negative margin
• Managed Care has a negative margin
• No reimbursement for telehealth
• No reimbursement for care transitions
• No reimbursement for intensive case management (TMP)

What has impacted home care finances recently?
• Continued Medicare payment reductions
• Sequestration
5. Local Demographic Influences:

- 10,998 – total population over 65
- 31.9% live alone
- 28.2% self-reported in fair or poor health
- 39.8% with diabetes
- 60.7% with 4+ chronic conditions
- 21.2% inpatient hospital readmission rate (vs 17.8% MA)
- 4.0 home health visits per year (vs 4.2 MA)

Source: Mass. Healthy Aging Report
6. About BVNA

- Scope of services
- Patient census
- Geography
- Employees
- Payor mix
- A typical week
7. BVNA’s Response to Change

- Business Model
- Investment in Value-Added Specialties
Example of a Slide

- **Acute Care Specialties**
  - Oncology
  - Palliative Care program
  - Caring for Kids program
  - Wound care (WOCN)
  - IV Therapy
  - Orthopedic Rehabilitation
  - OB/GYN: maternal/child health
  - Pediatrics

- **Chronic Care Specialties**
  - Cardiac care w/telehealth
  - ADA recognized Diabetic education
  - Chronic Care Management program
  - LifeLine
8. Brief Case Study

- Program overview
- Outcomes
- Key success factors
Complex Care Program

• An evidence-based, collaborative program which provided care to ___ patients last year, who collectively received ____ home visits.

• Complex Care Manager coordinates services and collaborates with physicians, Payor case managers and community resources.

• We provide Medication Reconciliation, Fall Risk & Depression screenings

• Manager provides the required expertise to provide appropriate oversight, coordination and collaboration with the rest of the cross-continuum team.
Complex Care Program Outcomes

• ACH rate of ___%
• ER visits have been decreased
• Patient satisfaction @ ____% vs. ____% MA avg for specific care issues
• Follow up with PCPs w/in 7 days has increased

Key Success Factors (from bvna perspective):
• Intensive case management
• Improved communication
• Collaboration
• Added up front-costs to fund piloted position
9. Summary

- Recap of key points
- Conclusion that supports goals
- Lead to next steps
• Needs in our mutual community are increasing
• Collaboration is critical for best outcomes
• A continuum that addresses inpatient, post-acute and community health is essential
• Signature Healthcare and bvna have proven compatible and successful
• Formalizing a process of collaboration makes sense to ensure programs are built to succeed
• Health care financing, as presently constituted, does not adequately meet bvna needs
• We must be innovative clinicians and business people
• We are better together
Evaluating Your Initial Meeting
Identifying Appropriate Next Steps

- Did your meeting achieve its goals?
- What are the next steps that came out of it?
- Follow up is critical, but recalibrate.
- Keep at it until you achieve your goal.
Managing the Relationship

- What are your big picture goals?
  - Relationship objectives
  - Volume objectives
  - Financial objectives
  - Operational objectives

- Every meeting must have a goal; set the agenda
- Formalize working relationships
- Communication methods; keep everyone informed and engaged at every level
- Reporting and data exchange
- Evolve as new opportunities present themselves
Ways we are Working Together Because of this Partnership

- Chronic Disease Management
- Specialty HF Program
- Bundled MJR Program
- BPCI
- Community Coalition for Care Transitions
- Post Acute Predictive Modeling Program
- LEAN Healthcare
- Shared accountability
Measuring the Value

- Impact on business development opportunities
  - Growth in Admissions
- Impact on VBP, HHCAHPS and Star Rating
  - Reduction in ACH rate
- Impact on financials
Why a Partnership?...revisited

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What’s Next for You?

1. Agency and market assessment
2. Identify partners
Contact Info

- **Larry Baker:**
  - lpbaker51@gmail.com
  - 781.526.2398

- **Andrew Eaves:**
  - andrew@ameavesconsulting.com
  - 203.887.4088

- **Kate Mercier**
  - kmercier@brocktonvna.org
  - 401.527.5442