Rethinking Post-Acute Care Under ACOs and Bundled Payments: A Clinical Perspective

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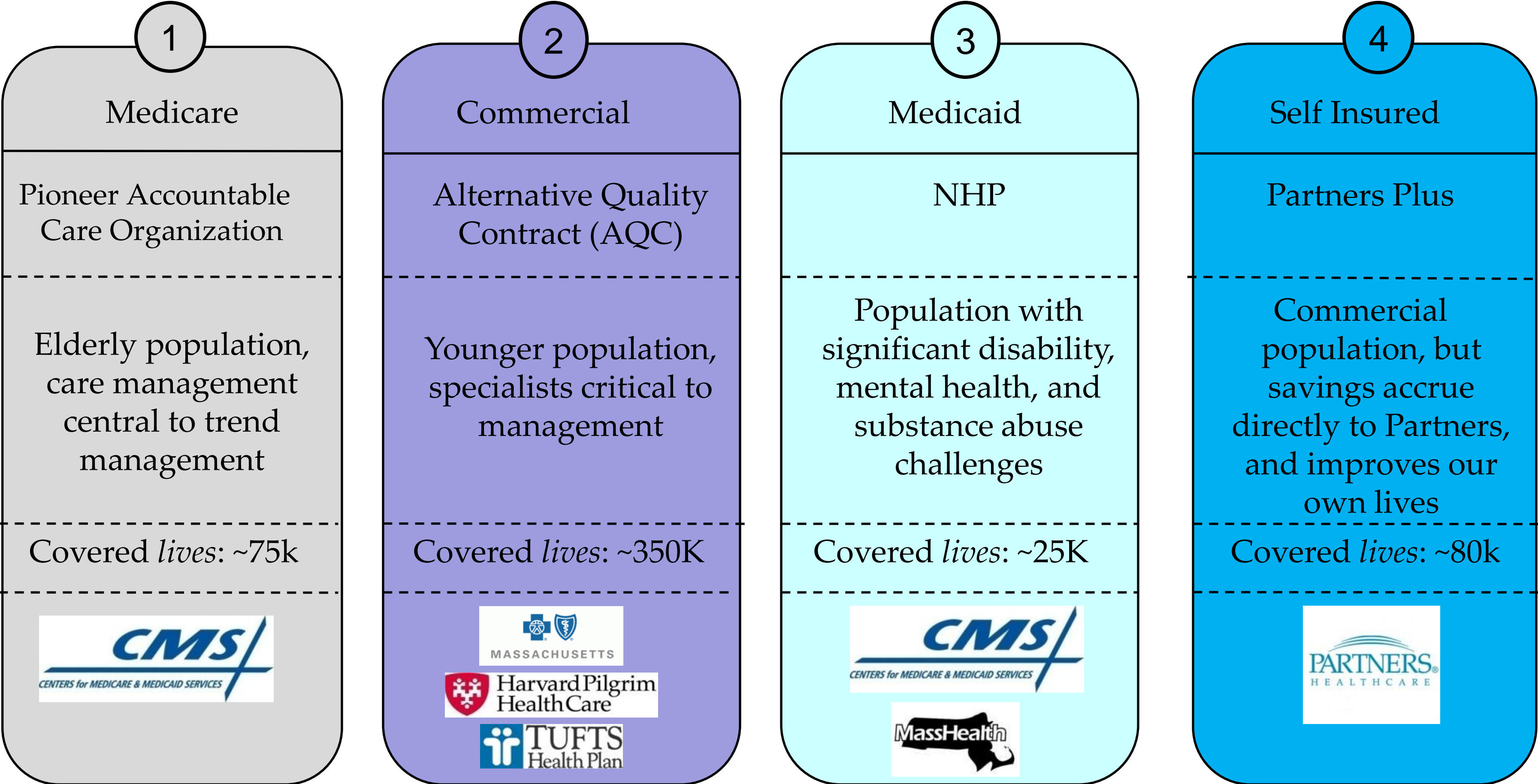
Outline

- **Partners HealthCare and Population Health Management**
- **Clinical Challenges in Post-Acute and Continuing Care:**
  - **Post-Acute Care** (institutional or home-based care post-hospitalization)
  - **Continuing Care** (non-hospital acute care or non-office-based long-term/primary care)
- **Select PHS PACC Initiatives**

Partners HealthCare – Population Health Management



Partners currently manages roughly +500k lives in various accountable care relationships, in a network of over 600 PCPs.

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Vision and Aims for PACC Work

- **Improve patient health:**
  - Keep patients healthy and at home
  - Promote independence and function
- **Succeed in risk contracts:**
  - Avoidable admissions/ED utilization, readmissions, total episode costs
- **Succeed in other financial models:**
  - Bundled payments
  - VBP, readmission penalties
- **Lay groundwork for future efforts:**
  - Build seamless care continuum for ALL patients
    - eCare, transition programs, longitudinal care planning
  - Evaluate opportunities in new risk spaces:
    - Medicaid, Duals/LTC
  - Evaluate other related opportunities:
    - Home-Based Primary Care

General Model - Creating Value in PACC

Data Liberation and Collaboration

- Support the identification/creation of quality measures; measure success; share best practices; support continuous quality improvement

Build Clinical Capacity

- Identify gaps; improve existing providers (e.g. QI, continuity/transitions/intensity of services); create new service lines

Support Efficient Utilization of Services

- Financial incentives; clinical decision support tools; virtual networks/teams

Improve Proximal Quality and Value Goals

- Hospital/Episode Measures (e.g. Readmit, MSPB, bundles);
- Population Measures (e.g. avoided hospitalizations, EoL spending).

Improve Population Health and Total Cost of Care

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Clinical Challenges in Post-Acute and Continuing Care

- **The "basics" required to provide effective PACC:**
  - Know the patient, family and his/her care needs
    - Vulnerable and underserved population
  - Know the capabilities of post-acute clinical partners
  - Match needs and services (chicken and egg)
  - Execute safe transition
  - Support on-going care management across continuum
- **Select inter-related clinical challenges:**
  - Silo'd practitioners (death of the old PCP model)
  - Equating "higher-level" with better care (risk aversion mixed with lack of understanding)
  - Limited evidence-base (e.g. assessment tools, protocols, etc.)
  - Insufficient clinical options:
    - Financial limitations (e.g. HHA 60 day episode)
    - Regulatory constraints (e.g. home-bound criteria)

PACC Programmatic Initiatives for 2014+

1. **Skilled Nursing Care:**
   1. SNF collaborative network
   2. 3 day waiver implementation
   3. "SNFist" preferred provider network

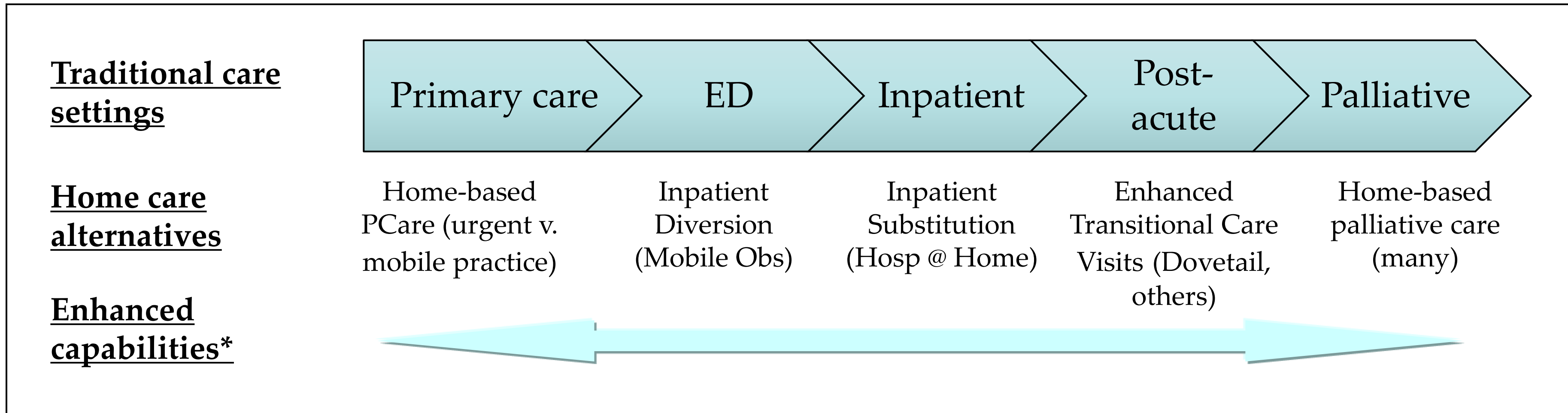
2. **Home Care Programs:**
   1. Build sustainable team and foundation for innovative program implementation
   2. Deliver on:
      1. CHF Telemonitoring
      2. Mobile Observation Unit
      3. Dovetail – Transitional Pharmacists
      4. Palliative Care
   3. Evaluate and support other programs:
      1. Home-based ____ (e.g. paramedics, community health workers, MDs)

3. **Next Gen Analytics, Evaluation and Payment:**
   1. Expand beyond SNF measures and double-down on PAC dashboard/analytics
   2. Deploy decision-support and "leveling" tools
   3. Evolve Post-Acute Internal/External P4P and risk sharing (early stage)

Skilled Nursing Facility Programs

- **Skilled Nursing Collaborative:**
  - Sustain momentum and evolve processes
  - Generate actionable data and benchmarks (e.g. improve risk adjustment)
  - Support local QI
- **3 day waiver implementation**
  - Support central processes
  - Support local implementation
- **SNFist capacity development:**
  - “Preferred provider” development
  - Internal capacity development
- **Other Innovation Work (pilot scale at various stages of development):**
  - Bundle and clinical program development (e.g. CHF, ortho protocols)
  - Telemedicine pilots:
    - SNFist Coverage
    - Specialty Consultations
    - Continuity Visits

Home-based intervention strategies



Home care interventions have the potential to substitute for (or enhance) traditional care settings everywhere along the care spectrum.

They can flexibly match patient needs to services, at a lower cost, but are often unreimbursed.

Can cover rehabilitative (i.e. episodic) v. advanced illness management (i.e. longitudinal).

*Enhanced capabilities can be used across the spectrum, including telemonitoring, patient self-management, etc.

Predictive Modeling Tools and Analytics

Is the patient high risk?

Does the patient have complex discharge planning needs?

HCC Risk Score, Prior acute/ ED hospitalizations, Diagnosis, Severity, Comorbidities, (claims-based) + CM screening for Social risk factors, Functional Status, MH/Behavioral Health (e.g., iCMP program paradigm, run asynchronously from admission)

Is the patient at high risk for readmission?

Diagnosis, Severity, clinical values, comorbidities

Where should the patient be discharged? (LOC)

Function (ADL &IADLs) at Admission, interim and discharge
- Relevant comorbidity/Medical Complexity (e.g., vent, wounds, IV, obesity, feeding tubes)
- Primary diagnosis
- Tx utilization

How much care does the patient need? (Days, Therapies)

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