Achieving Care Model
Transparency and Integration

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ISNP: Key Elements for Successful Clinical Integration
“Overwhelming to think of implementing a new care model”

“How is this really different than what we are already supposed to be doing?”
Step 1: Engagement

Golden Circle - Simon Sinek

Arbinger Institute

WHAT

HOW

WHY

RESULTS

BEHAVIORS

MINDSET
Start With Data
Step 2: Assessment

Review of all hospitalizations and ED visits identified:
- causes for avoidable hospitalizations/ED
- Physician/PA/NP issues
- staff issues
- lack of resources

Review of referrals
- Overutilization of specialist

Review of services utilized within facility
- Psych
- Hospice
Opportunities

- Competence
- Confidence
Step 3: Education

- SNF Operations Education
- Physician/NP/PA Education
- Direct care staff Education
Physician NP/PA Education

- WELL-BEING MODEL®
- ACP AND PALLIATIVE CARE
- CLINICAL BEST PRACTICE PATHWAYS
- OWNING THE CARE
- COMMUNICATION WITH CLINICAL STAFF
- HCC CODES
- HEDIS AND STAR MEASURES
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<td>ACP and palliative care</td>
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<td>Clinical pathways</td>
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<td>Communication with providers</td>
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<td>INTERACT®</td>
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ISNP: Strategies for Overcoming Challenges
Challenges and Strategies

Physicians/NP/PA
- Not geriatric trained
- Lack of palliative care training
- Lack of knowledge on behavioral health issues r/t dementia
- Need for “owning the care” of their residents

Staff competence and confidence
- Providers also lack confidence in staff

Resources:
- Access
- Timeliness
- EHR integration

Poor communication and collaboration:
- PCP and staff
- PCP and other medical staff
- PCP and SNF operators
ISNP: Techniques for Care Model Communication and Transparency
Communication and Transparency

- Communicate Expectations
- Communicate Outcomes
- Transparency - Everyone is Accountable
WE CANN Attitude!

- Well-being Model® Implementation
- Education
- Communication and collaboration strategies
- Advance care planning strategies
- Notifying the PCP of clinical changes
- Need for improved resources
Genesis Overview

Key Facts

- Nearly 400 facilities across 26 states
- 200+ clinical specialty units
- 550+ Genesis physicians, NPs, and PAs
In 2016, at least 30% of U.S. health care payments are linked to quality and value through APMs.

In 2018, at least 50% of U.S. health care payments are so linked.

CMS Goals for Adoption of Alternative Payment Models (APMs)

**U.S. Adoption of APMs**

- **2016**: 30%
- **2018**: 50%

**Shifting Payment Practices**

- **Low Risk/Low Accountability to High Risk/High Accountability for Quality**

![Diagram showing adoption of APMs in the U.S. with 2016 at 30% and 2018 at 50%]
PA/LTC Industry Pressures are Demanding a Rapid Pivot from FFS to VBC

- **Center-wide issues**
  - Reductions in short-stay admissions and length of stay
  - Increased medical complexity
  - 5-Star rankings
  - Narrow referral networks
  - Value-based rate adjustments

- **Provider-specific concerns**
  - MACRA/MIPS opportunities and penalties

Value Based Payment Models at Genesis
- MSSP ACO
- External ACOs
- BPCI
- Raven
- Episode-Based Payment Models
- MACRA/MIPS
- SNF Value-Based Purchasing Program
- …

Transformation applies to both short-stay (skilled) and long-stay (unskilled) patients!
“What if we don’t change at all ... and something magical just happens?”
Genesis Physician Services
- GPS is the Genesis provider group practice specializing in sub-acute & long-term care
  - Over 550 employed and contracted medical directors, attending physicians, NPs, and PAs
  - Over 500,000 patient visits annually

LTC ACO
- 2016 Performance Year: Short stay and LTC
  - $56K per beneficiary
- Since 2017: LTC only
  - Short stay eliminated
  - $24K claims per beneficiary

CURRENT MSSP ATTRIBUTION RULES:
- Plurality of primary care charges
- Excludes primary care claims on same date of service as Part A facility claim
## 2020 MSSP Quality Measures

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<tr>
<th>Domain</th>
<th>ACO Quality Measure #</th>
<th>ACO Quality Measure Title</th>
<th>Method of Data Submission</th>
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<td>CAHPS: Getting Timely Care, Appointments, and Information</td>
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The Medicare Shared Savings Program (MSSP) Was Not Designed for LTC
“The square peg in the round hole”

**ACO Tailwinds**

- Secular trend
- Patients never “lost to follow up” or “non-adherent”
- Inter-professional team
- Care management infrastructure
- Single EHR
- A lot of “opportunity”

**ACO Headwinds**

- Quality Measures
  - Some are medical inappropriate for LTC patients
  - Others require a more nuanced, patient-centric approach
- CAHPS – Patient/Caregiver Experience Survey
  - LTC patients are excluded
- Voluntary Attribution
  - Impossible for SNFists

Advocacy Opportunities!
Improving the Quality and Efficiency of Care Delivery

Key Tactics

- On-Site NPs and PAs
- Narrowed physician panels
- Clinical Decision Support embedded in EHR at the point of care
- Rewarding value not volume
- Robust analytics and benchmarking of provider performance
- Heightened expectations of medical director leadership
- Aligned incentives across the care team and with center operators

Strategic Priorities

- Hospitalization avoidance
- Evidence based medicine
- Advanced care planning
2018 ACO Performance

- 6,425 attributed lives
- 3.8% reduction in Medicare A/B costs
- 87% quality factor

$2.3M shared savings payment from CMS to Genesis
Lessons Learned

- Shifting from fee-for-service to value-based models involves a profound change in thinking, culture, strategy, and actions.
- Changes need to be applied throughout a facility and not vary patient-by-patient due to payment model.
- MSSP success requires true partnership between physicians, APPs, nursing, and operations.