Trending Insights >> Collaborative Partnerships >> Market Investments

THE
Remington Report®

FOR BUSINESS GROWTH AND REVENUE OPPORTUNITIES

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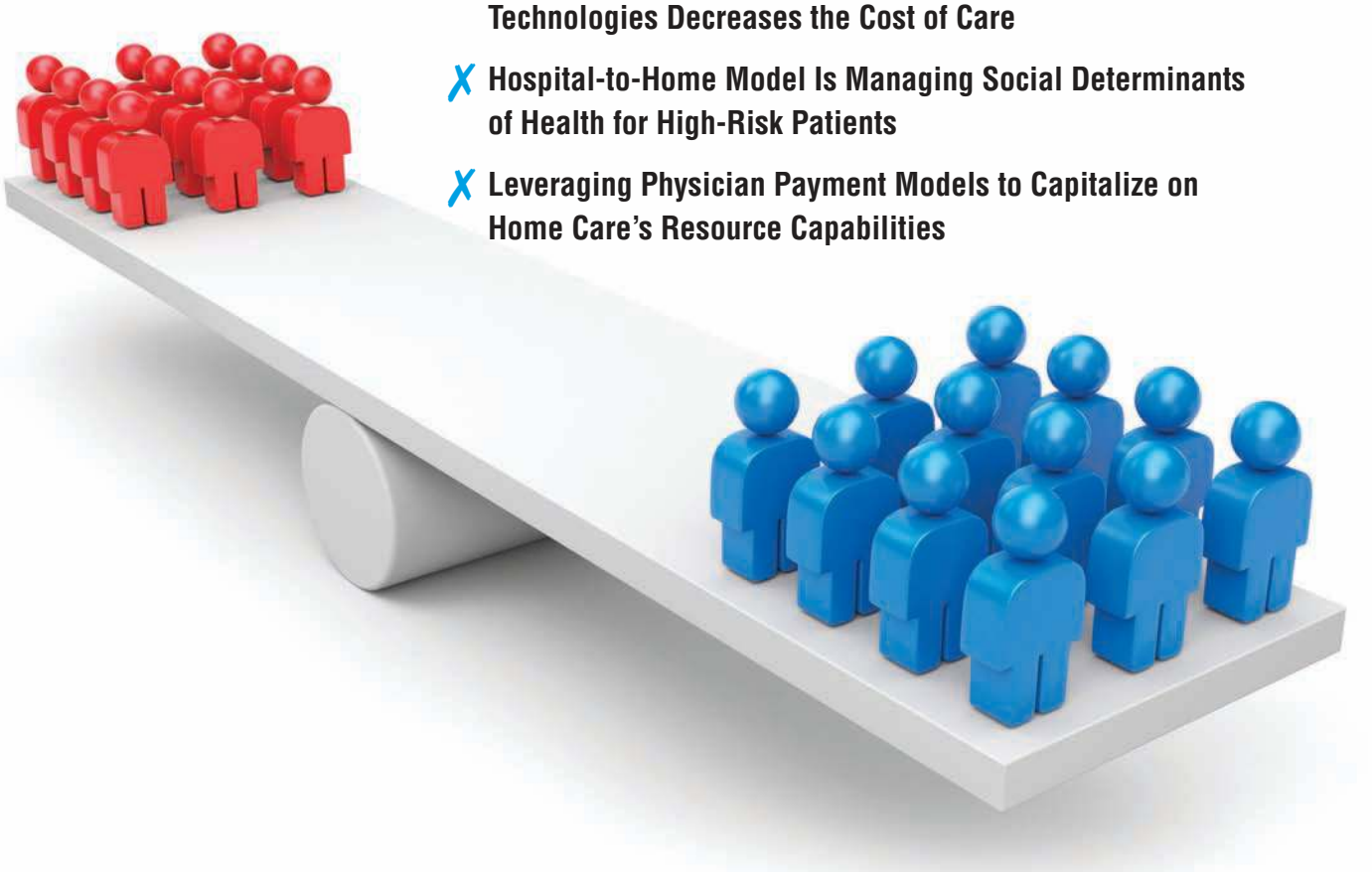
VOLUME 28 ▪ ISSUE 4

MarketScan

CAPITALIZING ON THE RISING VALUE OF THE HOME HEALTH CARE INDUSTRY

- How Real Time Actionable Data Leverages New Value for Home Health Aides and Stakeholders
- Greater Investments in Home Smart Healthcare Technologies Decreases the Cost of Care
- Hospital-to-Home Model Is Managing Social Determinants of Health for High-Risk Patients
- Leveraging Physician Payment Models to Capitalize on Home Care's Resource Capabilities



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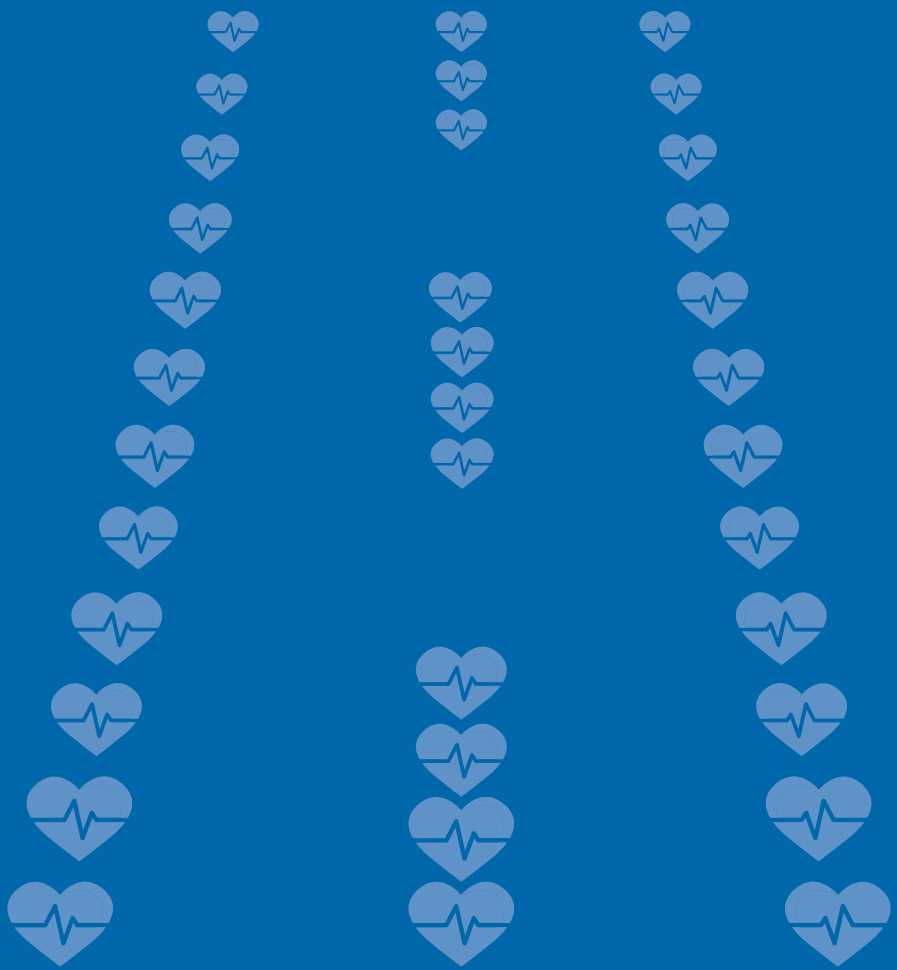

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TO THE POINT

By **LISA REMINGTON**

Capitalizing on the rising value of the home health care industry

Health systems and payers are organizing care delivery around the needs of the patients. Their most valuable asset is your organization.

What are evolving care models requiring to meet patients' needs?

1) The delivery of evidence-based clinical care and effective care management to support high-need patients.
2) Technology and analytic capabilities to identify high-risk, high-cost patients.
3) Team-based care management models to ensure at-risk patients are in the appropriate care setting to reduce readmissions.
4) New care delivery transformation to develop clinical alignment across the care continuum.

In this issue, we focus insights on what your organization can do to advance your value and prepare for the road ahead. How can your organization assess your current capabilities to determine different ways to meet patient needs, and align to evolving care models?

- How can your organization increase the value of your workforce?
- What technology investments decrease the cost of care?
- What clinical models best manage social determinants?
- How do new physician payment models leverage your organization's resource capabilities?

Push to make a difference. Keep focused on integration. Keep your eye on the ball … it's bouncing in your favor!

LISA REMINGTON is President of the Remington Health Strategy Group (RHSG) & Publisher of **The Remington Report**

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A **RHSG** Publication*

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Capitalizing on the rising value of the home health care industry

2019 Senior Health Report

HIGHLIGHTS

In the past three years, excessive drinking increased 12% from 6.6% to 7.4% of adults aged 65+

In the past six years, obesity increased 13% from 25.3% to 28.5% of adults aged 65+

In the past six years, smoking has not decreased and remains at 8.9% of adults aged 65+

In the past two years, food insecurity decreased 14% from 15.8% to 13.6% of adults aged 60+

In the past four years, SNAP reach increased 13% from 71.8 to 80.9 participants per 100 adults aged 60+ in poverty

In the past six years, home health care workers increased 44% from 93.8 to 135.5 aides per 1,000 adults aged 75+

In the past six years, hospital deaths decreased 31% from 30.1% to 20.8% of Medicare decedents aged 65+

In the past three years, hospice care use increased 6% from 51.4% to 54.4% of Medicare decedents aged 65+

In the past six years, high health status increased 8% from 38.4% to 41.3% of adults aged 65+

In the past six years, depression increased 23% from 13.0% to 16.0% of adults aged 65+

SOURCE: UnitedHealth Foundation

Gone are the days when aide services are merely support with activities of daily living.

It is critical, for the survival of home and long-term care, that aides now be viewed as the center of the interdisciplinary team and the source of critical, actionable information to care for the client and support organizations as they manage the changing healthcare system and payment environment.

HOME HEALTH AIDE WORKFORCE

How real time actionable data leverages new value for home health aides and stakeholders

By **CHRISTY JOHNSTON, MPH**

This is the first article in series of articles to discuss how to leverage and support a culturally competent home health aide workforce synchronized by real-time data.

Additionally, a six web-based Signature Education series provided by The Remington Report and Premier Home Health Care Services is offered to support company-wide training in the areas of:

- **Culture/Organizational Change,**
- **Workforce Value/Data Training,**
- **Payer Strategies,**
- **Alignment of Quality Measures**
- **Data Analytics, Technology Solutions and Workflows.**

See details on page 9.

One constant in the world of healthcare is change. The evolving nature of healthcare financing and delivery systems, along with changing demographics, demands that those involved in any aspect of the healthcare system innovate, transform, and identify the best ways to manage change and complexity.

All of this seems daunting and sometimes unmanageable, but without a doubt, home and community-based care providers are well-positioned to offer solutions. In fact, the solutions are right in front of us and they are simple approaches that capitalize on our strengths – home health aides, data collection opportunities, and our understanding of client needs and effective in-home interventions.

Premier Home Health Care Services, Inc. (Premier), a multi-state home care company with a comprehensive community-based service delivery platform, has capitalized on these strengths with the development of ***RTD—Real Time Data,*** which uses actionable data, secured by the home health aide, to bring the necessary value and quality outcomes to meet the evolving needs in the healthcare system.

THE CHANGING HEALTHCARE LANDSCAPE

Changes in healthcare are happening in all areas, but the long-term care sector, particularly home and community-based care, is under uniquely intense pressures as greater demands are placed on the system by demographic variations – the "graying" of the nation – while simultaneously there is the need to navigate the challenges of sweeping healthcare system changes.

Many are familiar with the Pew Foundation's reporting that 10,000 Americans will turn 65 every day through 2029. The US Census Bureau predicts that by the year 2035, the number of older adults (age 65 and over) will be larger than the number of children (under age 18). This will mark the first time in US

history when older adults will outnumber children.

Additionally, as the population ages, people are living longer with more chronic illnesses. Three out of four Medicare beneficiaries who also receive services through Medicaid (dual-beneficiaries) have three or more chronic conditions and one in five Medicare beneficiaries is readmitted to the hospital within a month of discharge. This creates both service delivery and fiscal challenges in the healthcare system.

These demographic changes and population characteristics have significant implications for the long-term care sector. Essentially, there will be fewer people available to care for an increasing number of seniors with more complex needs, which will further drive the need for providers and payers to identify innovative solutions to keep people healthier and in less costly home and community-based care settings for longer.

"With data, organizations can develop strategies to improve client outcomes; reduce potentially avoidable hospitalizations and readmissions; identify population trends; and increase the value of home and community-based care providers to myriad stakeholders."

– CHRISTY JOHNSTON, MPH IS VP OF GOVERNMENTAL & MANAGED CARE SERVICES FOR PREMIER HOME HEALTH CARE SERVICES, INC.

Meanwhile, as the population picture and demand for services continues to evolve, we also are experiencing sweeping changes in healthcare. In all sectors, service delivery has moved toward a focus on value versus volume and quality versus quantity, and as a result, financing models have followed suit. These changes are major shifts in thinking for anyone providing or paying for care and require access to actionable data and timely interventions to meet defined quality metrics of relevant stakeholders such as Accountable Care Organizations (ACOs), integrated healthcare systems, or managed care plans.

It is critically important for home and community-based care providers to shift their thinking and ask stakeholders about their needs and how home care can help them achieve their goals. Providers also must be prepared to remain flexible as stakeholder needs will vary by the incentives (quality bonuses for positive outcomes) and penalties (payment reductions for readmissions) to which stakeholders are being held. Whether the stakeholder is an ACO or an integrated healthcare system, a Medicare Advantage plan or a Medicaid Managed Care plan providing long term care services, an organization's success will be based on the quality of services they can provide and the value they can bring to the table.

THE HOME HEALTH AIDE'S CHANGING ROLE AND VALUE

Fortunately, home and community-based care providers are in a strong position to offer solutions to meet the needs of many stakeholders (payers, providers, clients) in the changing healthcare landscape and we need look no further than our own organizations for the most untapped and historically overlooked resource – the home health aide. As healthcare systems change, so must the role of the aide and our understanding of the full value that they bring to the equation.

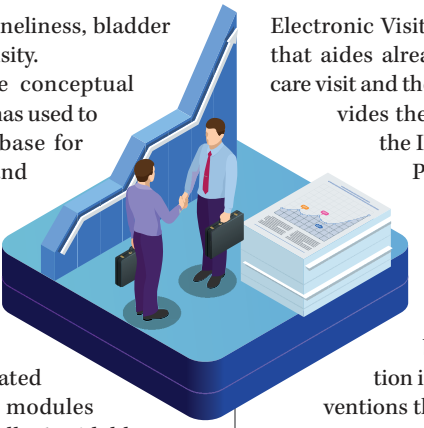
Home health aides are the eyes and ears in home care. Their presence in the home, their work to support members with activities of daily, and their often strong, emotional connection with clients and their families, contributes immensely to securing positive health outcomes.

In addition to the invaluable care and support that an aide provides in the home, they also must be viewed as a valued, contributing member to the Interdisciplinary Team that cares for a client and a key source of information. If aides are the eyes and ears in the home, we should rely on them to capture and transmit real time data about the client's status and turn their observations into actionable data.

In recent years, as Premier assumed more risk for client outcomes, the Company focused on making home health aides partners and began engaging and educating them to the fullest. In 2016, the Observe, Ask, Report (OAR) Training campaign was developed. The goal of OAR training is to prepare home health aides and the entire home care interdisciplinary team (IDT) – all management, administrative, coordinator, clinical staff and aides – for their roles in improving client health outcomes. The training is multi-pronged and focuses on educating aides on what signs and symptoms to "Observe, Ask, and Report" on when they are in the client's home. The OAR approach is then applied to specific quality measures that are important to payers, such as annual flu vaccine, falls,

shortness of breath, loneliness, bladder control, and pain intensity.

OAR I became the conceptual platform that Premier has used to expand a knowledge base for home health aides and other IDT staff and since the initial OAR module was developed, Premier has expanded the targeted OAR training approach and has created three additional OAR modules that address: Potentially Avoidable Hospitalization (PAH) diagnoses; Social Determinants of Health, and Behavioral Health & Chronic Disease Management. Future OAR modules will cover HEDIS measures and Medicare Advantage Star Measures. All of this training ties to the measures and concepts that are important to stakeholders.



HOW TIMELY DATA DRIVES INCREASES VALUE

Once aides understand the full role that they play in supporting the client and improving health outcomes, they understand the value of the information that they are able to collect and share with the IDT. But why is all this data important? It is simple – the organizations that have access to and can utilize timely data to improve outcomes, increase their value to stakeholders. With data, organizations can develop strategies to improve client outcomes; reduce potentially avoidable hospitalizations and readmissions; identify population trends; and increase the value of home and community-based care providers to myriad stakeholders.

Success in avoiding readmission penalties, capturing financial savings in a Value Based Payment (VBP) arrangement, or securing quality bonus dollars, is contingent on being able to hone in on issues in a timely manner and deploying health and supportive care resources to the client to prevent higher cost interventions.

In Premier's ***RTD—Real Time Data*** model, the home health aide helps ensure that client issues are identified so interventions happen. In order to support data collection, Premier developed an effective, yet simple approach that utilizes the telephonic Electronic Visit Verification (EVV) system that aides already use during each home care visit and then the transmitted data provides the information necessary for the IDT to support the client.

Premier's ***RTD—Real Time Data*** EDGE Dashboard and Quality Incentive Program Unit (P-QIP) take the data that aides send from clients' homes on a daily basis and turn the information into actionable, timely interventions that:

- Prevent members from being readmitted to hospitals;
- Slow disease progression by changing behavior or securing additional supports;
- Identify social determinants of health that may be impacting health outcomes;
- Manage medication adherence;
- Manage immunizations, screenings, PCP visits; and
- Target other interventions that can improve client health outcomes and success in meeting person-centered care plan goals.

THE NEW ROLE OF HOME CARE AIDE'S RESPOND TO HEALTHCARE'S TRANSFORMATION

Gone are the days when aide services are merely support with activities of daily living. It is critical, for the survival of home and long-term care, that aides now be viewed as the center of the IDT and the source of critical, actionable information to care for the client and support organizations as they manage the changing healthcare system and payment environment.

Observations and reports made by home health aides generate valuable, timely data from the home about the client. Collecting and acting effectively on the information, is critical to impacting client outcomes and supporting the goals of providers and payers with which you are working.

Providers that collect, analyze, and take action on data, can impact outcomes and improve quality measures, increase medica-

Whether the stakeholder is an ACO or an integrated healthcare system, a Medicare Advantage plan or a Medicaid Managed Care plan providing long term care services, an organization's success will be based on the quality of services they can provide and the value they can bring to the table.

Older Adults Stats

10,000 Americans will turn 65 every day through 2029.

The US Census Bureau predicts that by the year 2035, the number of older adults (age 65 and over) will be larger than the number of children (under age 18).

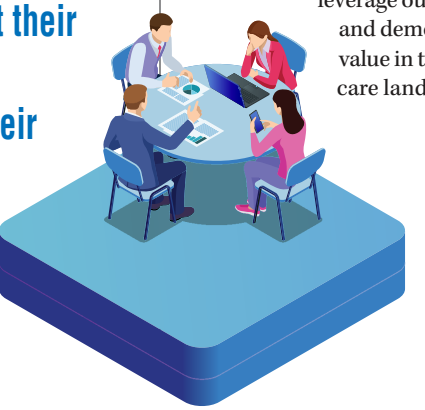
tion adherence, and reduce Potentially Avoidable Hospitalizations (PAHs)/readmissions, which benefits:

- Health plans and other payers by improving quality measures, star ratings, risk adjustment scores, and quality bonuses;
- Hospitals by reducing readmissions and lowering readmission penalties;
- Home care providers by improving quality measures, shared savings and quality bonuses; and most importantly;
- Members by providing better health outcomes, managing chronic diseases, and supporting them to help them remain at home.

"It is critically important for home and community-based care providers to shift their thinking and ask stakeholders about their needs and how home care can help them achieve their goals."

Premier's ***RTD—Real Time Data*** is exciting and transformative. The approach to leveraging the value of home health aides is already demonstrating significant positive outcomes and is transforming how healthcare system stakeholders view the value that home and community-based care providers bring to the evolving healthcare landscape. In the end, whether your organizations is prepared to develop your own tools and approaches to engaging your workers or if you choose to work collaboratively with other organizations to achieve your change, it is clearly time for home and community-based care providers to look at our most valuable assets and leverage them to their fullest.

As community-based care providers, we know the value that home care brings to the healthcare system. Home care is less costly and people prefer to be in control of their care, in settings in which they are comfortable – their homes. It is time to leverage our assets, utilize data, and demonstrate home care's value in this changing healthcare landscape.



About Premier Home Health Care Services

Established in 1992, Premier maintains its Corporate Headquarters in New York State and operates in seven states – New York, New Jersey, Connecticut, Massachusetts, Illinois, North Carolina, and Florida. Led by a management team with decades of experience in community-based home care, managed care, and care management services, Premier provides personal care and care management services to approximately 34,000 long-term care members on a monthly basis through both traditional and Value Based Payment (VBP) risk contracts with health plans and other payers.

Next Generation Home Health Aide Model

SIX WEB-BASED TRAINING AND LEADERSHIP PROGRAMS

Invest in the career development of your workforce.

"Rethink" service delivery in a community-based setting.

Create value-driven solutions with health plans.

Maximize the value of the aide in the home in the VBP era.

Interdisciplinary model ... synchronized by real-time data ... valued by Health Plans

The Remington Health Strategy Group and Premier Home Health Care Services, Inc. collaborate on a web-based Signature Series to address the ways your organization can interlink a culturally competent home health aide workforce to the goals of health plans to drive population health outcomes in a value based purchasing environment.

Each of the six sessions offers targeted VBP insight and solutions to:

- Culture and Organizational Change to Respond Effectively to Healthcare Transformation
- The Home Health Aide's New Strategic Role as a Member of the Interdisciplinary Team
- Comprehensive Training Platform: The OAR Team Model (Observe, Ask, Report Training)
- The Real-Time Data Solution, Dashboards, Outcome Intervention Management and Data Management & Population Health Data Aggregation
- Process Workflows, Tracking and Quality Scores
- Payer Strategies: Alignment of Quality / Potentially Avoidable Hospitalization Measures and Data Analytics

Web-Based Series Dates!

- September 10, 2019
- October 24, 2019
- November 20, 2019
- December 10, 2019
- January 14, 2020
- February 11, 2020

About Our Organizations

Two knowledge-packed organizations come together to provide the next generation model for home health aides. Premier Home Health Care Services, Inc. (Premier), a multi-state home care company with a comprehensive, community-based service delivery platform, delivers home care and care management services to over 34,000 health plan members monthly and trains over 10,000 aides annually. The Remington Health Strategy Group has educated over 6,000 healthcare organizations for over 25 years.

For additional information:
https://remingtonreport.com/next-generation-home-health-aide-model-webinar-series.html

Remington
Empowering Organizations to Meet the Future

Enroll Today!

Access to the six web-based Signature Series is subscription-based only. Each session builds on the previous lessons.
Enrollment ends: September 3, 2019. Each web-based program is from 3:00 pm – 4:00 pm (Eastern)

Investments in Home Smart Healthcare technologies decrease the cost of care

By **LISA REMINGTON**

Investors are pouring billions of dollars to enhance care in the home. The global smart home healthcare market is forecasted to attain a revenue of $30.0 billion by 2023. The market is mainly driven by the growing geriatric population escalating the demand for personalized healthcare which in turn is increasing the demand for mHealth technologies and advancements in smart home healthcare technologies.

$14.6B of venture funding pumped through digital health in 2018, making it the most-funded year since tracking the market according to a report by Startup Health.

FOUR KEY DRIVERS

- **Growing demand for advanced smart home healthcare technologies**
- **Rising geriatric population**
- **Increasing demand for mHealth technologies**
- **Increasing demand for personalized healthcare**

According to World Health Organization(WHO), falls are the second leading cause of accidental or unintentional injury deaths worldwide and people above 65 years of age suffer the greatest number of fatal falls. For example, in the U.S., 20–30% of older people who fall suffer moderate to severe injuries such as bruises, hip fractures, or head trauma. In order to reduce this, people tend to opt for fall prevention and detection devices, globally.

Companies like CarePredict and Emerald are examples of companies creating the next generation of care in the home. CarePredict uses a wearable and smart sensor system placed throughout the home to learn behaviors and trigger interventions by caregivers or families. MIT's startup Emerald created a radio mesh network that interacts with the water composition in a person's body and measures their breathing, heart rate and movements on an entire floor of a home. It can also tell if a person is sitting, standing, crawling or falling, making it useful in fall detection and prevention.

HEALTHCARE MARKET REACTION

Technology enabled solutions have payers and providers investing in home healthcare. The value: keeping patients away from costlier settings.

Take for example Pennsylvania-based Geisinger Health System. To help keep patients in their homes and their providers in touch after hip or knee surgery, an app called Force Therapeutics allows patients to access detailed care plans, videos demonstrating post-operative exercises, and check in with the health system's nurse navigators.

Geisinger's orthopedic team has used the app for over three years and will continue rolling it out to all of its hospitals.

Results are impressive:

1. Skilled Nursing Facility (SNFs) utilization dropped 20%.
2. Inpatient utilization in inpatient rehabilitation facilities (IRF) is down 55%.
3. Readmission rates dropped from 5.5% to 4.5%.

"Patients from costly institutional care to be monitored in the home shortens length of stay and keeps patients in touch via virtual supervision in the home."

– LISA REMINGTON, PRESIDENT, REMINGTON HEALTH STRATEGY GROUP
PUBLISHER, THE REMINGTON REPORT

Recent changes in reimbursement, policy, and bundled payment initiatives combined with remote monitoring technologies now allow more patients to be discharge to home for rehabilitation after hips and knee surgery.

Post-acute accounts for nearly 40% of the spend within an episode of care. Shifting patients from costly institutional care to be monitored in the home shortens length of stay and keeps patients in touch via virtual supervision in the home.

RETAIL STORES ARE CREATING SEAMLESS CARE IN THE HOME

Retail stores are jumping on the band wagon to provide more care in the home. Companies such as Best Buy and Amazon are changing-up traditional models.

Ochsner Health System, based in New Orleans is participating with retailer BestBuy with a digital kit called TytoHome. Consumers with a handheld device conduct remote exams in their homes and transmit the data through a smartphone. In turn, Best Buy connects the consumer to a physician's telehealth provider for live video encounters. Seamless integration flows through to medical health records and other platforms. Last year, Best Buy acquired the company GreatCall, a mobile device that connects health and emergency response services to older people and their caregivers.

Amazon is building out their own healthcare solutions with Alexa. Following a trial in patients rooms at Cedar-Sinai, the company invited select developers to create and launch HIPPA-compliant healthcare skills for Alexa. This means that voice app developers who follow HIPAA guidelines can now create skills for Alexa.

With new healthcare skill sets offered by Amazon, payers like Cigna can expand their offering to eligible employees. Cigna Health Today™ offers daily tips to help them keep track of their incentive program status, listen to daily health and wellness tips and tips on how to navigate their health plan.

Boston Children's Hospital is part of the Enhanced Recovery After Surgery (ERAS) program, which is designed to help parents and caregivers of children who have recently undergone heart surgery. Amazon's voice technology will support parents and caregivers post-discharge, allowing them to provide quick updates to their care team around recovery progress (including pain and activity

Cost of Care}

Below are some national average costs for long-term care in the United States (in 2016)

- **$225 a day or $6,844 per month for a semi-private room in a nursing home.**
- **$253 a day or $7,698 per month for a private room in a nursing home.**
- **$119 a day or $3,628 per month for care in an assisted living facility (for a one-bedroom unit).**
- **$20.50 an hour for a health aide.**
- **$20 an hour for homemaker services.**
- **$68 per day for services in an adult day health care center.**

SOURCE: HHS 2017

"Remote monitoring, wearables, and virtual health visit capabilities are changing the future to allow for greater care in the home."

level). Alexa can provide parents and caregivers information regarding their scheduled post-op appointments.

Alexa is now in the behavioral health space. Beginning this summer, a new group of apps including Talkspace and The Difference will help people struggling with anxiety and depression.

The "digital behavioral health" market is moving into a new era allowing the use of smartphones, the web, and Amazon Alexa for mental health consults.

PROVIDERS' "GO-TO" MARKET SIGNAL

Remote monitoring, wearables, and virtual health visit capabilities are changing the future to allow for greater care in the home. As more technology enabled integration occurs, people will be able to seamlessly use a variety of devices to capture their health data, nutrition, activities and other information for personal use and shared data.

For stakeholders, technology enabled solutions are advancing with the support of payment reform and policy expansion. The goal: to reduce the cost of care and provide seamless clinical management. This will completely restructure the way that providers think about aging in place and the care that can be delivered in the home.

Case Study: Home-based Services Infused with Technology

INTERMOUNTAIN HEALTHCARE, located in Salt Lake City, UT is expanding its home-based services this year to include primary care, some traditional hospital-level services, and palliative care for patients with chronic or serious medical conditions.

The new service, called Intermountain at Home, is a comprehensive program that will expand established Intermountain Homecare & Hospice services to prevent or shorten hospital admissions, and enable patients to receive care where they prefer to receive it – in their homes.

"Intermountain at Home is a thoughtful, proactive, and preventive healthcare approach that extends complex medical treatment and technologies beyond clinics and hospitals to help us care for patients in their own homes," said Seth Glickman, MD, Intermountain chief medical officer of community-based care.

Technology Infused Solutions

Intermountain at Home will help patients transition directly to new home-based, hospital-level services that will include:

- remote monitoring
- expanded telemedicine capabilities
- virtual urgent care visits through Intermountain Connect Care, a 24/7 online service that allows patients to receive personalized care from Intermountain caregivers via their smartphones, tablets, and computers
- appointment-based video visits
- home caregiver and family support tools
- dialysis and intravenous medication
- physical therapy

The new model will include daily living support through Homespire, an Intermountain company that helps seniors and other people live healthy and independent lives at home.

This support will focus on the social determinants of health, or factors in the places where people live, learn, work, and play that can impact their well-being and quality of life, including finances, education, physical environment, social support, coping skills, healthy behaviors, and access to health services.

"Providing these types of services in the home versus a traditional hospital setting has been proven to be effective in reducing complications, rehospitalizations, and trips to emergency departments while cutting the overall cost of care by 30 percent or more," said Rebekah Couper-Noles, RN, Intermountain Healthcare's chief nursing officer of community-based care.

Where do the highest risk of readmissions come from?

By **LISA REMINGTON**

"The rate of readmissions increases in the first two days after a SNF discharge. If SNFs lower their readmission rates, providers can earn the two percent. CMS reports almost three-quarters of the providers in the country will receive a cut under VBP."

– LISA REMINGTON, PRESIDENT, REMINGTON HEALTH STRATEGY GROUP, PUBLISHER, THE REMINGTON REPORT

Approximately one in five Medicare beneficiaries are discharged from hospital's to skilled nursing facilities (SNFs). Patients discharged from a skilled nursing facility to home face the highest risk of readmission in the first two days after SNF discharge.

Pressure is mounting for SNFs. 2020 marks the implementation of the new SNF Patient-Driven Payment Model (PDPM). The update to the Medicare payment rates and quality programs aligns payment rates for SNFs to the cost of providing care.

The SNF Value-based Purchasing Program adjusts Medicare reimbursements based on SNF's performance on the program's hospital readmissions measure. For FY 2019, the withholding percentage is 2%.

THE SNF VALUE-BASED PURCHASING PROGRAM

The key metric for the readmission program is SNF 30-Day All-Cause Readmission Measure (SNFRM). This measure was designed to identify outcomes of unplanned all-cause hospital readmissions within 30 days of discharge from their prior acute hospital discharge.

Under the SNFRM, hospital readmissions are identified through Medicare claims. Readmissions within the 30-day window are counted regardless of whether the beneficiary is readmitted. Rates will be risk-adjusted based on patient demographics, principal diagnosis during prior hospitalization, comorbidities, and other health status variables that affect the probability of readmission.

TOP 10 THINGS YOU SHOULD KNOW ABOUT THE SKILLED NURSING FACILITIES READMISSION MEASURE (SNFRM)

The SNFRM is the measure used to evaluate SNFs in the SNF VBP Program. The program ties portions of SNFs payments to their performance on this measure, which is calculated by assessing the risk-standardized rate of all-cause, unplanned hospital readmissions for Medicare fee-for-service SNF patients within 30 days of discharge from a prior proximal hospitalization.

Top Five Diagnoses on Claims of all Hospitalized Medicare Nursing Home Residents in FY 2011

CCS Primary Diagnosis Category and Percentage of Hospitalizations

Septicemia | 13.4%

Pneumonia | 7.0%

Congestive Heart Failure, Non-hypertensive | 5.8%

Urinary Tract Infections | 5.3%

Aspiration Pneumonitis, Food/Vomitus | 4.0%

1. The SNFRM tracks hospital readmissions, not readmissions to the SNF. Hospital readmissions are identified through Medicare claims, so no readmission data is collected from SNFs and there are no additional reporting requirements for the SNFRM.

2. The SNFRM includes all Medicare fee-for-service Skilled Nursing Facility patients, with the exception of certain measure exclusions.

3. The SNFRM tracks readmissions within 30-days after discharge from a prior hospitalization, not discharge from the SNF. The readmission window starts on the day of or up to 24 hours after discharge from a prior hospitalization.

4. A prior hospitalization for the SNFRM's calculation is defined as an admission to an inpatient prospective payment system (IPPS) hospital, critical access hospital (CAH), or psychiatric hospital.

5. As a reminder, the SNFRM does not assess the rate of readmission for SNF patients to a SNF following discharge. The measure instead assesses the rate of readmission of SNF patients to an IPPS hospital or CAH, either before or after discharge from the SNF, within 30 days of discharge from a prior hospitalization.

6. The SNFRM includes all unplanned readmissions. Unplanned admissions are identified using a modified version of the CMS Planned Readmissions Algorithm.

7. The SNFRM is adjusted to account for patient differences, such as comorbidities, when comparing facility readmission rates.

8. The SNFRM will form the basis for the SNF Performance Score for the SNF VBP Program. Facilities' scores under the program will be based on performance on the measure, and value-based incentive payments will be determined by comparing all SNFs' performance scores.

9. SNFRM performance information will be made available to each SNF through confidential quarterly feedback reports.

10. As required by the SNF VBP Program's statute, CMS has proposed to adopt the SNF 30- Day Potentially Preventable Readmission Measure (SNFPPR). CMS will propose to replace the SNFRM with the SNFPPR in future rulemaking.

SNF PENALTIES CONTINUE TO BE HIGH

The majority of skilled nursing facilities will receive a penalty on their Medicare payments for fiscal 2019 for poor 30-day readmission rates back to hospitals, according to CMS data. Of the 14,959 skilled nursing facilities subject to the CMS' Skilled Nursing Facility Value-based Purchasing Program, 73% received a penalty while 27% got a bonus. CMS data also shows that the SNFs on average got worse at managing readmissions the longer they were in the program.

Case Study – SNF Heart Failure Discharged to Home

A recent study published in *The Journal of Post-Acute and Long-Term Care Medicine* included 67,585 Heart Failure hospitalizations discharged to SNF and subsequently discharged home. The objective was to study outcomes for the 30 days after discharge from SNF to home among Medicare patients hospitalized with heart failure (HF) who had subsequent SNF stays of 30 days or less.

Overall, 16,333 (24.2%) SNF discharges to home were readmitted within 30 days of SNF discharge. The rate of readmissions increased on days 0 to 2 after SNF discharge. • **Highlights from the study of heart failure patients:**

24.2% of patients discharged from SNF to home were readmitted to a hospital within 30 days of SNF discharges.

Risk for readmission was **2 to 4** times higher immediately after SNF to home discharge compared to later time periods.

Early readmission risk dropped by half for patients with SNF stays of **1 to 2 weeks** compared to those with shorter stays.

Nursing Home Bonuses And Penalties, By State

Nationally, Medicare is cutting payments to 7 in 10 nursing homes to discourage rehospitalizations. Most other facilities are getting bonuses. This chart shows what portion of each state's skilled nursing facilities are receiving bonuses and penalties.

STATE	PERCENT BONUS	PERCENT PENALTY	NO CHANGE	GRAND TOTAL
AK	78%	11%	11%	9
AL	23%	76%	1%	245
AR	14%	85%	0%	230
AZ	34%	62%	4%	144
CA	28%	70%	2%	1,118
CO	37%	58%	6%	219
CT	25%	75%	0%	224
DC	41%	59%	0%	17
DE	33%	64%	3%	39
FL	22%	78%	0%	690
GA	23%	75%	2%	373
HI	54%	37%	10%	41
IA	23%	72%	4%	419
ID	50%	45%	5%	74
IL	18%	81%	1%	708
IN	32%	66%	2%	544
KS	23%	73%	5%	302
KY	22%	75%	3%	296
LA	14%	85%	1%	291
MA	19%	80%	2%	396
MD	45%	54%	1%	224
ME	31%	67%	2%	100
MI	25%	73%	1%	444
MN	21%	69%	10%	363
MO	17%	80%	3%	513
MS	14%	85%	1%	201
MT	30%	54%	16%	61
NC	32%	67%	1%	423
ND	33%	52%	15%	75
NE	27%	66%	7%	198
NH	26%	74%	0%	72
NJ	30%	69%	1%	357
NM	36%	61%	3%	70
NV	27%	71%	2%	51
NY	33%	66%	2%	621
OH	22%	76%	2%	960
OK	15%	81%	4%	310
OR	46%	54%	0%	125
PA	31%	68%	1%	699
PR	0%	100%	0%	6
RI	25%	72%	2%	83
SC	29%	70%	1%	194
SD	26%	67%	7%	99
TN	29%	69%	1%	314
TX	20%	79%	2%	1,229
UT	47%	50%	3%	94
VA	33%	67%	0%	283
VT	46%	49%	6%	35
WA	51%	48%	0%	204
WI	30%	67%	4%	371
WV	30%	70%	1%	115
WY	27%	67%	6%	33

SOURCE: Kaiser Health News analysis of U.S. CMS data

Hospital-to-Home model manages social determinants of health for high-risk patients

By **KERIN ZUGER**

Lexington Medical Foundation and Right at Home, based in South Carolina, built a strategic partnership based on a community-based, patient-centered program to provide social determinants of health support for high-risk patients once they transition home.

When healthcare providers focus on coordination of care, health outcomes are improved. Hospitals across the nation continue to seek out ways to reduce avoidable readmissions, and overutilization of ED's. Implementation of community-based and patient centered programs that provide social support for high-risk patients, during their transition homes has become a new emphasis in the post-acute industry. The healthcare industry is beginning to recognize that partnering with non-medical, community providers and improving communication during patient transfers, allows patients to receive an additional level of care following a hospitalization, enabling them to remain in the least costly, yet most desired setting, their home.

Hospital to Home Programs are most effective when there is a collaboration between a hospital, home health agencies, and non-medical home care company to provide additional support to patients when they transition home. Utilizing a Care Team approach led by a transitional care coordinator, the program provides eligible patients with appropriate non-medical assistance in their home. The interdisciplinary care team consisting of the hospital, home health agencies, and the in-home care company hold weekly face-to-face meetings to improve communication and coordinate patient care.

A non-medical care model provides the necessary services for patients to safely transition to their home environment. The focus on the psychosocial needs is critical to a safe, viable transition home. Services are customized based on the needs of the patient, but may include; meal preparation, assistance with activities of daily living (ADLs), chronic disease management education, medication reconciliation, and transportation to physician appointments.

TRANSITIONS PROGRAMS

Transitions programs have been around for years, dating back to 2010, when one of the very first transition programs was launched by Right at Home, in Winston-Salem, North Carolina. At that time, the goal of the program was simple. Ensure patients had the support they needed to stay safely in their home and reduce the risk of readmission.

The results of that early pilot illustrated the need and urgency to develop these type of programs, even before readmission penalties were enforced. The pilot saw a 65% reduction in readmissions and over a million dollars in hospital savings. Right at Home owners, Greg and Jackie Brewer were lucky enough to have funding through a Duke endowment, but unfortunately when grant funding ended, participation in the program also tapered off.

Since that time, a variety of transitions

models have entered the landscape. All different types of companies have found ways to support and augment transitions from acute care settings to home. From DME and software companies to Home Health Care and Non-Medical in Home Care. There are all sorts of methodologies and tools to get a patient home safely and keep them there. The ultimate goal of these programs has stayed consistent over the years; bending the cost curve through reduction of hospital readmissions.

There have been numerous case studies illustrating huge hospital savings and improved patient satisfaction, however reimbursement for these types of programs continues to be a struggle. Finding the right partners, and the right approach is critical to hospital buy in and funding.

This article will explore a success story in Columbia, South Carolina, where Right at Home VP of Operations, Mike Brown and his colleague, Kathrine Watts, Director of Case Management for Lexington Medical Foundation were able to work together to illustrate how transitions programs can benefit providers, payers and most importantly, the client.

I recently caught up with Mike about the success of their collaborative care transitions program, and there was one thing he wanted to make clear. "It's not easy. This takes work and the clients we help aren't always typical private pay clients, with long hours. But, it's worth it."

Brown and Watts sought out to develop a care transitions program that was patient-centered. Recognizing the impact social determinants have on hospitalizations and overall cost; they wanted to build in processes to address vulnerable patients with complex needs that would allow them to stay in their homes. They felt strongly that to improve care transitions and reduce hospital readmissions, there must be focus on the patient's physical comfort and emotional well-being.

"… Creating a transition program through partnership with non-medical, community providers improves communication during patient transfers and allows patients to receive an additional level of care enabling them to remain at home following a hospitalization."

– KERIN ZUGER IS SENIOR VICE PRESIDENT OF BUSINESS DEVELOPMENT & STRATEGIC PARTNERSHIPS FOR RIGHT AT HOME

ADDRESSING SOCIAL DETERMINANTS OF HEALTH

Social determinants of health are the conditions in which people are born, grow, live, work and age and include factors like physical environment, social support, and access to health care. Vulnerable patients with complex needs who have recently been discharged from the hospital may need additional community support and social services in addition to post-acute medical care to safely stay in their home. Transitions models that use a patient-centered approach can lead to improved health outcomes and reduced expense throughout the care continuum (NEJM Catalyst).

Targeted Population & Projected Outcomes

Prior to Implementation (2016):
33% readmission rate for targeted population

Goals:

- Providing in- home support for approximately 20 patient per month (up to 20 hours of non-medical home care within 30 days of hospital discharge) for those with chronic, complex, co-morbid conditions.
- Reducing unnecessary 30-day discharge readmissions by 40% or more for program-enrolled patient with diagnosis including but not limited to CHF, COPD, Pneumonia, AMI, CVA, Total Joint Replacement and CABG.
- Increasing the ability for patients to manage their health care needs by providing transportation, arranging meals, obtaining medications, scheduling MD appointments, and supporting daily living activities.

Projected Outcomes:

- ✓ Improve publicly reported quality data (readmissions rated on CMS Hospital Compare)
- ✓ Reduce unnecessary consumption of healthcare resources
- ✓ Reduce unnecessary cost to the health system

Non-Medical Social Determinants of Health

The "social determinants" of health (SDOH) are a subset of the non-medical determinants.

Non-medical factors account for 80 to 90 percent of a person's health, and the contribution of medical care remains 10 to 20 percent.

The leading causes of death in the United States – cancer, heart disease, and chronic respiratory disease – demonstrate the importance of the non-medical determinants to health, as all three chronic diseases are tied to unhealthy behaviors such as smoking and poor diet.

As we consider the role of non-medical in home care, there is a recognition of their caregiver's being the "eyes and ears" in the home, which puts them in a position to capture and collect valuable data and insights to support the work of Home Health providers and acute care facilities.

Leveraging Home Care provider's ability to report psycho-social needs early on, feeds into a new emphasis on implementing community-based, patient-centered programs that provide social support for high-risk patients once they transition home.

Creating a transition program through partnership with non-medical, community providers improves communication during patient transfers and allows patients to receive an additional level of care enabling them to remain at home following a hospitalization. The key is improving coordination of care in all healthcare settings, which leads to improved health outcomes.

During the early stages of the program people did not understand the benefit and therefore were not interested in enrolling. In response, the nurse navigators changed their script and started using language like, "the doctor feels you would benefit from the program" or include that it "is a part of the transition process." As a result of the script changes, patients were more responsive to the program and more enrolled.

Study of the Interventions, Measures and Analysis

Not unlike other transitions programs, the goal of this project is to reduce preventable 30-day readmissions for high-risk patients. However, they focused on a population diagnosed with the Medicare Hospital Readmission Reduction Program's selected conditions – heart attacks, heart failure, pneumonia, chronic obstructive pulmonary disease (COPD), hip/knee replacement, and coronary artery bypass graft surgery. Data from the hospital and the home health agencies (HHAs) are used in the analysis of this program, while hospital monitor the following measures:

- Total referrals to the program. Total number of enrolled participants.
- Enrolled patients with a previous 30-day readmission.
- Enrolled patients with a previous ED or in-patient stay prior to admission, 30, 60, and 90-day all cause readmissions for enrolled patients.
- In the early stages of the program, the hospital also tracked refusals. (Due to low enrollment, the hospital changed their approach when introducing the program to potential participants.)

INTERDISCIPLINARY APPROACH

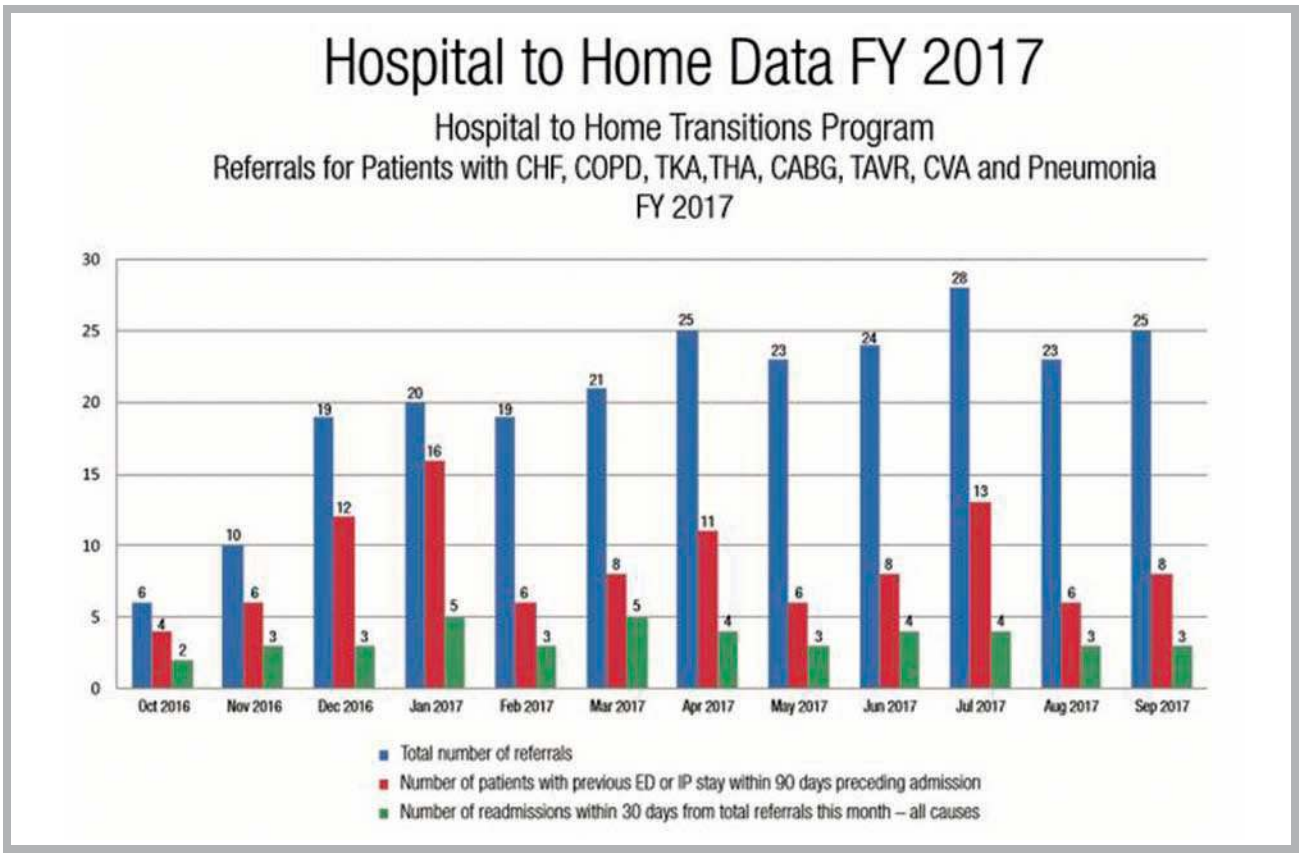
Mike and Katherine designed a team approach led by a transitional care coordinator, who assisted in determining which patient were eligible for non-medical assistance in their home. The interdisciplinary care team consists of the hospital, home health agencies, and the in-home care company. This care team held weekly face-to-face meetings to improve communication and coordinate patient care.

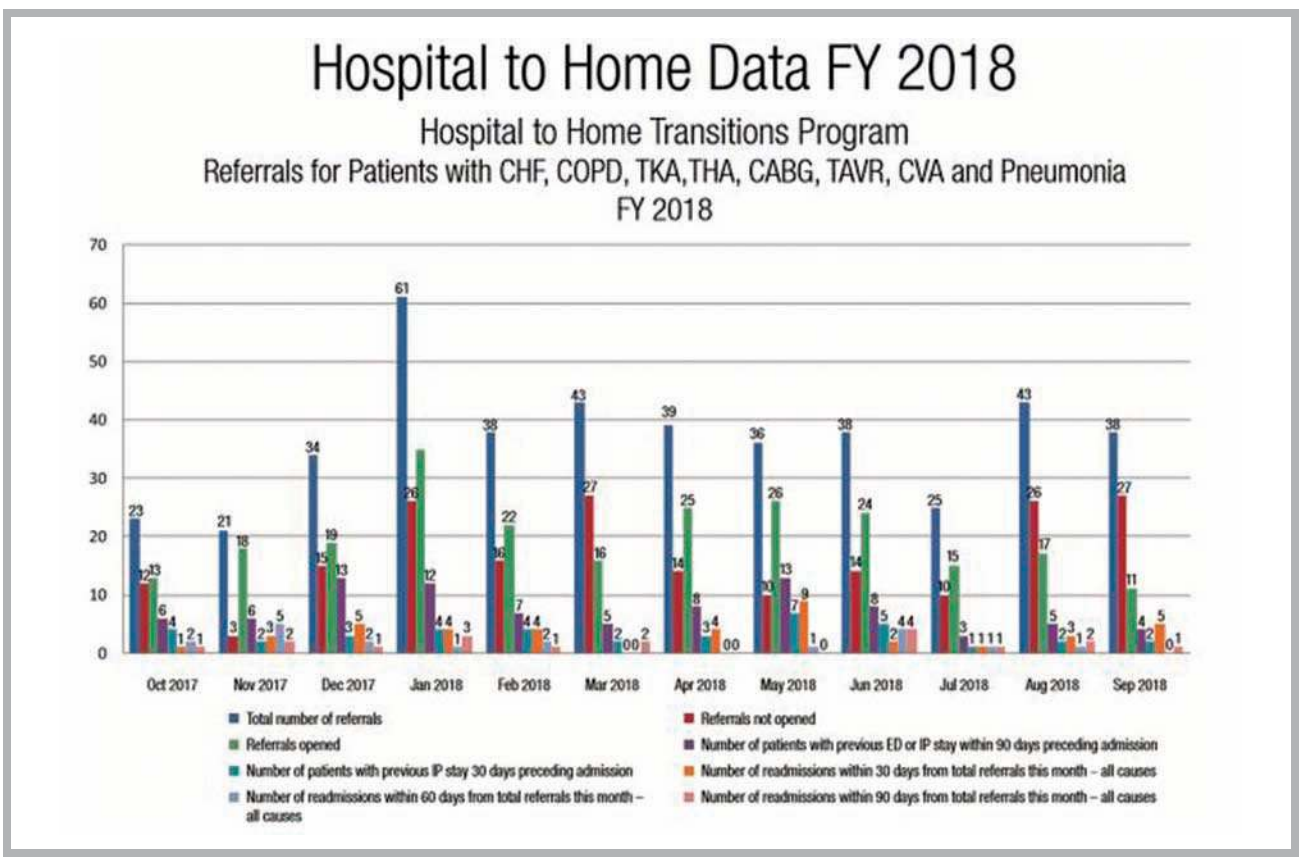
There was a focus on the psychosocial needs of the patients to ensure they have the proper supports in place to transition safely back to their home. Services provided typically include meal preparation, assistance with activities of daily living (ADLs), chronic disease management education, medication reconciliation, and transportation to physician appointments, but are tailored to meet the needs of the patient.

Measured Outcomes:

Progress – October of 2016 through March of 2019

- Providing Hospital To Home ("HTH") for approximately 20 patients per month. Since Oct 2016, we have provided HTH services to 484 patients which is an average of 20 patients per month.
- Reducing unnecessary 30-day post-discharge readmissions by 40% or more for program-enrolled patients. Our readmission rate for this program prior to Duke Endowment involvement was 24%. We are happy to report that as of September 2018 our readmission rate for the program is 17%, a total reduction of 30%.
- Increasing the ability for patients to manage their health care needs. We work


Hospital to Home Data FY 2017
Hospital to Home Transitions Program
Referrals for Patients with CHF, COPD, TKA,THA, CABG, TAVR, CVA and Pneumonia
FY 2017
30
25
20
15
10
5
0
6 4 2
10 6 3
19 12 3
20 16 5
19 6 3
21 8 5
25 11 4
23 6 3
24 8 4
28 13 4
23 6 3
25 8 3
Oct 2016
Nov 2016
Dec 2016
Jan 2017
Feb 2017
Mar 2017
Apr 2017
May 2017
Jun 2017
Jul 2017
Aug 2017
Sep 2017
Total number of referrals
Number of patients with previous ED or IP stay within 90 days preceding admission
Number of readmissions within 30 days from total referrals this month – all causes


Hospital to Home Data FY 2018
Hospital to Home Transitions Program
Referrals for Patients with CHF, COPD, TKA,THA, CABG, TAVR, CVA and Pneumonia
FY 2018
70
60
50
40
30
20
10
0
Oct 2017
Nov 2017
Dec 2017
Jan 2018
Feb 2018
Mar 2018
Apr 2018
May 2018
Jun 2018
Jul 2018
Aug 2018
Sep 2018
Total number of referrals
Referrals not opened
Referrals opened
Number of patients with previous ED or IP stay within 90 days preceding admission
Number of patients with previous IP stay 30 days preceding admission
Number of readmissions within 30 days from total referrals this month – all causes
Number of readmissions within 60 days from total referrals this month – all causes
Number of readmissions within 90 days from total referrals this month – all causes

About Right At Home

Right At Home based in Omaha Nebraska was founded by Allen Hager in 1995. The company began franchising in 2000, when Brian Petranick was hired as CEO and President. Franchisee's work with clients and their families to develop a custom care plan and match them with caregivers to provide in-home care services. Right at Home has 500 locations in the United States and over 100 locations in 6 other countries, serving tens of thousands of clients annually.

with Right at Home to address any barriers to transitioning home successfully. We have even addressed pest control issues, transportation barriers, language barriers, access to care concerns and many other psychosocial needs.

Initiatives:

- ✓ Hospital – wide team addressing CHF readmissions
- ✓ Focus on HTHH program with Total Joints to improve transitions of care
- ✓ COPD Navigator program
- ✓ CVA/Pneumonia program
- ✓ EPIC Readmission Risk tool

Addressing care transitions through a patient-centered approach focused on the specific non-medical needs of high risk, medically complex patients has demonstrated success through a decrease in avoidable readmissions for the target population. Patients receive an additional level of support to help them successfully transition to their home environment and stay there.

Brown and Watts believe the transitions care coordinator is critical to the success of the program. As this role manages the patient and the communication process among healthcare providers. The non-medical Right at Home team becomes the eyes and ears for the hospital to avoid readmissions, if at all possible.

Improving communication among the care team members through weekly meetings also contributes to the success of the program by providing a more coordinated approach and allowing the patients to have more points of contact to support their transition home.

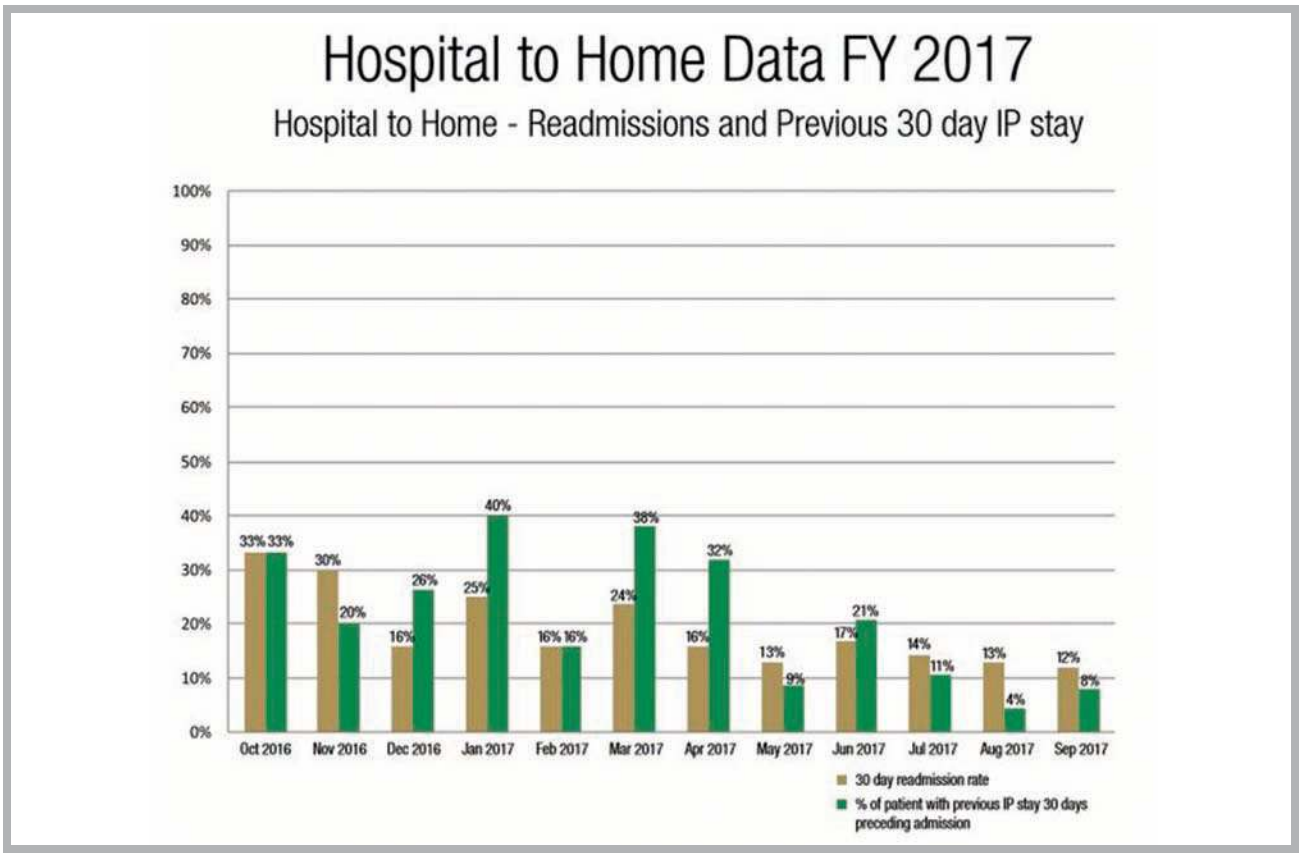
The Duke Foundation will continue funding this program for the next year, at which point, Lexington Medical Center will take over the program expense, recognizing the return is well worth their investment.

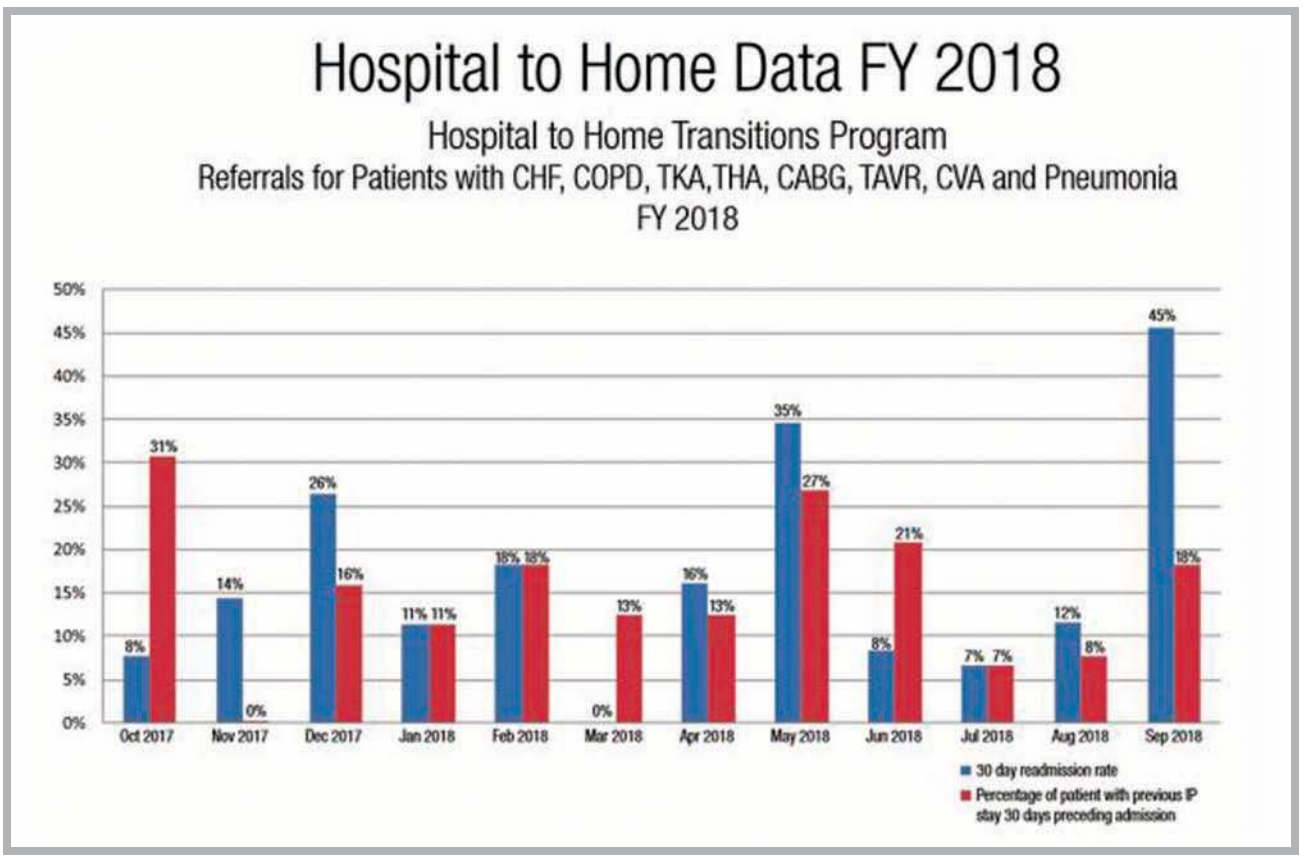
These types of programs are truly a breath of fresh air, as providers explore ways to broadly collaborate throughout the continuum. We all know the days of dropping-off donuts and business cards are over. It's time for payers and providers to sit around the table and figure out how to work together to achieve a common goal. A common goal that has been in place well before transition programs were even a thing. A common goal that should encourage us all to build strategic partnerships and leverage each other's skillsets. A common goal of keeping patients out of the acute care settings and avoiding unnecessary spend.

As the dynamics of the industry change, so will the partnerships within.

Internal Hospital Data for Readmissions (Medicare)

	FY 2017	FY2018	National Benchmarks (06/2016)
Overall	12.7%	13.9%	15.3%
CHF	18.6%	19.7%	21.6%
Total Joints	4.0%	4.4%	4.4%
Heart Attacks	14.5%	9.9%	16.3%
COPD	16.1%	11.8%	19.8%
Pneumonia	15.2%	11.0%	16.9%
CVA	11.6%	8.0%	12.2%
CABG	14.2%	9.4%	13.8%


Hospital to Home Data FY 2017
Hospital to Home - Readmissions and Previous 30 day IP stay
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
33% 33%
30%
20%
16%
26%
25%
40%
16% 16%
24%
38%
16%
32%
13%
9%
17%
21%
14%
11%
13%
4%
12%
8%
Oct 2016
Nov 2016
Dec 2016
Jan 2017
Feb 2017
Mar 2017
Apr 2017
May 2017
Jun 2017
Jul 2017
Aug 2017
Sep 2017
30 day readmission rate
% of patient with previous IP stay 30 days preceding admission


Hospital to Home Data FY 2018
Hospital to Home Transitions Program
Referrals for Patients with CHF, COPD, TKA,THA, CABG, TAVR, CVA and Pneumonia
FY 2018
50%
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
8%
31%
14%
0%
26%
16%
11% 11%
18% 18%
0%
13%
16%
13%
35%
27%
8%
21%
7% 7%
12%
8%
45%
18%
Oct 2017
Nov 2017
Dec 2017
Jan 2018
Feb 2018
Mar 2018
Apr 2018
May 2018
Jun 2018
Jul 2018
Aug 2018
Sep 2018
30 day readmission rate
Percentage of patient with previous IP stay 30 days preceding admission

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PEER-TO-PEER CASE STUDIES	READINESS & ACTION

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Remington

Empowering Organizations to Meet the Future

Ten Powerful Questions We Answer!

1

GROWTH & READINESS

How can your organization broaden market position? And, competitively meet the future of health care, and identify key investments for growth?

2

EFFECTIVELY RESPONDING TO CHANGE

What are your peers doing to prepare and manage the future?

3

TECHNOLOGY + VALUE

What technologies are your peers using to increase the flow of data, connect patient care across the continuum and adding value to a shared vision.

4

PATIENT CARE MANAGEMENT AND ENGAGEMENT PARTNERSHIPS

How can your organization better align clinical, financial and quality measures to build seamless models?

5

SCORECARDS, KEY PERFORMANCE INDICATORS AND METRICS

Your organization may be using scorecards, key performance and metrics already. We want to share a different perspective of how to align your operational, quality and financial goals to your strategic priorities. And, how to use information to drive success across the post-acute continuum.

6

LEADERSHIP & HIGH-PERFORMANCE POSITIONING

How is your organization preparing culture, financial, and clinical models for value-based care?

7

VALUE-BASED REIMBURSEMENT

How does the changing reimbursement landscape expand opportunities for PAC providers in the areas of care management, care coordination and chronic care management?

8

PERFORMANCE & PROFITABILITY

How are your peers improving performance and profitability? What's the secret sauce?

9

INNOVATION AND MARKET POSITIONING

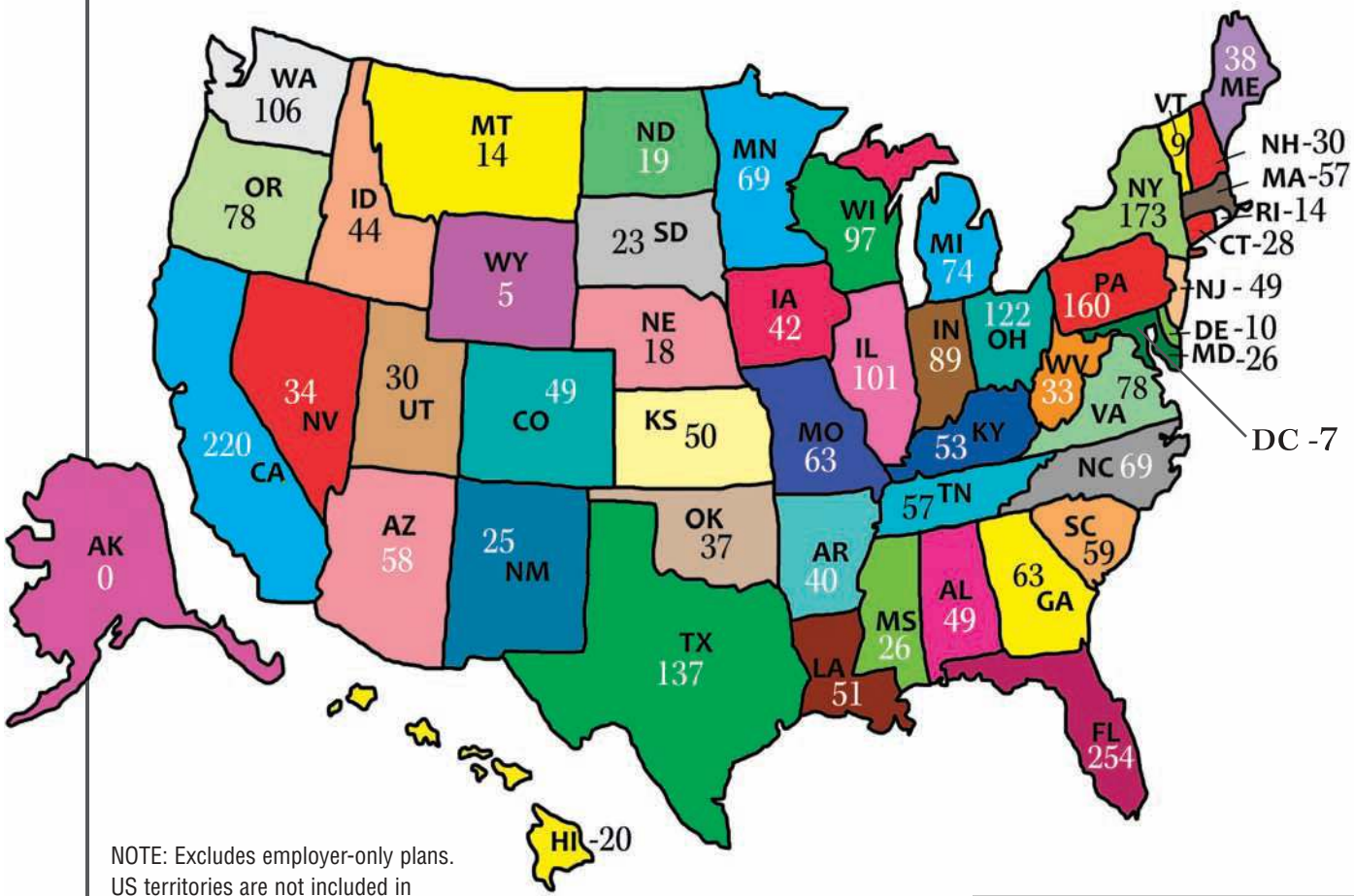
How are your peers advancing their organizations, innovating, and meeting the future of healthcare?

10

STRATEGY DEVELOPMENT

How can prioritizing strategy initiatives keep your organization on track? What's keeps growth and opportunity at the forefront?

Medicare Plans by State 2019



NOTE: Excludes employer-only plans. US territories are not included in metro, non-metro, or MSA measures.

SOURCE: Data are from CMS MA Landscape Source file, released October of each year.

United States – 2734

FACTS AND STATS

In 2019, access to MA plans remains high:

- ✓ 99 **percent of Medicare beneficiaries have access to an MA plan.**
- ✓ 97 **percent have an HMO or a local preferred provider organization (PPO) plan operating in their county of residence.**
- ✓ 90 **percent of Medicare beneficiaries have access to an MA plan that includes Part D drug coverage and charges no premium (beyond the Medicare Part B premium).**
- ✓ **The average beneficiary in 2019 has** 23 **available plans to choose from.**

PHYSICIANS

Leveraging physician payment models to capitalize on home care's resource capabilities

By **LISA REMINGTON**

For the home care industry, the announcement of new value-based physician payment models should have caused a gleeful outburst. Under these new models, Medicare will be rewarding practices for providing more convenient access to care, and start paying for chronic disease care management, acute care in-home services, and hospice and palliative care.

Not only do models provide greater flexibility for physicians to deliver high-quality care, the models are designed to encourage Medicaid Managed care plans, State Medicaid programs, commercial insurers, and Medicare Advantage Plans to take similar approaches.

CMS anticipates these payment model options could:

- Provide better alignment for over 25 percent of all Medicare FFS beneficiaries – nearly 11 million Medicare beneficiaries would potentially be included (a collective 5 million beneficiaries in the Direct Contracting payment model options and a collective 6.4 million in PCF payment model options);
- Offer new participation and payment options and opportunities for an estimated one in four (25 percent) primary care practitioners as well as other health care providers; and
- Create new coordinated care opportunities for a large portion of the 11-12 million beneficiaries dually eligible for Medicare and Medicaid, specifically those in Medicaid managed care and Medicare FFS.

HIGHLIGHTS:

Primary Care First models are oriented around comprehensive primary care functions:

1. **access and continuity;**
2. **care management;**
3. **comprehensiveness and coordination;**
4. **patient and caregiver engagement; and**
5. **planned care and population health.**

The Primary Care First (PCF) and Primary Care First SIP Models

Both PCF and SIP models are regionally-based, and a multi-payer approach to care delivery and payment. The models tests whether financial risk and performance based payments that reward primary care practitioners and other clinicians for actionable outcomes will reduce total Medicare expenditures, preserve or enhance quality of care, and improve patient health outcomes.

Primary Care First (PCF) offers new higher payments for practices managing complex, chronically ill beneficiaries. Models are designed for small practices and provide a monthly, flat revenue stream for each patient. Practices could be responsible for downside risk of up to 10% of practice revenue, but also be eligible for an "asymmetrical" 50% bonus if patients stay healthy and out of the hospital, states Adam Boehler, director of the Center for Medicare and Medicaid Innovation (CMMI).

"Through the PCF payment model options, high need patients with serious illness who do not have a primary care practitioner or care coordination and indicate an interest in receiving care from a practice participating in the model will be assigned to a model participant."

– LISA REMINGTON, PRESIDENT, REMINGTON HEALTH STRATEGY GROUP
PUBLISHER, THE REMINGTON REPORT

Primary Care First High Need Populations (called Seriously Ill Population (SIP) will focus on patients with complex and chronic needs and seriously ill populations.

Practices may limit their participation in Primary Care First to exclusively caring for SIP patients, but in order to do so, practices must demonstrate in their applications that they have a network of relationships with other care organizations in the community to ensure that beneficiaries can access the care best suited to their longer-term needs.

Through the SIP payment model option, high need patients with serious illness who do not have a primary care practitioner or care coordination and indicate an interest in receiving care from a practice participating in the model will be assigned to a model participant. Participating practices that choose to care for Seriously Ill Patients (SIP) patients will be required to provide care to clinically stabilize the patient. All payment model options include enhancements to encourage participation of providers who are focused on care for these populations.

Clinicians enrolled in Medicare who typically provide hospice or palliative care services (e.g., those affiliated with a hospice, palliative care or similar organization) will be able to provide care for SIP patients either by participating as a practice in the Primary Care First general payment model option or by partnering with a Primary Care First practice participating in the general payment model option that includes these clinicians on their roster of participating practitioners.

Primary Care First models are oriented around comprehensive primary care functions:

1) access and continuity;
2) care management;
3) comprehensiveness and coordination;
4) patient and caregiver engagement; and
5) planned care and population health.

TEN WAYS TO IDENTIFY FUTURE PARTNERSHIPS BETWEEN PHYSICIAN PRACTICES AND THE HOME CARE INDUSTRY

1/ Identify practices that can participate

Eligible practitioners are those in internal medicine, general medicine, geriatric medicine, family medicine, and/or hospice and palliative medicine.

They must:

- Be located in one of the selected 26 regions PCF regions;*
- Include primary care practitioners (MD, DO, CNS, NP, and PA), certified in internal medicine, general medicine, geriatric medicine, family medicine, and hospice and palliative medicine;
- Provide primary care to at least 125 attributed Medicare beneficiaries at a particular location;
- Have primary care services account for at least 70% of the practices' collective billing based on revenue. If the practice has multiple specialties, 70% of the practice's eligible primary care practitioners' combined revenue must come from primary care services;
- Have experience with value-based payment arrangements or payments based on cost, quality, and/or utilization performance;
- Use 2015 Edition Certified Electronic Health Record Technology (CEHRT);
- Attest on the application to advanced primary care delivery capabilities;
- Be able to meet the requirements of the Primary Care First Participation Agreement.

2/ Align financial and quality measures

The two models are designed to encourage improvement on quality metrics, and lower costs. CMS will assess quality of care based on a focused set of measures that are clinically meaningful for patients with complex, chronic needs and the serious illness population. Measures include a patient experience of care survey, controlling high blood pressure, diabetes hemoglobin A1c poor control, colorectal cancer screening, and advance care planning.

3/ Be prepared to go "at-risk

Participation lets practices receive a bonus of up to 50% of Medicare revenue with a downside risk of 10%, if patients stay healthy and out of the hospital. Models are designed for small practices and provide a monthly, flat revenue stream for each patient.

4/ Develop robust chronic care management programs

The crux of the two models focus on chronic care management and high-risk, high-need beneficiaries. Seamless integrated chronic care infrastructures are important and should be positioned as high-performing networks, or preferred providers.

5/ Enhance relationships with hospitalists

Through the PCF payment model options, high need patients with serious illness who do not have a primary care practitioner or care coordination and indicate an interest in receiving care from a practice participating in the model will be assigned to a model participant.

6/ Create community-based partnerships

Practices must demonstrate they have a network of relationships with other care organizations in the community to ensure that beneficiaries can access the care best suited to their longer-term needs.

7/ Close any gaps in care coordination programs

Practices will be responsible for care coordination ensuring that care is coordinated and that SIP patients are clinically stabilized.

***These regions are:**

Alaska (statewide)
Arkansas (statewide)
California (statewide)
Colorado (statewide)
Delaware (statewide)
Florida (statewide)
Greater Buffalo region (New York)
Greater Kansas City region – (Kansas and Missouri)
Greater Philadelphia region (Pennsylvania)
Hawaii (statewide)
Louisiana (statewide)
Maine (statewide)
Massachusetts (statewide)
Michigan (statewide)
Montana (statewide)
Nebraska (statewide)
New Hampshire (statewide)
New Jersey (statewide)
North Dakota (statewide)
North Hudson-Capital region – (New York)
Ohio and Northern Kentucky region (statewide in Ohio and partial state in Kentucky)
Oklahoma (statewide)
Oregon (statewide)
Rhode Island (statewide), Tennessee (statewide)
Virginia (statewide)

8/ Focus on readmissions and ED programs

Physician payment options test whether delivery of advanced primary care can reduce total cost of care and are accountable for patient outcomes. Practices will be incentivized to deliver patient-centered care that reduces acute hospital utilization.

9/ Invest in technology

Remote monitoring, wearables, and virtual health visit capabilities are changing the future to allow for greater care in the home, reduced costs, and seamless care management.

10/ Focus on patient engagement strategies

Patient engagement is a quality measures under these models.

Primary Care First

Primary care is central to a high-functioning health care system and thus, there is an urgent need to preserve and strengthen primary care as well as a need for support of complex, chronic, and serious illness care services for Medicare beneficiaries. PCF addresses these needs by creating a seamless continuum of care and as a result, accommodating a continuum of interested providers at multiple stages of readiness to assume accountability for patient outcomes.

+ Primary Care First Payment Model Option

The PCF payment model option tests whether delivery of advanced primary care can reduce total cost of care and focuses on advanced primary care practices ready to assume financial risk in exchange for reduced administrative burden and performance-based payments. The PCF model option also introduces new, higher payments for practices that care for complex, chronically ill patients.

+ Primary Care First High Need Population Payment Model Option

Through a second payment model option, PCF also encourages advanced primary care practices, including practices whose clinicians are enrolled in Medicare and typically provide hospice or palliative care services, to take responsibility for high need, seriously ill beneficiaries who currently lack a primary care practitioner and/or effective care coordination. These population groups are referred to under this payment model option as the Seriously Ill Population or SIP.

HOW ARE PRIMARY CARE FIRST MODELS SIGNIFICANTLY MOVING HEALTHCARE INTO VALUE-BASED CARE?

Remington's Key Takeaways:

- **The Primary Care First Model is based on the underlying principles of the existing CPC+ model design: prioritizing the doctor-patient relationship; enhancing care for patients with complex chronic needs and high need, seriously ill patients, reducing administrative burden, and focusing financial rewards on improved health outcomes. Physician practices already in the CPC+ Model will be a target audience.**
- **The model moves physicians into population-based payment model.**
- **Models are risk-based. For example, shared savings, performance-based incentive payments, and episode-based payments, and/or alternative to fee-for-service payments such as full or partial capitation.**
- **The models in the future could be adopted by Medicaid Managed care plans, State Medicaid programs, commercial insurers, and Medicare Advantage Plans to take similar approaches.**
- **The models accelerate value-based care by moving more Medicare-fee-for-service beneficiaries into Medicare Advantage plan.**

Business

News Report

By **PETE LEWIS**

MERGERS & ACQUISITIONS

Encompass Acquires Alacare: Encompass Health Corp. purchased substantially all the assets of Alacare Home Health & Hospice, a privately owned home health care and hospice provider based in Birmingham, Alabama. Alacare operates 23 home health locations and 23 hospice locations in Alabama and generated about $117 million revenue in 2018. The transaction is expected to close in the second quarter of 2019, subject to certain customary closing conditions and regulatory approvals. Encompass Health will fund the purchase with cash on hand and borrowings under its revolving credit facility. Encompass Health offers facility-based and home-based patient care through its network of inpatient rehabilitation hospitals, home health agencies and hospice agencies. Encompass's national footprint includes 130 hospitals, 220 home health locations, and 58 hospice locations in 36 states and Puerto Rico.

LHC & Capital Region Medical Purchase Missouri Hospice and Home Health Agencies: Joint venture partners LHC Group Inc. and Capital Region Medical Center (CRMC) purchased a hospice agency in Mexico, Mo. and two home health agencies, one of which is located in Jefferson City, Mo. Financial terms of the transaction were undisclosed. LHC Group reported that it anticipates about $5 million in revenue annually from the venture, and it does not expect it to materially impact its 2019 diluted earnings per share. The three acquired agencies will rebrand as Central Missouri Home Health and Central Missouri Hospice. Combined, they serve 250 patients per day. With this acquisition, LHG Group will operate 112 hospice locations in 35 states. CRMC is a 100-bed inpatient hospital that also provides hospice and home health care. LHC Group formed the joint venture with CRMC in 2018.

Equity Firm Buys Comfort Hospice & Palliative Care: A Salt Lake City-based private equity firm paid $20 million for Comfort Hospice & Palliative Care in Portland, Ore. The purchasing company – a large regional operator with 30 additional hospice locations primarily in the western United States – was not identified publicly. Comfort Hospice & Palliative Care earns nearly $8.3 million in annual revenue and cares for an average of 143 patients per day in four Oregon counties. The hospice will not be rebranded, and aside from the owner's retirement, no staff changes or reductions are planned.

Ensign Expands in Ariz., Texas & California: The Ensign Group Inc., the parent company of the Ensign™ group of skilled nursing, rehabilitative care services, home health care, hospice care, medical transportation, and assisted living companies, continues to expand through acquisitions. On May 1, Cornerstone Healthcare Inc., Ensign's home health and hospice portfolio subsidiary, acquired the assets of Resolutions Hospice, which operates hospice agencies in Austin and Houston, Texas. In separate transactions on the same day, Ensign acquired the operations of four facilities in California – The Hills Post Acute, in Santa Ana, St. Elizabeth Healthcare and Rehabilitation, in Fullerton, Villa Maria Post Acute, in Santa Maria, and Mainplace Post Acute, in Orange – and the operations of two campuses in Peoria, Arizona and Mesa, Arizona. In another separate transaction, Ensign's senior living services portfolio company purchased the real estate and operations of Rockbrook Memory Care, a 52-unit memory care community in Lewisville, Texas. On April 1, in another transaction, Ensign purchased the real estate and operations of Phoenix Mountain Post Acute, a 130-bed skilled nursing facility in Phoenix, Arizona. These acquisitions bring Ensign's growing portfolio to 197 skilled nursing operations, 26 of which also include assisted living operations, 57 assisted and independent living operations, 26 hospice agencies, 25 home health agencies and nine home care businesses across sixteen states. Ensign owns the real estate at 77 of its 254 healthcare operations.

PETE LEWIS IS A CONTRIBUTING WRITER FOR THE REMINGTON REPORT®

AccentCare Acquired By Advent International: Dallas-based AccentCare, a post-acute and hospice provider, was acquired by private equity firm Advent International for an undisclosed amount. Advent is purchasing the company from private equity company Oak Hill Partners based in New York. AccentCare provides services on 16 states.

CORPORATE MANEUVERS

Ensign To Spin off Home Health, Hospice and Senior Living Segment: Mission Viejo, Calif.-based The Ensign Group Inc., the parent company of the Ensign™ group of skilled nursing, rehabilitative care services, home health care, hospice care and senior living companies, announced a plan to separate its home health and hospice agencies and substantially all of its senior living businesses into a separate publicly traded company. Upon consummation of the spin-off, the two companies will include The Ensign Group Inc., which will include transitional and skilled services, rehabilitative care services, healthcare campuses, post-acute-related new business ventures and real estate investments; and The Pennant Group Inc., which will include Ensign's home health and hospice operations, substantially all of Ensign's senior living operations, and Ensign's mobile diagnostic and clinical laboratory operations. At the time of the spin-off, it is anticipated that Pennant, which is currently a wholly owned subsidiary of Ensign, will consist of 60 home health and hospice agencies, 51 senior living operations, and mobile diagnostics and lab operations located in 13 states. Pennant anticipates 23 of the senior living assets will remain subject to leases with third-party landlords. In addition, Pennant will operate 28 senior living communities pursuant to a new, long-term triple-net leases with Ensign subsidiaries.

Cavanaugh Named ProMedica CFO: Steve Cavanaugh was appointed chief financial officer of ProMedica, a not-for-profit health organization based in Toledo, Ohio. He succeeds Mike Browning. Cavanaugh has 26 years experience in the healthcare industry. Since ProMedica's acquisition of HCR ManorCare in July 2018, he has served as president of ProMedica's HCR ManorCare division. Prior to the acquisition, he held several executive roles at HCR ManorCare, including president and chief executive officer, chief operating officer, and chief financial officer. As the former CFO of a publicly traded, multi-billion-dollar company, Cavanaugh is well versed in providing strategic oversight for accounting, financial services, tax, treasury, internal auditing, reimbursement, purchasing and investor relations. In a related move, David Parker, current chief operating officer for ProMedica's HCR ManorCare division, was promoted to president of HCR ManorCare. Parker has held several leadership roles over the past 25 years at HCR ManorCare.

KUDOS

Nathan Adelson Hospice Recognized for Work with Veterans: Las Vegas-based Nathan Adelson Hospice has achieved Level Four in the We Honor Veterans Program. Nathan Adelson Hospice is recognized as an organization that actively works to increase access to hospice and palliative care for veterans in the community. Part of the Level Four practices include conducting veteran-specific educational presentations and increasing access to care within the community. Nathan Adelson Hospice will expand its Veteran-to-Veteran program that pairs veteran volunteers with hospice patients who are also veterans. Veteran volunteers help assist with informing veterans about available benefits. The volunteers encourage patients to share their stories, allowing them to feel validated, open up, and to reach peace at the end of their lives. Nathan Adelson Hospice has provided home care hospice service in Southern Nevada since 1978. In 1983, it opened an inpatient hospice in Las Vegas. Today, the hospice cares for an average of 400 patients daily.

Oostra Honored by Ohio Hospital Association: Randy Oostra, president and CEO of ProMedica was awarded the Donald R. Newkirk Award by the Ohio Hospital Association (OHA.) The award recognizes and honors individuals who have made a significant lifetime contribution to the health care field in Ohio and bears the name of the individual who led OHA for 27 years. Oostra has worked for ProMedica for over 20 years and has worked in health care for nearly his entire 40-year career. He is regarded as one of the nation's top leaders in health care and has earned a spot on several prestigious listings, which include Modern Healthcare's 100 Most Influential People in Healthcare and Becker's Hospital Review's 100 Great Leaders in Healthcare. He also received American Heart Association's Pulse of Toledo Award in 2018 and the AHA Grassroots Champion Award (Ohio) in 2015. Oostra has been recognized nationally for his focus on the social determinants of health, with a particular emphasis on hunger, shelter, education, and most recently behavioral health, helping to advance a national conversation about how health systems can provide more comprehensive, integrated and coordinated mental health services in northwest Ohio and Toledo neighborhoods.

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DON'T MISS THESE **KEY TRENDS**

PAGE 25

10 Ways To Identify Future Partnerships With New Physician Payment Models

1. Identify enrolled practices that can participate.
2. Align financial and quality measures.
3. Be prepared to go "at-risk.
4. Develop robust chronic care management programs.
5. Enhance relationships with hospitalists.
6. Create community-based partnerships.
7. Close any gaps in care coordination programs.
8. Focus on readmissions and ED programs.
9. Invest in technology.
10. Focus on patient engagement strategies.

– LISA REMINGTON, PRESIDENT, REMINGTON HEALTH STRATEGY GROUP, PUBLISHER, **THE REMINGTON REPORT**

The Hospital to Home Program is a collaboration between a hospital, home health agencies, and non-medical home care company to provide additional support to patients when they transition home. PAGE 16

Real-Time Actionable Data

It is critically important for home and community-based care providers to shift their thinking and ask stakeholders about their needs and how home care can help them achieve their goals. Providers also must be prepared to remain flexible as stakeholder needs will vary by the incentives (quality bonuses for positive outcomes) and penalties (payment reductions for readmissions) to which stakeholders are being held. PAGE 4

The Remington Report

Strategy >> Insights >> Analysis

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