The Times They Are A Changin’

Leading Age Texas
2016 Annual Meeting
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Objectives

• At the end of this session participants will be able to:
  – Identify key initiatives that have penetrated their geographic service areas
  – Understand the specific facility operational impact of the key initiatives that are active in their geographic service areas
  – Identify three key strategies for dealing with the key initiatives that will help minimize any negative effect on facility operations

New Models

• New models require care coordination across the continuum
  – Fee for service—the good old days
  – Managed care
    • Optimal care measured through financial outcomes
  – Capitation/Shared Savings/Risk
    • Bundled payments
    • Accountable care organizations
  – Hospital value-based purchasing
    • 3 days pre-acute care episode through 30 days post-acute care
Operational Impact Of New Models

- Narrowing of provider networks
  - Right care
  - Right place
  - Right time
  - Right cost
- Payment schedules with deep cuts to provider payments
  - Insurer promises volume to preferred providers
- Expected performance
  - Reduced readmissions
  - Reduced SNF length of stay
- Substitute lower cost settings
  - What about the patient’s choice?
  - Patient/resident satisfaction

Strategies For Dealing With New Models

- Cost Management
  - Case management
  - Length of stay
  - Hospital readmission performance
  - Cost tracking per episode
  - Contract negotiating skills
- Quality Outcomes
  - Clinical care pathways
  - Hospital readmission performance
  - Physician integration
  - Post-discharge management
- Electronic Health Records
  - Interoperability and interfaces
  - Physician integration
  - Ability to track and analyze metrics
- Marketing Initiatives
  - Education regarding types of benefits available
  - Post-discharge management

Cost Management

Ensuring Profit Margins In Skilled Nursing
## Utilization vs. Case Management

- **Utilization Management**
  - A delivery system which manages both clinical and financial outcomes
  - The system analyzes the relationship of financial spending to clinical results
- **Case Management**
  - Management of an individual case to ensure efficient and effective clinical care at the correct level of care to achieve desired outcome

## Pre-Admission Process

- Determine coverage eligibility
  - Verify coverage days
- Determine clinical and therapy needs
  - Co-morbidity/course of stay
  - Too medically unstable to admit—probability of hospital readmission
- Determine costs
- Compare costs to reimbursement
  - Compare to anticipated RUGS
  - Compare to anticipated MCO contract level
- **Managed Care**
  - Authorization obtained

## Ongoing Cost vs. Revenue

- **Understanding Overhead Costs: Per Patient Day (PPD)**
  - Building
  - Equipment
  - Transportation (van, etc.)
  - Administration
  - SS, Housekeeping, Dietary, Maintenance
- **Fixed costs if bed empty or full**
Ongoing, cont.

- Understanding Direct Costs: PPD
  - Nursing PPD costs
  - Variable costs
    - Pharmacy
    - Therapy
    - Supplies
    - DME
    - Diagnostics

Decision To Admit

- Estimated revenue covers direct costs
  - Estimated RUG/MCO level minus...
    - Nursing PPD
    - Estimated variable costs
- Determine contribution margin to overhead
  - Impact of decision not to admit
    - Community relations
    - Physician relations
    - Referral source relations
- Anticipate course of stay
  - Longer is not always better
    - FFS—28 days
    - MA—11-14 days
    - ACO—7-10 days

Length Of Stay

- Know your length of stay
- Benchmark your length of stay
  - By RUG
  - By Diagnosis
  - By Payer
  - By Physician
- Impact of length of stay
  - Increase revenue
    - Managed care/ACO threats
      - Home Health referral sources
        - Consider non business vs. contractual arrangements
      - Key partnerships
      - Key metrics
        » Clinical outcomes
        » Hospital readmissions
Establish Key Indicators

- Determine data needs
  - Pharmacy utilization
  - Diagnostic utilization
  - Supply utilization
  - Therapy utilization
  - Nurse staffing ratios

Calculating PPD Costs

- Actual monthly invoice, parsed by payer type
  - Total cost of indicator for month (i.e. Medicare Part A) divided by payer census for the month
- Charge for month, less mark-up percentages
  - Indicator charges for month on claim form totals divided by facility mark-up divided by payer census
- Total costs on statement of operations
  - Total indicator charges from statement of operations multiplied by payer cost as percent of charges total charges divided by payer census for the month

Where's your Margin?

<table>
<thead>
<tr>
<th>Service</th>
<th>Cost Per Medicare Resident Day</th>
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<tbody>
<tr>
<td>Nursing</td>
<td>$114</td>
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<tr>
<td>Pharmacy</td>
<td>$35.00</td>
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<tr>
<td>Therapy</td>
<td>$78.37</td>
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<tr>
<td>Supplies</td>
<td>$5.48</td>
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<tr>
<td>Diagnostics</td>
<td>$6.93</td>
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<tr>
<td>Total Medicare Part A Cost PPD</td>
<td>$241.73</td>
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</tbody>
</table>

Medicare Per Diem Rate $467.75
Net Income Per Medicare Resident $467.75 - $241.73 + $226.02
Profit Margin $226.02/$467.75 48%

Did not account for expenses such as ambulance, respiratory therapy, inhalation therapy, nutritional therapy, IV supplies, equipment rental, specialty beds, other DME, fixed overhead costs, etc.
**Sample Costing Form**

<table>
<thead>
<tr>
<th>Revenue</th>
<th>Days</th>
<th>MU</th>
<th>Total</th>
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<tbody>
<tr>
<td>$128</td>
<td>19</td>
<td>$661.75</td>
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<td>Total Revenue</td>
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<tr>
<th>Expenses</th>
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<tr>
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<td>Supplies</td>
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<td>Dietetics</td>
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<tr>
<td>Parper</td>
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<td>$1,499.00</td>
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<tr>
<td>Total Variable Cost</td>
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<tr>
<td>Consolidation Margin</td>
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<tr>
<td>Percent</td>
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<tr>
<td>Total Cost Assumption</td>
<td>$1,177.07</td>
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<td>Total Cost</td>
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<td>$17,977.26</td>
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<td>Profit Margin</td>
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<tr>
<td>Percent</td>
<td></td>
<td>3.3%</td>
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</tbody>
</table>

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**Establish Benchmarks**

- Cost reports
- CMS
- Managed Care Organization Data
- Provider Organizations

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**Case Management**
**Case Manager**

- Consider designated case manager position—RN
- Responsibilities:
  - Provide single point of contact for health plan to ensure consistent communication
  - Build strong relationships with health plan creating climate of trust
  - Verifies eligibility and payer on admission
  - Ensures correct level of initial authorization and monitors levels of care throughout resident’s stay
  - Advocates for the most appropriate level of care and facility reimbursement
  - Coordinates exclusions and communicates with Business Office Manager for appropriate billing
  - Coordinate ancillary services with contracted vendors to avoid paying for these services
  - Negotiates Letter of Agreement with health plans you are not contracted with
  - Obtains authorizations for additional skilled days as needed
  - Develop and lead a clear and efficient system of communication with facility team

**Case Manager—Daily Tasks**

- Pre-admission/admission
  - Request change in orders prior to admission
  - Request tests be completed prior to admission
  - Immediately request change in orders at admission
    - Request to align to facility protocol
  - Pharmacy review within 24 hours of admission
    - Track requests for change and physician refusal
    - Outside formulary/lowest cost alternatives

**Daily Tasks, cont.**

- Daily review of status, documentation and new orders
- Request orders be within established protocol
- Use Medical Director to collaborate with other attending physicians
- Develop internal authorization process for non-routine orders
  - Consolidated billing exclusions
  - Contract review for exclusions
- Training for key staff when case manager is off duty
PPD Costs As Case Management Indicators

- Direct Nursing
- Therapy
- Pharmacy
- Diagnostics
  - Laboratory
  - Mobile X-Ray
- Medical Supplies
- Total Medical Ancillaries

Nursing Costs PPD

- Overtime
- Agency usage
- Advanced Practice Nurses
  - Benefit or cost
  - Clinical parameters
  - Length of stay
  - Hospital readmissions
- Staffing models
  - Unit Specific
    - Rehab
    - Trauma
    - Organ Rejection
    - Critical care
    - Intermediate Care
    - Oncology
    - Hemodialysis
    - Demands
    - Long term care
    - PRN vs. PTN vs. CNA

Therapy Costs

- Pricing
  - Value added services
    - Marketing
    - Clinical Specialty Programs
    - Hospital Readmission Programs
- Outcomes
  - Right Track
  - Clinical Mapping Tool
  - Grand Rounds
  - Screen Right
  - Innovations
  - VRP
- Safe Care Transition Tools
- Denial management
- Utilization
  - Flexibility by payer source
Pharmacy

• Case manager knows formulary
  – Manage to formulary
  – Quick reference for alternatives by drug class
  • Preferred
  • Acceptable
  • Precautions, warnings or restrictions
  • May use more expensive drug but with lower side effects

Pharmacy, cont.

• Case manager and pharmacy review of all new medications
• Develop an IV to oral switch program
• Deliver medications based on length of stay
• Do not order over the counter drugs from pharmacy
• Billing audits
• Minimize use of need for stat med delivery: expand emergency box
• Use preventative vaccines i.e. flu and pneumonia

Pharmacy, cont.

• Staff education
• Reduce prophylactic use of antibiotics
• Develop natural bowel management program
• Review drugs at daily stand up meetings
• Correct administration of drugs
• Use aspiration for wound cultures rather than surface swab
• Standing orders
  – Acetaminophin vs. tylenol
Pharmacy, cont.

- Evaluate TPN/tube feeding usage as end-of-life measure for emotional reasons
- Improved assessment skills to see if simple non-pharmacological remedies will work
- Avoid trap of prescribing more drugs to treat undiagnosed drug-related effects
- Early detection of infections  
  - Baseline temperatures
- Prevent medication errors  
  - Double-check for insulin-heparin-IV meds

Pharmacy, cont.

- Follow-up when physicians fail to respond to written pharmacy monitors  
  - Physician comparison charts

Diagnostics

- Manage medical necessity of labs, diagnostics, x-rays and procedures  
  - Review unexpected ER, hospital admission, deaths  
  - Develop clinical protocols with physicians or specialists  
    • Criteria for medical necessity  
    • Protocols for care  
    • High cost items require authorization by case manager
### Diagnostics, cont.

- Coordinate lab draws
- Do own lab draws
- Use lab values from hospital
- No routine admission labs
- Labs before physician office visits
- Labs needed to support nutrition, hydration, an pressure ulcer programs

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### Supplies

- Obtain supplies from discount supplier rather than pharmacy
- Review all current practices
  - Foley catheters
  - Tube feedings
  - Preventative skin care
  - Wound/pressure ulcer protocols
  - Nutritional supplements
  - IVs

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### Supplies, cont.

- Monitor for waste
  - Room patrols
  - Treatment sheet outlines exact supplies to use for dressings
  - Treatment supply delivery improvement
  - Infectious waste

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### Cost Management

- Intake admission forms
- Software to calculate costs versus revenue
- Detailed information readily available to assign costs
- Contract information for exclusions
- Ongoing method for resident specific costs/revenue comparison

### Cost Management, cont.

- Trending data with resident specific data and ppd data
- Training for case manager
- Utilization management committee in place
- Medical Director involvement
- Physician education and communication
- Peer review

### Cost Management, cont.

- Cost finding systems to support the case manager
- Process for protocol development
- Best practices implementation
- Develop protocols and/or authorization process
Cost Tracking Per Episode

- Medicare Spending Per Beneficiary
  - Hospital Value-Based Purchasing Initiative
    - 3 days pre-acute care episode through 30 days post-acute care
      - Length of stay
      - Hospital readmissions
      - Post-discharge management
        » Transition Coordinators

Resources For Committee

- Vendor Contracts
  - i.e. formulary
- Managed Care Contracts
- QI Data
  - Length of stay
    - Discharge to community
    - Infection rates
    - Medication errors
    - Falls
    - ER visits
    - Unplanned hospital admissions
      » Observation stays
      » ED visits
    » Unexpected deaths

Target High Cost Areas

- Target areas for further analysis and improvement opportunity
  - Additional data collection
  - Literature search
  - Chart reviews
  - Determine root cause
- Develop action plan
- Implement action plan
- Monitor action plan for effectiveness
Contract Negotiating Skills

- Do your homework: Understand your business, the competition, and the network position
- Complete a cost analysis: Know your break-even point and the profit margin you need to create a successful position and a profitable practice
- Position your business for success: Build your story and sell it to the network
- Read all of the contract terms: Be prepared for “gotchas”
  - Timely filing and authorization
  - Network fees
  - Exclusions
  - Appeal rights
  - Termination terms
- Don't undersell yourself: Negotiate for more than what you need, and settle for what will allow you to make a profit
- Walk away: Don’t be afraid to walk away when the deal won’t bring you the patient flow you are expecting or the revenue you need

Quality Outcomes

- Medicare Nursing Home Compare five-star ratings are a routine point of reference
  - Pressure ulcers
  - Urinary tract infections
  - Weight loss
  - Falls
  - Fractures
  - Decline in activities of daily living
  - Restraint
  - Discharge to community
  - Outpatient ED visits
  - Rehospitalization
  - Observation stays
- Short-term post-acute rehab stays
  - Functional gains outcomes
  - Therapy performance
Quality, cont.

• IMPACT ACT—October 2014

<table>
<thead>
<tr>
<th>Table 1: Timeline for New Quality Domains*</th>
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</thead>
<tbody>
<tr>
<td>Quality Domain</td>
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<tr>
<td>-------------------------------------------</td>
</tr>
<tr>
<td>Functional Status</td>
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<tr>
<td>Skin Integrity</td>
</tr>
<tr>
<td>Medication Reconciliation</td>
</tr>
<tr>
<td>Major Fall</td>
</tr>
<tr>
<td>Patient Preference</td>
</tr>
</tbody>
</table>

*Deemed data are deadlines for measure specification and data collection. Confidential feedback reporting and public reporting is required one and two years, respectively, after the dates displayed above.

Secretary shall specify resource user reporting requirements
- Medicare spending per beneficiary
- Discharge to community
- Hospitalization rates of potentially preventable readmissions

Quality, cont.

• Clinical and Rehab care pathways
  - Rehab
    • Orthopedic Recovery
    • Fractures
    • Cardiac rehab
    • Pulmonary rehab
  - Clinically Complex
    • Post-surgery recuperation
    • Stroke
    • Complex wound care
    • Palliative care
    • Oncology
    • Medically complex

• Lengths of stay
  - Discharge to community
  - Hospital readmission rates
  - INTERACT
  - Post discharge management
  - Transition Coordinator

Electronic Health Records
What Can You Do Now?

- Interoperability and interfaces
  - IMPACT timeframes
    - October 1, 2017—reporting of quality measures, resource use and other measures
    - October 1, 2018—reporting standardized patient assessment data requirements
  - October 1, 2017—reporting of quality measures, resource use and other measures

- Engage in cross-continuum dialogue with other PAC providers to understand care similarities and differences
  - Physician integration

- Post-discharge management
  - Establish transfer communication and coordination methods with tracking and accountability reporting

What Can You Do Now?, cont.

- Ability to track and analyze metrics
  - Adopt systems to standardize measurement and documentation and reporting requirement
    - Quality outcomes
    - Lengths of stay
      - Clinical care pathways
      - Discharge to community
    - Rehospitalization performance
    - Cost tracking per episode
      - Identify cost of care variables, quantify and record
      - Anticipate the requirement to report patient-specific resource costs and begin integrating into clinical decisions
    - Resident satisfaction

Marketing Initiatives
Marketing to Managed Care

Who are the potential referral sources?
- Medical Director
- Hospitalist
- Hospital Case Manager
- HMO Case Manager
  - Hospital
  - PHP
  - Ambulatory

Track Key statistics and data to present to referral sources
- Hospital readmissions
- Length of Stay
  - By Clinical Condition
  - By Payer Source and Contract
- Utilization of Ancillary Services
- VBP

Marketing to Managed Care

How do you become a preferred SNF for the HMO?
- Accept and manage complex patients
- Treat in place – manage changes in condition at SNF
- Specialty Programs
- Data on preferred outcomes
- Be a ONE STOP shop
- Health plan wants:
  - 24/7 admission
  - Admissions from ER/Admissions from home
  - Shorter length of stay
  - A discharge plan within 24-48 hours of admission
  - A single contact
  - Low percentages of hospital re-admissions

Resident Satisfaction
Patient Preference

- Post-discharge client satisfaction scores
  - Facility length of stay
  - Clinical outcomes
  - Hospital readmission rates
- Post-discharge management
  - Discharge setting
  - Hospital readmission rates
- Resident advocacy
  - Resident rights
    - Education regarding types of plans and benefits available
    - Center for Medicare Advocacy
    - Jimmo vs. Sibelius
    - Medicare appeal process—unjust and inefficient

Questions?

- Sheila G. Capioti, RN-BC, NHA, MHSA
  - VP Clinical and Compliance Services
  - Functional Pathways
  - 865-356-0256