

Turning Around a Health Care System in a Global Cap Environment: A Balancing Act in Acute and Post-Acute Care

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Executive Summary

Extensive government regulation of hospital prices has placed pressure on health systems to cut costs as well as improve their quality of patient care.

In a pilot bundled payment program, Maryland has capped hospital spending and set prices in an effort to cut \$330 million in Medicare spending over the five-year life of the program.¹ This regulation marks a trend expected to expand to other states in the transition from a volume- to value-based health care system.

In this paper, we examine the challenges health systems face under new budget policies, such as the Global Budget Revenue cap, and key areas providers should address in acute and post-acute care settings to successfully meet the target rate and quality care measures. We discuss a methodology used in a Maryland health system as an example.

Issue Background

Global Budget Revenue (GBR) methodology is central to promoting better care, better health, and lower cost for Maryland patients. The new all-payer model focuses on controlling increases in total hospital revenue per capita.² The GBR is a pilot program in Maryland that is expected to be implemented in other states if it successfully reduces Medicare spending.

Under this methodology, hospital revenue must fall within 5% of the budget. If a hospital is outside of this window, CMS penalizes the hospital relative to its size and structure.

¹ The Washington Post. "Maryland's Plan to Upend Health Care Spending." Last modified January 10, 2014. <http://www.washingtonpost.com/news/wonkblog/wp/2014/01/10/%253Fp%253D74854/>

² The Maryland Health Services Cost Review Commission. "Completed Agreements under the All-Payer Model." Accessed September 22, 2015. <http://www.hsrc.maryland.gov/gbr-tpr.cfm>

Key results at a Maryland health system

- 6% closure on global cap, placing the hospital within 2% of budget
 - 16% reduction in 30-day readmissions
 - 7% increase in skilled nursing facility RUG scores
 - 23% increase in resident satisfaction scores
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In the world of cap management, seamless communication and high quality care are necessities. Acute and post acute settings within the health system must work hand in hand to optimize patient outcomes and focus on key revenue-driving areas in their respective settings to meet budgetary requirements.

Methodology

Acute

Patient Mix

Looking at patient mix, we see that utilization impacts cap in different shapes and forms. In facilities with a blend of high acuity patients with short length of stays combined with behavioral health patients with long lengths of stay and less utilization, achieving the right blend can help significantly influence cap rate. Navigating these two types of patients and the clinical support needed also makes the cost of care a challenge to balance.

To achieve a balanced patient mix, examining and adjusting these critical intake areas can significantly influence hospital revenue:

1. Payer sources
2. Patient types and how they drive or erode revenue
3. Communication among doctors, nurses, and administration

In a Maryland facility, the team identified poor payer sources, categorized patient types, and limited bad debt. Multi disciplinary rounding ensured patients received optimal care and as a result, patients transitioned out of the hospital sooner. The team worked to attract specific patient types, based on reimbursement and rate structure. With a dashboard to track admissions, census, and discharges, administrators were kept abreast of trends. With the hospital at 8% under cap with only 4 months left in the fiscal year, we were able to quickly and efficiently narrow the gap to 2%, well within the 5% threshold. . This adjustment saved the health system over \$1 million in CMS penalties.

Readmission Rates

One of the biggest challenges faced today by hospitals is the risk of readmission penalties. Coordinating the care for patients beyond an acute care stay is a duty that increasingly falls on hospitals.

1. Attention to patients condition and proactive medicine
2. Projecting the patients future conditions and possible needs
3. Aligning the staff (nursing and physicians) goals and work flow
4. Multi disciplinary rounding with rigorous preparation and process
5. Shift management and case management
6. Improved relationships with home health agencies and aligning expectations and plans of care

At one facility the rate for readmission was over 23%. McBee Associates consultants worked with the facility and within three months, this rate was reduced to less than 7% with better care planning, coordination, and referral relationships.

Cost of Care and Utilization Ratios

Cost of care in high utilization low stay units can help quickly drive hospital revenue, yet also increase the cost of care provided. The balance of nursing needs and capabilities are among the biggest challenges. For medium- to large-sized health systems, reducing readmissions is a major priority. In assessing the contribution to cap while addressing the cost of care we see that the high intensity unit can help drive down readmissions for the entire health system.

Costs of care can be lowered by assessing each cost center and aligning the cost centers to the quality of care goals. Working with the staff (clinical and administrative) to establish goals and create a clear road map to meet those goals helps reduce costs and improve quality. In a number of health systems in the Mid-Atlantic region, we found that engaging in close and transparent relationships with patients and their families helped encouraged mutual respect and appreciation among the hospital staff and patients. These relationships allowed the staff to work with patients and better address challenges as they arose.

Human Resources

We have found that having a theme to the facility (e.g. behavioral health focus) instead of a comprehensive traditional hospital setting can help in driving down turnover and properly utilize the expertise of the clinical staff. It is easier to attract, on-board, and train the staff when there is a focus to the organization. However, in vertically integrated health care systems, dealing with a variety of patients is common and the need for multidisciplinary staffing is necessary.

In traditional hospital settings without a guiding theme, appointing liaisons to inform and communicate with clinical staff about specific care quality and financial goals of the health system, as well as monitor progress toward those goals, helps increase quality and morale in clinical staff.

Quality Measures and Costs

One of the first priorities for all health systems should be to meet and exceed all quality goals and measures. In health care organizations with weak financial outcomes, there is often a direct correlation with unmet quality metrics. In one facility, our team worked with the quality department and the clinical staff to meet quality metrics. Figures 1a. and 1b. show the charted measures and changes within five months.

“ If you can control quality and control expenses, you’re going to make a profit.”

— Alon Moritz, Practice Director,
Turnaround and Strategic Planning

Figure 1a. Hospital Revenue and Variance from 5% Benchmark

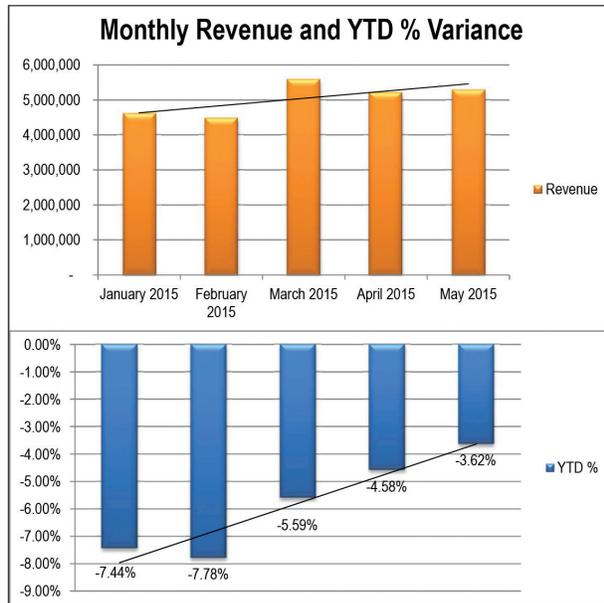


Figure 1b. Quality Measure Improvements

Quality Measure	Goal	March	April	May
Percent of falls with injury	24%	25.64%	18.6%	19.23%
Rate of facility acquired UTIs	.21	.33	.00	.00
Rate of facility acquired catheter related UTI's	4.80	4.20	4.65	7.98
Long term care—Abaqis	83%	93.1%	89.29%	92.86%
Pressure Ulcers—Specialty Hospital	1.58	.30	1.27	2.09
Pressure Ulcers—Long term care	.78	.98	.17	.32
CAUTI—Specialty Hospital	4.80	4.00	.00	.00
CAUTI—Long term care	4.80	4.20	4.65	.00
Readmissions—Specialty Hospital	14.7%	26.92%	16.33%	6.38%

Leadership

For any organization to be successful, leadership needs to understand the task at hand and buy into the goals. From the outset, it is important to assess the issues, analyze how they occurred, and implement a corrective plan and time frame.

Once the goals are clear and a new strategic plan is set, the tactical execution of the plan involves making sure that everyone from top to bottom understands what needs to be done, how, and by when. We also focus on making sure that the floor level has leadership that understands the big-picture mission at hand. Floor leadership is very important to the clinical service level and the oversight that process needs.

Communication between the nurses and the doctors is very important. Strong communication leads to the best outcomes. To foster a high level of communication, several important techniques can be applied:

1. Open communication with a team approach
2. Multi disciplinary rounding
3. Weekly clinical leadership meetings

The combination of these techniques leads to a better understanding of the patients and their needs, and it encourages the team to openly communicate and plan each patient's care as a unit.

Post-acute

Interdepartmental Communication

The relationship between the floor and the billing department of the Maryland long-term care facility needed to be strengthened. We found that increasing communications between the floor and the billing group is fundamental to improving quality scores in post-acute care.

As in all long-term care settings, patient status may change frequently over time. Monitoring patient status, understanding the direction of care needed, and aligning caregivers to the goal of care are important factors to increasing care quality in this setting. Using strategic analysis to predict future care needs is a critical first step that helped the organization become more proactive and prevent medical issues. This analysis addressed the first two factors in improving care.

In addressing the third factor, aligning the care givers to the mission led us to improved quality results as seen across all the quality measures and was highlighted in patient satisfaction scores increasing by 23%. RUGs scores improved dramatically (Figures 1a., 1b.).

Falls

Patient falls can have a major impact on long-term care providers. On average, the cost of a fall with injury (legal costs) is approximately \$90,000 per case at a minimum.

We found that falls with injury accounted for approximately 25%–30% of all falls in one single month at the Maryland long-term care facility.

In most discussions surrounding falls, it is common to focus on preventing injury more than preventing the falls. In the Maryland facility, the team analyzed issues that may cause falls, such as memory loss, in an effort to better understand these issues and attempt to decrease the probability of falls. Understanding these issues in detail and breaking down the components that contribute to fall risk and injury is key to improving in this area. These are among the key analytics:

1. Call bell response time
2. GNA and nursing routines
3. Memory care issues and vulnerabilities (stages and potential behavioral aspects)
4. Preventative measures and risk management
5. Training and awareness
6. Family participation

Aligning Clinical Skill Sets

As the type of patients entering long-term care changes, a change in the type of clinical staff is needed for LTC facilities is also needed. The focus is now on shorter stays with higher utilization of resources (more intense care in a shorter time). The new “super skilled nursing facility” is becoming a reality. As such, the quality of care givers and their skill sets are similar to the care given in acute care.

It is now more likely that the patient going to a skilled nursing facility will need highly skilled care, while in the past we have seen longer stays with less intensity. Hospitals that discharge a patient to an assisted living facility or a home health agency save a great deal of money. Statistically, hospital discharges could be as much as 50% higher than needed to skilled nursing facilities depending on the hospitals and the physicians. We see a trend that in the future these discharges will be planned differently. Most likely, discharges to home health agencies and assisted living facilities will become more frequent under bundled payment arrangements. Thus, the patient population going to skilled nursing facilities will need caregivers who can deliver high intensity, short term care.

In light of this trend, we have changed the caregiver focus to highly skilled staff who are able to provide high levels of care and function closely with the physician staff at the Maryland long-term care facility. This process was supported by:

1. Communications plans
2. Multi disciplinary rounding
3. Data analysis and predictability
4. Proactive care planning

Conclusion

As states across the nation adopt bundled payment programs, such as the GBR, providers must focus on meeting key metrics that drive both care quality and revenue.

Bundled payment programs require providers to have seamless communication and high quality care across acute and post-acute settings. Therefore, each setting across the health system must work in concert to optimize patient outcomes, monitor key revenue-driving areas, and adjust as necessary to meet budgetary goals.

We found that working to meet the following quality measures was fundamental in influencing both patient care and revenue at a Maryland facility under GBR:

Acute

1. Patient mix
2. Readmission rates
3. Costs of care and utilization
4. Staffing to patient needs and clinical competency
5. Patient length of stay in relation to their payment sources
6. Alignment of billing process, care provided, and insurance requirements
7. Quality measures

Post-acute/Long term care

1. Interdepartmental communication
2. Falls
3. Clinical skill sets

In both settings, providing multi disciplinary care and increasing communication among clinicians and administrators were important adjustments that improved quality metrics. The methodology used and the results outlined in this paper may serve as an example for other health care organizations under bundled payment arrangements.

Sources:

The Maryland Health Services Cost Review Commission. “Completed Agreements under the All-Payer Model.” Accessed September 22, 2015. <http://www.hscrc.maryland.gov/gbr-tpr.cfm>

NPR. “Maryland’s Bold Plan to Curb Hospital Costs Gets Federal Blessing.” Last modified January 10, 2014. <http://www.npr.org/sections/health-shots/2014/01/10/261370766/maryland-s-bold-plan-to-curb-hospital-costs-gets-federal-blessing>

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