Welcome!

• Please remember to turn off your cell phone.

• When asking a question, please wait for a facilitator to bring you a microphone.

• Complete the survey in the Guidebook mobile app or return your session survey to a facilitator as you leave. This is Session # 407.

• Following this session, there will be a 30-minute break with snacks in the vendor fair.

Financial Survival in Challenging Times

Terri Wimms, MSN RN
Chief Administrative Officer
Visiting Nurse Association of Ohio
Agenda

• Current situation
• Existing opportunities
• Potential new opportunities
• Additional opportunities we envision

Introduction

A case study of how one agency took on the challenge to improve financial performance

• Eroding profit margins
  – Highly competitive market
  – Decreasing reimbursement
  – High labor costs

• Managing to key performance metrics is challenging
  – Managing paper instead of the business
  – Wrong reports to wrong people with wrong data

• Inefficient processes
Financial Survival in Challenging Times

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VNA of Ohio: A 113-Year Legacy
A Century of Innovation

A long history of firsts in Home Healthcare

1902
VNA formed by 13 women ("Baker’s Dozen") in Cleveland, Ohio

1903
First to form a committee to address communicable diseases

1906
First to provide Therapy and Rehabilitation Services in the home

1956
First in NEO to provide community reintegration of psychiatric patients

1958
First to provide Therapy and Rehabilitation Services in the home

1965
First to provide a federally funded maternal and infant care program

1969
First to form an education-practice partnership with CSU

1978
First to offer point of care technology via laptop for home health

1988
First home care agency to provide personal care and concierge service

1992
First to form an education-practice partnership with CSU

1994
First technology supported health-promotion program for at-risk seniors

1998
First home care agency in Ohio to launch Telecare initiative

2006
First home care agency in Ohio to launch Telecare initiative

VNA of Ohio Today

VNA of Ohio

Key Statistics

- 245,000 patient visits per year
- 350,000 Home Assist hours per year
- 33 counties served
- 51% of Ohio pop. in service areas
- 12,440 volunteer hours of service
- $1.3M charitable assistance
- Approx. 700 employees

Services

- Med/Surg
- Mental Health
- Rehabilitation
- Special Care/Palliative
- Hospice
- Concierge
- Home Assist™
Current Situation

How our agency is managing today:

• Close scrutiny & management of Key Performance Indicators (KPIs)
  – Supported by custom reporting tools, scorecards and dashboards

• Improved management of revenue cycle
  – Management team
  – F2F, unsigned orders, incomplete docs, cancellations, productivity, RAPs, etc.
  – Physician Portal

• Re-evaluating and re-engineering processes
  – Intake / Admissions, Finance (AP and AR)

Efficiencies gained:
  – Significantly improved management of the "paper" trail to dollars and cash flow.

Costs to our agency
  – Increased personnel costs to better manage the "paper" trail: F2F, orders
Financial Survival in Challenging Times

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Existing Opportunities

Revitalized Strategic Plan: Focus on GROWTH, rather than constraint & retraction

• Targeted geographic expansion

• New partnerships
  – ACO, Preferred Partner, JV and Merger opportunities

• “Refreshed” services
  – Telemonitoring, Chronic Disease Management

• New service offerings:
  – Therapies: Lymphedema, Low Vision, Vital Stim, Therapy Connect
  – Mental health: New partnerships
  – Home health: Mobile IDT Conferences with physician groups
  – Caregiver Concierge: Family-focused support services
Existing Opportunities

How we achieved buy-in

- ENGAGEMENT
  - Board of Directors' engagement
  - Involved the Board of Directors and executive leadership in the Strategic Plan definition phase
  - Involved all Directors, Clinical Managers and select staff in the Strategic Plan implementation phase – with executive leadership as Team Leaders

Efficiencies gained:

- Improved awareness of innovation opportunity within each department
- Greater collaboration between sales & clinical management teams
  - As referrals and admissions grow in targeted areas, clinical staff is added to match the need
  - As new programs are ready to launch – clinical managers strategize with the sales team to ensure operational readiness

Costs to our agency:

- Time associated with the strategic planning process
Financial Survival in Challenging Times

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Driving the Search for New Opportunities

- Lower Reimbursement
- Increase Managed Medicare
- CMS Pay for Performance
Ideally, how we’d handle these changes:

COST
- Drive down cost of delivering care

QUALITY
- Ensure highest quality of care

VOLUME GROWTH
- Ensure distinct advantages in a highly competitive market to drive volume

Potential New Opportunities

Opportunities engaged …

- Expand managed Medicare contracting

- Generate additional Revenue not tied to Medicare/ Medicaid
  - Created new service opportunities
    1. Concierge Services (Navigation)
       - Private Pay service, supporting private or insured clients
    2. Administrative Support Services (EMR in a box)
       - EMR (acquisition, training, all software & technical support)
       - IT Support Services
       - Financial Services (Patient Billing)
    3. Private Pay External Services (Agency Nursing)
Next Steps

- Ensure our strategic initiatives are aligned with Cost, Quality & Volume
- Align and engage all employees in these initiatives
- Execute

Surviving Challenging Financial Times

Employee Engagement

Positive Margin
Innovation
Growth
Quality & Continuous Improvement
Home Care Advisory Council Challenges & Opportunities: Specialty Programs

Rhonda Combs
Chief Operations Officer
Christiana Care VNA

Cynthia Struk
President, Home Health & Hospice
Summa Home Health

Agenda

• What is driving the change: Key industry drivers
• Why expand the traditional model
• Potential programs
• Non-traditional home care decision tree
Key Industry Drivers

- Population health
- New payment models
- Quality focus
- Efficiency
- Aging population and chronic disease

Focus on Population Health
Key Industry Drivers: Population Health

- Programs designed to meet outcomes targeted at high risk groups
- Disease management programs
- Transitional care programs
- Population specific programs
- Community partnerships
  - Aligning with health systems or ACO for specialty or risk populations
  - Alignment with ALF/ECF for specialty or risk populations

Key Industry Drivers: New Payment Models

- Programs designed to meet specific outcomes – targeted at high risk groups
  - Reduction in utilization
  - Improvement in quality of life
- Disease management programs
  - CHF, COPD, Oncology
- Shared risk managed programs
  - Bundle payment models
Key Industry Drivers: Quality Focus

- Home care and Hospice subject to new quality reporting
  - STAR Rating
  - Publicly report quality metrics for hospice
- Alignment with Health Systems to improve core measures
  - 30-day re-hospitalization
- Alignment with insurance payers
  - HEDIS measures
  - NQF

Key Industry Drivers: Efficiency

- Reduce Unnecessary Admissions
- Reduce Preventable Readmissions

Enhancing Core Operations
1. Manage Staffing Mix, Productivity
2. Perfect Patient and Family Experience
3. Solidify Comprehensive Referral Strategy
4. Leverage Technology Investments

The Broader Home Health Ambition
1. Support Cross-Continuum Coordination
2. Promote Cost-Effective Care
3. Improve Care Quality
4. Expand Services Beyond the Home
Key Industry Drivers: Efficiency

- Manage labor costs
- Flexible productive workforce with performance metrics
- Support cross-continuum care coordination
- Comprehensive strategy “one-stop shop” with easy access
- Positioning for cost-effectiveness...demonstrating value as a cost-effective provider with high quality
- Data analytics that demonstrate value or drive improvement

Key Industry Drivers: Aging Population

Source: Department of Health and Human Services, Administration on Aging
Key Industry Drivers: Chronic Illness

- Chronic diseases and conditions – such as heart disease, stroke, cancer, diabetes, obesity, and arthritis – are among the most common, costly, and preventable of all health problems.

- As of 2012, about half of all adults – approximately 117 million people – have one or more chronic health conditions. One of four adults has two or more chronic health conditions.

- Eighty-four percent of all health care spending in 2006 was for the 50% of the population who have one or more chronic medical conditions.

- The total estimated cost of diagnosed diabetes in 2012 was $245 billion, including $176 billion in direct medical costs and $69 billion in decreased productivity (CDC 2015).

Why Expand the Traditional Model?

<table>
<thead>
<tr>
<th>Strengthen efficiencies</th>
<th>Growth</th>
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<tbody>
<tr>
<td>Lower the per patient overhead/administrative costs</td>
<td>Increased volume/revenues – adding value as a community partner</td>
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<tr>
<td>Development of expertise in community care</td>
<td>Allow for a more comprehensive service model</td>
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<tr>
<td>Improved access to capital, technology, and other expertise through partnership</td>
<td>Increase the service area or market share</td>
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<tr>
<td>Diversification</td>
<td>Add or retain volume and revenue streams</td>
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<tr>
<td>Manage labor costs</td>
<td>Pilot new models of care</td>
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<tr>
<td>Demonstrate value – both from a quality and cost perspective</td>
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Potential Opportunities

- Palliative Care: Home and Clinic
- Bridge to hospice
- High-risk for return to hospital
- Case management
- Geriatric care management
- Geriatric wellness programs
- Chronic disease management and patient coaching
- Senior placement service
- Care transitions
- Palliative care for dementia
- Psychiatric
- Home physician practices
- Others??

Clinical Innovation Services

Bill Belec
CIO and VP,
Operations and Business Analysis
Visiting Nurse Signature Care
Clinical Innovation Services Include:

- Transition coaching
- Managed long-term care
- Embedded care managers
- Telehealth
- Nurse family partnership

Care Transitions Program®: Coaching

- Four-week program
- Patients with complex care needs
- Four conceptual domains, or pillars
Contact between the coach and the patient occurs in three ways:

1. The first patient visit in the hospital before discharge
2. One follow-up home (or SNF) visit, ideally 24-48 hours post-discharge
3. Three follow-up phone calls, ideally at 2, 7 and 14 days post-discharge

Each visit and phone call has a specific goal that includes addressing the unique needs / goals of the patient.

<table>
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<tr>
<th>Care Transitions Program: Four Pillars</th>
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<tbody>
<tr>
<td><strong>Medication Self-Management</strong></td>
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<tr>
<td>Goal</td>
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<tr>
<td>Hospital Visit</td>
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<tr>
<td>Home Visit</td>
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<tr>
<td>Follow-Up Calls</td>
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Targeted Patients

- Provide to targeted eligible candidates specified by the payor, typically CHF, COPD, Diabetes, Pneumonia, PQIs (dehydration, UTIs)...
- History of more than one admission in past year

Outcomes to Date

- Patients served: 1000+
- Outcomes: 25% reduction in hospitalization overall
- MVP: 30% reduction in hospitalization
- Facilitated by FLHSA
Managed Long Term Care

Managed Long Term Care Program (MLTCP)
• Care coordination model for Medicaid beneficiaries

MLTCs are responsible for:
• Coordinating access to covered and non-covered services
• Facilitating appropriate utilization of these services
• Providing payment for covered services

Managed Long Term Care

• PMPM care management
• Enrollment & reassessment visits
• Service provider: CHHA,LHCSA
• Future shared risk
Embedded Care Management

- Funded by HEAL 9 grant from NYS through March 30, 2013
- Facilitated by FLHSA
- ECMs at three practices:
  - Highland Geriatrics
  - Highland Family Medicine
  - Westside Health Center

Goal of Demonstration

Incorporate Care Managers into primary care practices to identify patients at risk of PQI*-related admissions and ED visits, and reduce these risks in order to produce a meaningful reduction in the 180-day Medicare readmission rates.

*Prevention Quality Indicators identify hospital admissions in geographic areas that evidence suggests may have been avoided through access to high-quality outpatient care.
ECM Objectives

- Identify those at risk for hospitalization or ED visits using a combination of diagnoses and utilization metrics
- Interface medical and social support to connect patients with community resources
- Provide regularly scheduled quality face-to-face time with the doctor and practice team, thereby providing continuity of care over time
- Focus on care transitions, patient/family management of chronic diseases in order to reduce preventable admissions and ED visits

Encounter Form
Telehealth Outcomes

CHF Patients: Jan 2007 – Dec 2011

<table>
<thead>
<tr>
<th>Events</th>
<th>Non Telehealth</th>
<th>Telehealth</th>
<th>Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Care Hospitalization</td>
<td>27.18%</td>
<td>13.57%</td>
<td>50%</td>
</tr>
<tr>
<td>Emergent Care</td>
<td>18.67%</td>
<td>10.80%</td>
<td>42%</td>
</tr>
</tbody>
</table>

* All patients included in data have been discharged from home care.

Telehealth: Patient Satisfaction

89% stated they had a better understanding of their disease and were able to better manage their disease

88% wanted to continue with Telehealth

95% would recommend Telehealth to their friends

91% stated they are satisfied overall with Telehealth
Nurse Family Partnership

- Unique arrangement

- Evidence-based program provided by Monroe County Health Department, BUT staffed by VNS

- Follow first-time moms from 16 weeks gestation to child's second birthday

- Growth only limited by county's ability to obtain further funding

- Provides great service and margin for VNS

Non-traditional Home Care Decision Tree

**Step 1: Program Criteria** (must define)

Define who is eligible for program:

- Diagnosis- / population-specific
- Payor
- Risk stratification score, if applicable
- Geographic location
- Other population requirements (i.e. functional, lab values, service needs)
Non-traditional Home Care Decision Tree

Step 2: How does intake information come into agency?

- Electronic feed
- Population log
- Phone
- Fax
- Other

Step 3: Information required for program

- Name and demographic fields
- Payor fields
- Is diagnosis required: yes or no?
- Is physician needed, or are orders required: yes or no?
- Initial tracking data to assist in outcome measurements
- Other eligibility criteria
Non-traditional Home Care Decision Tree

**Step 4: Patient system set up** (based on contract, outcomes to be tracked and reporting requirements)

- Organizational level
  - Important to consider, so that patient information can be segregated for regulatory, accreditation reporting, cost report impact
- Funding profile: Is a separate and distinct fund required?
  - Provider number considerations
  - Is a NPI number required?
  - Taxonomy code associated with services
  - Is this a standard discipline or a new discipline? (Service type)
  - What service codes are required for a client (Based on desired reporting and charges in contract)

**Step 5: Determine clinical content**

- Type of assessment
  - OASIS
  - Non-OASIS
  - Custom
- Recurrent activity
  - Visit notes
  - Phone or other
- Visit / encounter documentation
- Tool library: Pick from selection to assist with outcomes, as well as program criteria.
  - Examples: depression scale, mini-mental, morisky scale
- Encounter template or note
Non-traditional Home Care Decision Tree

Step 6: How will planned activity be scheduled through scheduling process?

- Visits
- Phone contacts
- Other

Non-traditional Home Care Decision Tree

Step 7: Positioning for outcome measurement

Identification of key clinical program outcomes (would be optimal to have a frequently used list):

- Hospitalization
- ED utilization
- Functional improvement
- Medication adherence
- OASIS (select) questions to be utilized
- Pre- and post- measures (as well as defined program goals)
- Other nationally recognized tools
Non-traditional Home Care Decision Tree

Step 8: Administrative reporting

- Enrolled patients/clients
- Clients discharged
- Productivity of staff completing program activities
- Cost of providing service (direct and non-direct effort)

Step 9: Billing and processing

- Billing unit
  - 15 minute increment
  - Visit
  - Hourly
  - Per-diem
  - Bundle
  - Performance-based bonus

- What is required to hold a bill?
  - Orders: Yes / No
  - Authorizations: Yes / No

- Billing frequency
Questions?

Bill Belecz: bbelecz@vnsnet.com
Rhonda Combs: rcombs@christianacare.org
Cynthia Struk: strukc@summahealth.org
Terri Wimms: twimms@vnaohio.org