

With Partnerships, Mission and Money Align

BY KATHLEEN M. GRIFFIN, Ph.D. and JADE GONG, M.B.A., RN

The Patient Protection and Affordable Care Act (ACA) brings unprecedented opportunities for aligning financial incentives with high-quality, person-centered patient care. That makes it a boon for Catholic health care, offering, as it does, opportunities to align patient-centered care with reimbursements.

Against that background, Catholic health care providers around the country have vigorously embraced and adopted many of the best practice models of care that are embedded in the law. Provisions such as accountable care organizations (ACOs) and bundling of Medicare payments to cover an entire episode of care already have been formally adopted by the Centers for Medicare and Medicaid Services (CMS) through federal regulations and pilot projects. Other provisions that impose penalties upon hospitals with excessive rates of 30-day readmissions for Medicare patients will be implemented in October 2012. Further, private payers are following the same path and adopting risk-based provider payment models that contribute to the momentum for transforming the health care delivery system in many markets across the country. A common goal of these new payment models is creation of a clinically integrated system of care that results in better patient outcomes, improved overall population health and lower per-person health care costs.

These changes are aimed at improving on the current fee-for-service health care delivery system, which rewards volume of services over value and consists of multiple, non-integrated silos of acute, post-acute, long-term and outpatient care.

“You have to be the change that you wish to see in the world.”

— Mahatma Gandhi

That delivery model has had a particularly negative impact on older and chronically ill patients who most need and utilize health care services.

Where chronic illnesses are managed well, hospitalizations are brief and transitions are successful, financial benefits will accrue to providers in ways not possible under a fee-for-service system. This will help to optimize a seamless continuum of care for the most frail and vulnerable patients — older adults, persons with chronic diseases and people who lack resources.

That said, implementing a law as complex and transformational as the ACA requires extensive collaboration among policymakers, providers and payers. On Jan. 26, 2012, CMS, along with its partners, sponsored the first Care Innovations Summit, bringing together more than 4,000 individuals to discuss innovative solutions to the nation's health care challenges. Six major themes emerged:

- The need to re-orient our health care system
- The need to overcome a culture of resistance to delivery system innovation
- Imperatives for payment reforms that incentivize value over volume
- Delivery system changes that promote coordination and collaboration across the care continuum
- Data and technology to enable real-time performance evaluation of system change
- Strategies to enable health care organizations around the country to quickly grow and replicate successful efforts

Although each of these requirements represents a major challenge, the ACA places post-acute and long-term care providers in a pivotal

position to achieve success. Successful collaboration between and among hospitals, post-acute and long-term care providers, health plans and ACOs are fundamental in reducing costs and improving outcomes for target populations such as the “dual eligible” — persons eligible for both Medicare and Medicaid. Further, interest among states in promoting new models of care for persons dually eligible under these programs places even more importance on the role of post-acute and long-term care providers.

In this new environment, Catholic health care providers are proactively adopting a variety of approaches to creating collaborative relationships with external and internal partners to ensure quality transitional care among acute-care settings, post-acute care, home care and long-term care. Here is a sampling of what is underway at three Catholic health care systems.

Bon Secours St. Petersburg Health System

COLLABORATION WITH COMMUNITY PROVIDERS

Bon Secours Health System is a \$3.3 billion non-profit Catholic health system sponsored by Bon Secours Ministries. Headquartered in Marriottsville, Md., the system owns, manages or joint ventures 19 acute-care hospitals, one psychiatric hospital, five nursing care facilities, four assisted living facilities and 14 home care and hospice services. However, its regional St. Petersburg, Fla., system operates in a market where there is no Bon Secours-sponsored hospital. The St. Petersburg campus includes a large skilled nursing facility, a home health agency and an assisted living facility.

As Bon Secours St. Petersburg management and trustees anticipated the challenges of maintaining referrals to its facilities under health care reform, they turned to Baycare, a large hospital-centric health system in St. Petersburg. Catholic Health East (CHE) is a 50-percent partner in the jointly owned system, and St. Anthony's Hospital, a Catholic hospital, is the nearest hospital to the Bon Secours St. Petersburg campus.

More than a year ago, the two organizations, Baycare and Bon Secours St. Petersburg, began collaborating on a pilot project to reduce 30-day hospital readmissions for heart failure patients. The project has extended to developing shared clinical protocols across the continuum from the hospital into the physician's office, skilled nursing facility and home health setting.



In addition, the managers of Bon Secours St. Petersburg initiated discussions with other non-profit post-acute and long-term care providers in order to establish a geographically attractive network that can serve the post-acute and long-term care needs of Medicare beneficiaries in ACOs and of both Medicare beneficiaries and Medicaid recipients enrolled in managed care plans.⁵

Trinity Health System, South Bend, Ind.

COLLABORATION AMONG INTERNAL PROVIDERS

Trinity Health, a Catholic health care system based in Novi, Mich., operates 49 acute-care hospitals, 432 outpatient facilities, 33 long-term care facilities and numerous home health offices and hospice programs in 10 states.

Within Trinity, the Trinity Health System in

South Bend, Ind., sought to enhance collaboration internally to meet the needs of frail Medicare and Medicaid beneficiaries. Specifically, three Trinity South Bend entities are working together to explore a more formalized collaboration by

“Without the involvement of long-term care services and supports, ACOs or other new collaborative models of service delivery will not be able to achieve sustained quality improvements and reduced costs.”

— Mark M. McClellan, director, Engelberg Center for Health Care Reform, The Brookings Institution

establishing a program of all-inclusive care for the elderly (PACE) for nursing facility eligibles in the community. Upon the request of Trinity Health System, the state of Indiana has decided to allow PACE programs to operate in Indiana and offer community-based options to individuals who would otherwise be admitted to nursing homes for care.

The proposed collaboration would engage an acute care hospital, a physician network, home health services, skilled nursing facilities that provide both sub-acute and long-term care, assisted living facilities and low-income senior housing.

Although the current Medicare payment system has not supported such an approach to caring for frail Medicare and Medicaid persons eligible for admission to a nursing facility for long-term care, the ACA offers incentives to integrate — and thereby improve — care. The new accountable care environment and 30-day hospital readmission penalties have changed the financial reality for the health system, making PACE advantageous for integrated delivery systems.

Catholic Health Initiatives

MARKET-SPECIFIC POST-ACUTE STRATEGIES FOR NATIONWIDE HEALTH SYSTEM

Catholic Health Initiatives (CHI), a nationwide health system based in Englewood, Colo., has 70 hospitals, 40 long-term care, assisted living and residential facilities and two community-based ministries in 19 states, both in urban and rural communities. CHI also operates a national home

care program.

Recognizing the “new normal” arising from health care reform, CHI set as a strategic priority for fiscal year 2012 to assume performance risk and accountable care capability. However, given the diversity of the markets in which the system operates, CHI developed an accountable care readiness program that was implemented in three different markets in 2010-2011. The program encompassed three areas of focus that together formed an integrated care management model: care transitions, office-based health coach and geriatric care management.

As reported at the Catholic Health Assembly in 2012,⁶ the model was shown to be effective in significantly reducing rehospitalizations and yielding improved patient outcomes for older adults with certain chronic diseases. The proven model can now be adopted in other CHI markets.

A more recent CHI initiative involves developing continuing care networks of post-acute providers to create integrated care delivery between acute hospitals and unaffiliated skilled nursing facilities, home health agencies, inpatient rehabilitation facilities or units and long-term acute care hospitals. This work involves:

- Assessing post-acute capability with the intent of developing a preferred post-acute care network with a credentialing process and clear expectations around quality, cost and satisfaction

- Market-specific network options, which may include ownership, management or provider agreements

- Infrastructure options to connect all entities across the continuum⁷

HOW POST-ACUTE AND LONG-TERM CARE PROVIDERS CAN DEVELOP COLLABORATIVE PARTNERSHIPS

In order to achieve the goals of this transformed health care delivery system, it is clear that collaboration among health care providers — acute, post-acute and long-term care — is essential to success. Here are some components of a plan a post-acute and long-term care provider might consider when seeking to develop a successful health care reform strategy:

- First, assess abilities and assess actions

needed to meet the needs of your current and future referral sources. For example, do you need to add enhanced clinical capability to handle medically complex patients? Do you need to use the INTERACT II tools to reduce 30-day hospital readmissions? What should you be measuring and reporting to demonstrate your value to a potential health system or ACO partner?

■ Next, identify components of the post-acute and long-term care continuum that a prospective health system or ACO partner does not have, and determine how you can meet these needs. For example, would creating a partnership or alliance with other nonprofit skilled nursing facilities that provide easy access throughout the ACO's or health system's geographic market area allow for one-stop shopping for sub-acute and long-term care? Is home health offered by your local health system, or would a partnership be mutually advantageous?

■ Finally, based upon the analysis of your capabilities and programs and your potential partner's needs, determine the right collaborative relationship that will ensure mutual success. For example, should you partner with one or more than one Catholic hospitals or health systems in your market? How can you facilitate internal collaboration among the post-acute venues sponsored by the Catholic hospital or health system and integrate your post-acute services to create a seamless care continuum?

For Catholic-sponsored providers, collaborative relationships to achieve the goals of health care reform — better patient outcomes and popu-

lation health at lower per-person costs — present a vehicle for expressing Catholic values and creating the ideal health care delivery system: one that is person-centered, respecting personal dignity with compassion and excellence.

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NOTES

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"We need to discover, invent and spread new delivery models that give us a patient-centered coordinated care system. We must harness the power of data, invest in new innovative payment and delivery models and help support partnerships committed to improvement. The Affordable Care Act gave HHS the tools to accomplish this."

— Rick Gilfillan, MD, director, Center for Medicare and Medicaid Innovation, Care Innovations Summit, January 2012

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