Era of Affordable Care Act (ACA):

Will your program take a dive, barely survive… or thrive?

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Outline

A. The ABCs of the Affordable Care Act (ACA)
B. Strategies to Improve Outcomes
C. Strategies to Improve Patient/Family Satisfaction
D. Strategies to Improve Population Health
E. Strategies to Decrease the per Capita Cost of SLP Services

A. The ABCs of the ACA

US Healthcare: Skyrocketing Costs

Average cost of delivering a baby:

- 2004: $7,700;
- 2014: $32,000
- More than 300% increase in 10 years!!! Highest cost in the world!

US Healthcare: Most Expensive

- The US spends 2.4 times more per capita on healthcare than the average spent in other developed countries
- Estimated that billions are spent on non-value-added expenses

US Healthcare: Not that Good

- US is ranked as the 37th best healthcare system in the world
- Infant mortality rate is better in many other countries, including: Korea, Lithuania, New Zealand, Portugal, Singapore, Spain, Slovenia, Sweden, Switzerland, Uruguay, and others
- There has been a lack of affordable care for a significant number of Americans, and many Americans have been without health insurance and therefore, healthcare
- Many studies have reported:
  - Pervasive problems with quality of care
  - Uncertainty about best practices that work
  - Lack of evidence for many popular procedures and services
  - Widespread clinical practice variation
  - Significant disparities in the access to care

US Healthcare: Not that Safe

Landmark reports published by the Institute of Medicine (IOM) in 1999 and 2001:

- **Published report:** To Err is Human: Building a Safer Health System and Crossing the Quality Chasm: A New Health System for the 21st Century
- **Conclusion:** There are major issues with quality and safety in US healthcare across the country

US Healthcare: Needs to Change

Need to decrease costs of healthcare:

- Increase in cost of medical care each year is unsustainable
- No one is arguing for status quo
- Everyone who pays for healthcare (employers and consumers) wants to pay less!

Need to increase quality (positive outcomes) and satisfaction:

- Advocated by regulators, healthcare rating organizations, accrediting bodies, employers, commercial payers, and the public

Affordable Care Act (ACA), AKA Obamacare

Healthcare reform was signed by President Obama in March 2010. Includes two pieces of legislation:

- The Patient Protection and Affordable Care Act (PPACA), and
- The Health Care and Education Reconciliation Act

Triple Aim of Healthcare Reform

1. Improve the patient/family experience (e.g., increasing quality, outcomes, and satisfaction)
2. Improve the health of populations (which includes expanding coverage to more people)
3. Reduce the per capita cost of care

Changes for Consumers

- Cannot be denied for pre-existing conditions
- Removal of lifetime limits
- Children under age 26 can stay on their parent's plan
- Preventative care is covered
- Individual mandate for coverage
- Health insurance marketplace for low cost plans

Ultimate Goal: High quality universal healthcare coverage

Changes for Providers

Among other things, a focus on:

- Value
- Comparison of outcomes
- Bundled payments

Value in Healthcare

- Value depends on patient outcomes, not on the volume of services delivered to the patient
- More care is not always better care (and can even be worst care)
- *Value-based, accountable care is patient-centered, produces superior outcomes, and is delivered efficiently by streamlining care processes to increase access and reduce waste.* Advisory Board Co.
- Value equals **benefit** (quality, outcomes, and satisfaction) divided by **costs.** We need to work on both sides of the equation by increasing the numerator and decreasing the denominator.
- Value is what really matters to patients

Need to focus on:

- **Quality:** We need high quality, evidence-based practices to deliver superior outcomes. We need to achieve goals with fewer sessions.
- **Patient/Family Satisfaction**: We need patient-centered care with personalized treatment plans. We cannot be clinician-centered or organization-centered
- **Costs:** We need increased efficiency and streamlined processes to reduce waste and lower costs

Value for Patient/Family

- Families are "shopping" for healthcare and considering cost more than ever due to:
  - High co-pays and very high deductibles
  - Indirect costs (i.e., time from work, gas, parking, etc.)

- Information about both cost and quality will become more readily available

We need to consider the following:

- What influences families' "willingness to pay"?
- What is the priority and the value to the patient?
- For an activity to be considered *value-added, the c*ustomer must want it AND be willing to pay for it

Value for Referral Sources

Physicians will be asking the following questions:

- Does our service provide a difference that is of value to the patient and family?
- Is our service worth the cost?

We need to educate referral sources about what services we can provide, and how they add value to the patient that is worth the cost. It's time to do lots of lectures!

Value for Payers

- Value-based purchasing started by CMS
- Payment will be based on:
  - Results instead of the volume of services delivered
  - Patient satisfaction and experience
  - Compliance with standard protocols
- Will measure performance, compare hospitals and providers, and adjust payments
- Aligns payment to efficiency and quality care
- Every hospital will have certain standards to receive full reimbursement
- Ultimately, payers will be selecting preferred providers based on ratings of value (outcomes, satisfaction, and costs)

Bundled Payments

- Initiated by CMS
- Meant to replace fee-for-service, which rewards high volume (lots of tests and procedures with a fee for each); Providers usually don't know the cost of the tests/treatments that they order
- Bundled payment is based on reimbursement for a diagnosis (i.e., diabetes, cardiac care, etc.); CPT (procedure) codes may be bundled
- Reimbursement based on median costs of procedures "typically done" for a diagnosis
- This rewards achieving outcomes with less service (e.g., costs)
- Physicians will care about costs (and therefore, order fewer services) because they will affect their reimbursement
- Although reducing costs is emphasized, there are penalties to cutting corners on care or poor quality under bundle payments. Example: Penalty for hospital re-admission within 30 days
- Coordinated care plans will be important, particularly for chronic care patients
- Providers with the highest quality and lowest cost will thrive
- Hospitals will look at systems and eliminate duplication or overlap of services

Bundled Payments and SLP

- Our biggest cost: Salary for time spent
- We can **reduce salaries** OR we can **reduce the number of visits** to achieve goals
- The less care (expenditure of resources) the better
- Need to achieve quality results with less care (expenditure of resources)
- Team care and collaboration will be critical

B. Strategies to Improve Outcomes

1. **Outcomes Research and Measures**
2. **Clinical Guidelines**
3. **Functional Goals**
4. **Provider Specialization**

1. Outcomes Research and Measures

Needed to determine which treatments work, for which patients, and with what trade-offs

Patient-Centered Outcomes Research Institute (PCORI)

- Independent, nonprofit entity with public and private funding
- AHRQ and NIH Directors serve on PCORI's board and methodology committee
- Sets priorities and coordinates with existing agencies that support patient-centered outcomes research

Five national priorities approved in May 2012:

- Assessment of prevention, diagnostic, and treatment options
- Improving healthcare systems
- Communications and dissemination research
- Addressing disparities
- Accelerating patient-centered outcomes research and methodological research

Outcome Measures

We need outcome measures in order to:

- Establish baseline status
- Determine effectiveness of interventions
- Inform patients of progress in a quantifiable manner
- Inform payers of progress to enhance reimbursement
- Provide data over time to improve care

2. Clinical Guidelines

Used to standardize clinical procedures and promote evidence-based practice

Clinical Guidelines should be:

- Based on systematic reviews of literature, with attention to the quality of and strength of evidence
- Developed by a knowledgeable, multi-disciplinary groups of experts and representatives of affected patients
- Based on a transparent process that minimizes biases and conflicts of interest
- Re-considered and revised as appropriate

Benefits of using clinical guidelines:

- Increases quality thru evidence-based practice
- Standardizes practice
- Increases efficiency
- Reduces variations and processes (resulting in cost) that do not add value
- Following clinical guidelines for treatments that have been **proven** to be effective will improve clinical outcomes

3. Functional Goals

Functional goals focus on what is important to the patient/family

- Treatment plans should be based on functional goals that reflect the patient needs and the patient/family desires

World Health Organization's (WHO's) International Classification of Function (ICF)

Body Functions:

List includes:

- Mental functions
- Voice and speech functions

Body Structures

List includes:

- Structures of the nervous system
- Structures involved in voice and speech

Activities and Participation

List includes:

- Communication
- Interpersonal interactions and relationships

ICF Framework: Expected to be used for:

- Clinical purposes: Set functional goals for outcome-based treatment and mapping progress
- Data purposes: Provide outcomes data to improve processes and compare providers (hospitals and individuals)

Task-Based Treatment vs. Outcome-Based Treatment

Task-Based Treatment	Outcome-Based Treatment
Assesses the patient's impairments	Uses a patient-centered assessment
Defines assessment parameters according to the discipline	Defines assessment parameters by the skill requirements for discharge
Organizes the treatment plan around patient limitations	Organizes treatment plan around skill requirement of the discharge environment
Focuses on reduction of impairments; remediates first and compensates last	Focuses on functional skill reacquisition; considers compensation first
Sets task-specific goals	Sets functional goals
Provides family teaching at the time of discharge	Begins family involvement at admission and incorporates into treatment

4. Provider Specialization

- Field of SLP is very broad; Impossible to be expert in all areas
- Specialization results in higher quality (at lower cost)

C. Strategies to Improve Patient/Family Satisfaction

Need feedback from our "customers" to help us to improve our services and family satisfaction

- Tools could include:
  - Satisfaction surveys
  - QOL tools, such as the Quality of Communication Life Scale (ASHA QCL)
  - Patient/family-reported outcomes.

Patient-Reported Outcomes Measurement System (PROMIS)

- PROMIS (funded by NIH): A system of tools that measure patient-reported health status, including symptoms, function, and well-being
- Use of PROMIS data:
  - Evaluation of effectiveness of interventions for various conditions
  - Research in chronic health conditions

Patient/Family Satisfaction: What patients and families want?

- High quality, low cost, and convenience

Family-friendly scheduling:

- Appointments are scheduled at the convenience of the family, not the SLP
- Includes evening and weekend hours
- Allows family to call-in each week to schedule

D. Strategies to Improve Population Health

Hospitals need to be concerned about those patients who are NOT coming in

- Registries need to be built
- Hospitals are developing more urgent care facilities for low acuity
- SLPs need to provide:
  - Service for as many children who need it as possible
  - Early intervention and preventative care
  - Parent/family training on stimulation or intervention strategies
  - Health literacy

E. Strategies to Decrease the Per Capita Cost of SLP Services

Primary Cost in Speech-Language Pathology: Salary/time of the SLP

- To reduce per capita cost of care, *we need to reduce the amount of time spent by the SLP to achieve the desired outcomes for each patient*

Current model of Healthcare Financing:

- Increase revenue by seeing lots of patients and providing lots of services to each patient

New model of Healthcare Financing:

- Increase revenue by seeing lots of patient, but providing *less service* to each patient, while also achieving good outcomes and high patient/family satisfaction

Strategies to Decrease Per Capita Costs of SLP Services

Decrease non-clinical/non-value-added time

1. **Top of License**
2. **Documentation**

Increase clinical/value-added time

3. **Productivity**
4. **Scheduling**

1. Top of License (AKA Leveraging)

- HC providers should ONLY spend time doing things that require their professional skills and training and NOT spend time doing things that can be done by those who are less skilled and/or lower paid
- This decreases costs, increases access (provider can see more patients), and generates more revenue
- SLPs should provide only those services that require a level of complexity and sophistication

Top of License for SLPs: Administrative Support

- Use paid support staff, students, and volunteers for all non-clinical tasks

Top of License for SLPs: Clinical Support

- Use clinical "extenders" (SLPAs, students, family members) to provide practice and drill work

Theories of motor learning and motor memory:

- **Motor learning** is dependent on instructions, trial and error, and feedback. Motor learning should be done in therapy.
- **Motor memory** is dependent on practice, which develops the automaticity of the movement and ultimate "carry-over." Motor memory (through practice) should be done primarily at home, and not in the therapy session.

2. Documentation

- Time spent in documentation is the biggest non-billable cost
- Evaluation charges are procedure-based, not time-based
- The charge of a procedure is NOT based on the length of a report. Charge is based on the time spent, degree of clinical expertise, degree of technology, expense of equipment and room, support staff and other overhead.
- Less time spent in evaluation, better reimbursement for time spent
- Cutting documentation time decreases costs, increases clinical time, and improves job satisfaction

Documentation should meet the needs of our customers (physicians, parents, other SLPs, and payers)

- Doctors want summary and recommendations
- Patients/families want info about the diagnosis and what can be done about it
- SLPs need the eval data
- Payers want to see the CPT code and ICD-9 code for auths and want to see progress for reauths

Streamlining Documentation

- Computerized templates with select lists to fill out reports
- For physician: One page summary that includes pertinent history, summary/ impressions, and recommendations
- For SLPs: Attachments with test scores and check list info
- For families: Copy of letter and handouts
- For Payers: ICD and CPT codes for eval; table of goals and progress for therapy

3. Productivity

- Measurement of the *collective efficiency* of a clinician, program, department, or organization in delivering products or services and gives an indication of the *financial health*
- In SLP, productivity is measured by the percentage of billed hours out of total hours worked
- Scheduling should not be done by SLPs; it should be done by support staff who should be responsible for ensuring full schedules
- SLPs should focus on management of cancels/no-shows, rather than scheduling

Business argument:

- Professional schedulers are cheaper than SLPs and do a much better job of it
- SLPs will be able to see more patients, and generate more revenue
- SLPs will be happier, which makes them provide better service

4. Scheduling

For maximum productivity through scheduling, need to:

- Make support staff accountable for full schedules each week
- Have support staff call families right away after no-show
- Reschedule canceled appointments the same week Patients should be scheduled considering the

Consider the following Scheduling Options:

Family Initiated Treatment (FIT) Program

- Done by having parents call in for individual appointments each week
- Appropriate for families who cannot commit to recurring appointments, but can schedule individual appointments

Consultative Therapy

- Done every few weeks or months as needed
- Appropriate for children who need infrequent sessions, or are in the habituation stage. Periodic rechecks are done to monitor function or update the home program
- SLPs design the treatment plan, teach the skill, and train the parents/family members to work with the patient at home
- Patient returns for a therapy session when ready for the next step

Block Scheduling

- Patients are scheduled in short blocks of time (Example: 8 weeks 8 weeks on/8 weeks off)
- Short-term increases commitment and attendance, and allows more practice and habituation of skills at home
- Blocks allow other patients to receive therapy in the off time to increase access

Family-Friendly Appointments

- Hours between 3:00-7:00 pm and on Saturdays are increased and reserved for recurrent therapy appointments
- Cancellations are decreased with increased convenience for the family

Long-Term Therapy

Need to consider the cost/benefit of continued therapy for all parties

- Some disorders cannot be corrected with therapy, but will be a chronic life-long condition
- Research shows that most progress is made in the initial stages of therapy
- Long-term therapy can overburden the family and healthcare system with minimal benefits
- Patients/family members are more likely to disengage and are more likely to cancel
- If there is a wait list, it deprives other patients from receiving services
- We devalue the profession by “practicing” with patients or keeping patients in therapy who are not making progress

What we can and should do for chronic conditions:

- Consider episodes of care rather than continuous care
- Spread out sessions to allow more practice between sessions
- Work on realistic, functional goals and then discharge
- Recheck patient periodically
- Discharge from therapy if there has been minimal or no progress
- Not allow parents/family members prescribe treatment or dictate the “dose”
- Not deliver therapy *without a reasonable expectation of achieving an outcome*

5. Waste Management

- There is significant waste in our healthcare system, which drives up costs
    - Unnecessary or costly procedures (Example: Do we need to do an entire single word articulation test for diagnosis of most mild-moderate speech sound disorders?)
    - Inefficient processes (Example: Do we need to have SLPs call families to reschedule an

appointment?)

- Focus only on what is of value to your customers and what your customers are willing to purchase (i.e., teaching a skill; teaching family to work with the patient; practice; writing a long report, etc.)
- Eliminate waste in the system by evaluating ALL processes and procedures and determining what we really need to do versus what we currently do "just because." (Example: Do we really need to create a 6 page evaluation report to start therapy?)

6. Making Staff "Partners" in the Business

- Share revenue/expense information with staff to help them to understand the threats to the business (i.e., need for later therapy hours, issues with high deductibles, etc.)
- Charts and graphs are easier to comprehend than numbers
- Share revenue/expense information with staff to help them to:
  - Feel that they have a personal stake in the business
  - See how they are doing as a team
  - Celebrate success as a group!

Summary:

With the changes of the ACA, will your program take a dive, barely survive, or thrive? We all need to make changes, with a focus on the Triple Aim. We need to:

1. Improve the patient/family experience (including increase quality and outcomes)
2. Improve the health of populations
3. Reduce the per capita cost of care

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ASHA- Evidence-Based Practice Webpage: http://www.asha.org/members/ebp/

ASHA- ICF: http://www.asha.org/slp/icf.htm

ASHA-Quality Improvement for Speech-Language Pathologists: http://www.asha.org/slp/healthcare/QI.htm

ASHA- National Outcomes Measurement System: http://www.asha.org/Members/research/NOMS/

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Patient-Centered Outcomes Research Institute: http://www.pcori.org/

Strategies for Meeting the Triple Aim of the Affordable Care Act

Worksheet

Strategy	Increase Quality or Satisfaction	Improve Population Health	Decrease Cost