RESEARCH REPORT

10 Tactics to Ensure Return on Specialty Investments

Part 3: Leverage existing specialty expertise to access new revenue streams

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RECOMMENDED FOR

Acute and post-acute care strategy leaders

READING TIME

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About this report

Executive summary

Recent developments in the health care market—such as growing inter-sector competition, the possibility of site-neutral payments, and increasingly narrowed networks—encourage post-acute care (PAC) providers to better define and promote their value proposition as a means of differentiation. These developments simultaneously offer new and exciting chances for PAC organizations to expand their roles in the care continuum and serve new patient groups.

Clinical specialization is one strategy to both guard against current threats and take advantage of future opportunities created by a marketplace in transition. Because of the unique nature of their patient populations, many PAC providers already consider themselves specialists. However, there is still significant space for PAC providers to move further into creating well-defined, high-quality clinical service lines. Embracing specialization allows providers to present a clear value proposition that can safeguard volumes by capitalizing on emerging health system needs and preferences.

For PAC providers to succeed in this strategy, a specialization must be a cohesive business venture, not just a marketing endeavor. It requires significant investment and organizational commitment. Building and sustaining a strong specialty over time means allocating dedicated resources to treating a specific patient population and driving to a high level of clinical quality. Providers must ensure that the specialty is different from and clearly, unquestionably better than competitors' offerings.

There are many benefits to a well-run specialty line. A strong clinical specialty can:

- **Drive volumes to a provider** by generating interest in the market among a wide variety of stakeholders—including case managers and patients.
- **Solidify partnerships with referrers and payers taking on risk** by achieving a high level of clinical quality and operational efficiency.
- **Enable a provider to access new revenue streams** by leveraging knowledge gained through practicing the specialty to form new business relationships.

This research report offers 10 tactics to help providers build and support specialty lines that deliver those benefits. These tactics can help providers achieve a full return on investment into specialization and successfully position themselves within the market.

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Specialization is not an end in itself. It's a means to enhance patient care and secure a critical place in the market. Program development should enable strong partnerships with referral sources, driving volume growth and inclusion in narrowing referral networks. Concurrently, a strong specialty enables an organization to explore new business opportunities amid continuing payment transformation.

This research report details 10 tactics to ensure successful return on specialty investment across three vectors. Part 1 covers how to drive volumes and reimbursement in the current, fee-for-service environment. Part 2 delves into how to make an organization attractive to referrers who are taking on downside risk, improving the likelihood of network inclusion. And part 3 looks at how to capitalize on specialty program development to access new revenue streams—often beyond the traditional payment structures of each post-acute sector.

INCLUDED IN PARTS 1 AND 2

1 **Maximize volume-driven specialty reimbursement**

1. Solidify volumes through program co-development
2. Harness specialty spillover volumes
3. Capitalize on unique payment system opportunities

2 **Strengthen the specialty's value-based appeal**

4. Address referrer cost of care priorities
5. Implement staff-driven care protocols
6. Support generalist staff with specialist experts

INCLUDED IN THIS REPORT

3 **Leverage existing specialty expertise to access new revenue streams**

7. Recapture lost volumes by expansion into new sectors
8. Fill downstream service gaps
9. Productize specialty knowledge
10. Realign traditional competencies into novel programs

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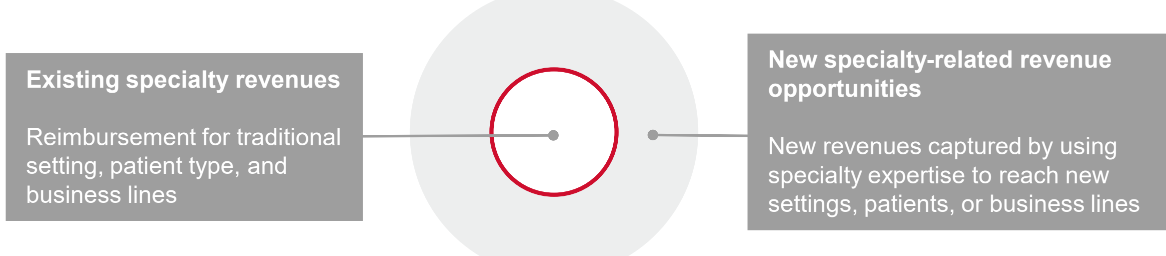
Specialties as a springboard to new opportunities

The benefits of specialization can extend beyond volume generation and partnerships within the traditional bounds of an acute/post-acute relationship. A strong specialty can also open the door to new business opportunities.

These opportunities take a variety of forms and allow post-acute providers to access new revenue streams could not previously. A well-operated specialty line can transition into a new care setting or adapt to reach new patient types. If PAC providers are sufficiently flexible, they can even establish different specialties to access funding beyond the guideposts of their traditional reimbursement structures.

Expansion of revenue sources, based on specialty care

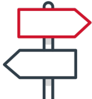


New care settings

- Extend specialty into novel setting or sector
- Capture revenue not available in traditional sector

New patient types

- Serve new patient population via existing specialty
- Expand patient base and attract higher-margin groups



New business lines

- Offer new product based on specialty knowledge
- Move beyond traditional funding sources

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Recapture lost volumes by expansion into new sectors

Armfeldt Rehabilitation (pseudonym)

IRF specializing in pediatrics, spinal cord injury, stroke, and orthopedics • Located in thr Northeast

Once a provider develops a successful specialty program, a logical next step is to extend that program to their other locations or care settings.

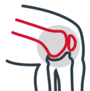
Armfeldt Rehabilitation successfully moved their specialty—rehabilitation following orthopedic surgery—from an inpatient rehabilitation facility (IRF) to a sub-acute unit to access their traditional patients in a new setting.

Armfeldt had developed significant specialty expertise in treating post-operative orthopedic patients, but changes in medical necessity requirements shifted such patients away from the IRF setting. To avoid losing that core patient group, as well as their institutional knowledge, Armfeldt partnered with a local hospital to operate a sub-acute unit specifically for post-operative joint replacement patients. The unit is a joint venture between Armfeldt and the hospital in which it is located, but accepts patients from all local hospitals. Currently, 60% of the referrals to the unit come from other hospitals.

Development of sub-acute unit to serve specialty population

Specialty expertise

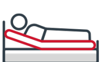
- Armfeldt Rehabilitation developed specialty line for simple joint replacement patients
- Invested considerable resources in training, protocol development, etc.
- Generated high-quality outcomes, saw strong volumes for specialty



Strategic response: Orthopedic sub-acute unit

Joint venture between Armfeldt and local hospital

Treats post-op joint replacement patients



Occupies dedicated unit with 35 beds

Receives 60% of referrals from outside partner hospital's system

Market pressure

- Change in medical necessity definition restricts volumes for simple orthopedic patients
- Most joint replacement patients sent to lower-acuity, non-specialty providers
- Armfeldt's specialty expertise no longer useful in traditional setting

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Recapture lost volumes by expansion into new sectors (cont.)

When transitioning a specialty to a new care setting, an organization must ensure that the strength of the specialty is not diluted. While care processes must adjust to meet the needs of the new setting, the same dedication to high-level specialty care must remain consistent.

To do so, Armfeldt maintained the same level of care for the patients in the sub-acute unit that they offered in their IRF, including delivering frequent, intense therapy not commonly offered in a sub-acute setting. They also followed the same clinical pathways they designed for IRF patients. Patients ambulate early and often, resulting in faster and more complete recovery than at similar sub-acute offerings.

The sub-acute unit breaks even financially, but it provides benefits by generating consumer interest in downstream Armfeldt services, such as home health and outpatient rehab. The program also strengthens referring relationships with orthopedists while enabling Armfeldt to continue to serve simple orthopedic patients.

Care at orthopedic sub-acute unit

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Fill downstream service gaps

Transitional Learning Center

3-facility system including inpatient rehabilitation and assisted living specializing in traumatic brain injury (TBI) • Lubbock, TX

In select cases, the opportunity to extend a specialty is not limited to a new sector or care setting, but also includes an opportunity to reach new patient types.

Transitional Learning Center (TLC) is a rehabilitation provider specializing exclusively in traumatic brain injury. Upon initial assessment, patients are segmented into one of four care pathways. Two pathways are aimed at returning patients to the community, and the other two intended to help more severely injured patients achieve basic physical skills.

In the past, the more severely injured patients frequently sought additional support from TLC after discharge, since they were unable to find specialized long-term care. At the time, TLC offered only short-term rehabilitation—failing to meet some patient needs and capitalize on an opportunity for programmatic growth.

1. Average length of stay

Source: Transitional Learning Center, Lubbock, TX.

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Fill downstream service gaps (cont.)

Transitional Learning Center's Tideway Facility

32-bed facility • Galveston, TX

Following a due diligence process, TLC expanded their specialty into a new care type: assisted living. They opened the Tideway facility specifically for the patients who, even after rehabilitation, would never live independently again.

In addition to moving into the long-term care space, Tideway allowed TLC to access patients they previously would not have seen—patients with traumatic brain injuries dependent on support for activities of daily living (ADLs), but who were not in need of intensive rehabilitation. Although many of Tideway's residents previously received rehabilitation services from TLC, Tideway also receives residents from other rehabilitation facilities. Texas law allows TLC's two original facilities, both assisted living facilities, to receive reimbursement for short-term, inpatient TBI rehabilitation despite their licensure.

TLC maintained not only their specialized staffing but also their community-focused care model at Tideway. While residents at Tideway are expected to live out the remainder of their lives within the facility, TLC provides many opportunities for residents to participate as fully as possible with activities in the community.

Tideway assisted living facility

IMAGE CREDIT: TRANSITIONAL LEARNING CENTER.

Profile of Tideway's target patient population

Primary resident needs require **long-term support**, not rehabilitation

Residents must have TBI, require **assistance with ADLs, IADLs**[1]

Many, but not all, residents **previously received rehab** therapy at main TLC facilities

1. Instrumental Activities of Daily Living.

Source: Transitional Learning Center, Lubbock, TX.

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Productize specialty knowledge

Oncology Care Home Health

Consulting and educational materials provider to home health agencies looking to add an oncology specialty line • Wilmington, DE

Extending a specialty to access new patients or new care settings can effectively achieve program growth. Another less common approach to growth is to think beyond care delivery and productize hard-earned specialty knowledge.

Originally founded by a home health nurse with an oncology background, Oncology Care Home Health developed extensive training materials and clinical guidelines for staff over 16 years of specialized clinical practice.

Recognizing the value of their intellectual property, they began offering training modules, clinical protocols, operational guidance, and marketing strategy (along with as-needed consulting services) to other home health providers wishing to develop a specialty oncology line.

Oncology care training collateral

Parenteral opiate therapy

Purpose: To ensure safe administration of parenteral opiates administered in the home

General information:

1. Parenteral opiates can be administered either intravenously or subcutaneously
2. A subcutaneous site for opiate delivery must be changed every 3 to 7 days; a subcutaneous site is best maintained when the hourly volume of the opiate infused does not exceed 2 mL/hour

Operational support system

Experienced clinicians
Specialized nurses and physicians with significant experience in the field available for consultation

Accessible by phone
Majority of communication is telephone; one-off calls and standing phone appointments

Unlimited duration
Extensive support provided during implementation with continued resources available on an ongoing basis as needed

Source: Oncology Care Home Health, Wilmington, DE.

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Productize specialty knowledge (cont.)

Walgreen Company

The product offered by Oncology Home Health meets a traditional delivery system need. However, understanding specialty lines in terms of nontraditional collections of services is a newer idea. It's a strength of companies such as Walgreens, which has been successful assembling sets of otherwise unconnected services into products aimed at meeting a specific market need.

Walgreens is one of the largest drug retail chains in the United States, with over 700 locations around the country and 372 Take Care Clinics. Created in 2012, Walgreens' WellTransitions^{TM} program is a set of services, such as medication reconciliation and follow-up phone calls, bundled together and marketed to health systems as a way to manage high-risk patients and reduce rehospitalizations and avoidable utilization. Initial response to the program has been strong. Patients enrolled in the program experienced a 5 point lower readmission rate over six months compared to eligible patients who did not enroll.

Post-acute providers have a similar opportunity to bundle their existing tasks into new service lines. By doing so, they can access new patients and revenue streams. That is the root of the final tactic of this book: "productizing" specialty expertise. This means understanding the value of the individual tasks an organization offers, then realigning them into service lines that not only allow access to new patients, but also create new reimbursement opportunities beyond the constraints of the post-acute sectors.

WellTransitions^{TM} program components

Source: "WellTransitions©," Walgreen Co., http://healthcare.walgreens.com/healthcare/business/ProductOffering.jsp?id=wellTransitions.

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Realign traditional competencies into novel programs

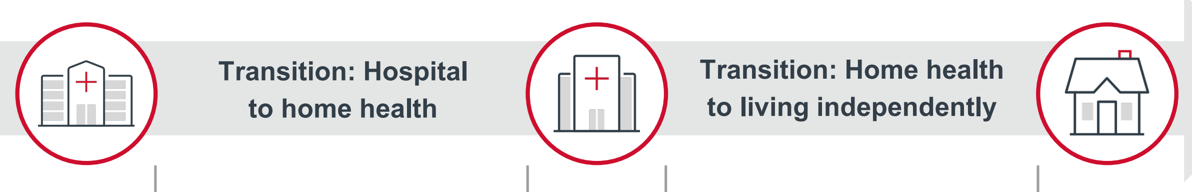
Visiting Nurse Association of Ohio

Home health provider specializing in readmission reduction and behavioral health • Cleveland, OH

Visiting Nurse Association of Ohio assembled their existing competencies to build a transitional coaching program for all high-risk patients. This program is for all patients, regardless of their eligibility for Medicare's home health benefit: and is funded through partnership with a local ACO. This enables Visiting Nurse Association of Ohio to build new relationships and access an entirely new revenue stream.

The program provides support for patients transitioning from the hospital to home or from home health to routine care. It offers two in-person visits and six phone calls over the 60-day period following discharge.

Many patients enrolled in the program do not qualify for home health coverage under Medicare because they are not homebound. However, they are high-risk, and without dedicated support at home, they are at risk for a readmission. As such, when presented with the planned transitional coaching program, an ACO agreed to pay a $250 case rate for these services for the top 10% of their most expensive Medicare beneficiaries.



Designed for high-risk patients

- Serves 10% most costly Medicare patients
- Program created to reduce expensive hospital readmissions

Based on intensive patient interaction

- Nurses visit within 24 hours of discharge
- Nurses make two visits and six phone calls during first 60 days post-discharge

Reimbursed directly by ACO

- ACO pays case rate of $250 for these services
- Many patients not eligible for Medicare coverage of home health services

Source: Visiting Nurse Association of Ohio, Cleveland, OH.

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Realign traditional competencies into novel programs (cont.)

FirstLight Home Care

Non-medical home care provider specializing in readmission reduction • Cincinnati, OH

The opportunity to assemble existing tasks into a new service line and use the resulting program to access new revenue streams is not limited to home health. FirstLight Home Care, a non-medical home care provider, took a similar path when developing their Readmissions Rescue program. The services FirstLight brought together, while not medical in nature, have a significant and proven impact on readmissions.

Understanding the impact of social determinants on health outcomes, local ACOs have funded the Readmission Rescue program for their Medicare patient populations—expanding FirstLight's client base. Previously, FirstLight, as a non-medical provider, served only private-pay clients.

Both Visiting Nurse Association of Ohio and FirstLight successfully leveraged a different-in-kind specialty type to access entirely new patient pools and revenue streams. The flexibility demonstrated by these programs is increasingly important as referrers and payers experiment with care management program design and funding.

Potential of non-medical home care

Factor affecting readmission	Self-care capability	Follow-up appointment	Home environment
Non-medical home care interventions	Offer patient education, assist with medication administration, and lead exercise regimen	Schedule follow-up appointments with physician and provide safe, timely transportation	Monitor vital signs remotely and offer personal emergency response system

Additional investments to create separate service line

Targeted protocols

Developed internally, guided by on-staff RN to reduce readmissions

Dedicated staffing

RN leads program nationwide with specialty care managers present at each branch

Technology acquisition

Upgraded data systems for greater compatibility with hospitals and easier access for physicians

Source: FirstLight Home Care, Cincinnati, OH.

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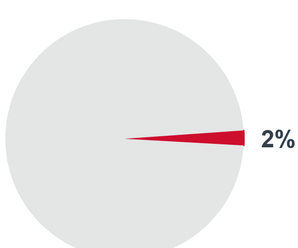
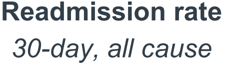
Realign traditional competencies into novel programs (cont.)

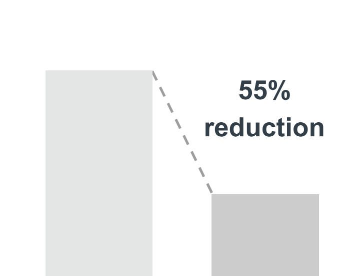
Both Visiting Nurse Association of Ohio and FirstLight have seen positive clinical results from their unique programs and focused their impact on readmission rates. To be successful with a new service line built from traditional competencies, it is critical that the new line must maintain the same level of dedication and focus as any other specialty. It must also continue to meet the hallmarks of a specialty as described throughout this report.

Readmission rate
30-day, all cause

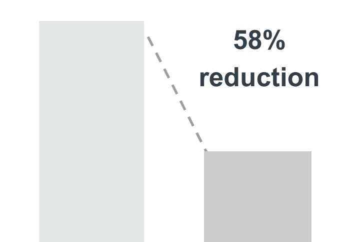




ED[1] Visits



Readmission rate
30-day, all cause



Appeal to physicians

"Physicians are making referrals like crazy because they didn't know these services were an option before."

Dana Traxler, Regional Executive Director
VISITING NURSE ASSOCIATION OF OHIO

DATA SPOTLIGHT

Building volumes

1,000

Patients currently enrolled in FirstLight readmission rescue program

STUDY IN BRIEF

For more information

To learn more about how to access new revenue streams by building a specialty service line from an organization's existing skills, access the Post-Acute Care Collaborative's workbook, Leveraging Traditional Competencies to Meet New Market Needs, available on advisory.com.

1. Emergency department

Source: Visiting Nurse Association of Ohio, Cleveland, OH; FirstLight Home Care, Cincinnati, OH

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Conclusion

As the health care industry evolves to incentivize long-term population health, new specialties focused on patient management continue to emerge. In addition, patients are becoming more complex, and specialties must maintain the clinical strength of a narrow focus, while providing care for a whole person rather than just a specific diagnosis or impairment.

Post-acute providers who do not recognize this change will fail to achieve the initial partnership and growth goals that drove their desire for specialty program development. Concurrently, new incentives provide opportunities for post-acute providers to offer services they would not have previously offered for financial reasons.

While the specific types of specialty offerings evolve, the importance of strong clinical programs remains critical for future growth amid industry change. Organizations must recognize these shifts and ensure their specialties keep pace.

1. Controlled for age, length of stay.

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Want more on post-acute strategy?

The Post-Acute Care Collaborative has developed numerous resources to help program leaders secure long-term growth and market share. The resources detailed below supplement the information in this publication. All of these resources are available in unlimited quantities through the Post-Acute Care Collaborative membership.

Available within Post-Acute Care Collaborative membership

Resource library: Care Pathways

Standardized care protocols can help reduce unwanted care variation and ensure high quality outcomes across an episode of care. This resource library provides a collection of implementation guidance and example protocols for specific conditions commonly managed in both acute and post-acute settings, including cardiovascular, neurological, orthopedic, and pulmonary.

Research report: Telehealth in Post-Acute Care

Telehealth continues to garner interest from providers and payers due to its potential to expand access to care, improve quality, and reduce costs. While acute care systems are currently leading the charge on telehealth implementation, it extends to the post-acute space as well. This research report will help post-acute providers understand the current market, payment mechanisms, and investment considerations for telehealth programs in order to help inform future strategy.

Implementation resource: Care Transitions Mapping Tool

The Care Transitions Mapping Tool provides insights on patient movement between acute and post-acute providers within 30 days of discharge from the acute care setting. Providers can use this data to better understand relationships between acute and post-acute care partners. They can also learn about opportunities to forge new partnerships that improve outcomes and reduce cost of care.

Implementation resource: SNF Benchmark Generator

The Skilled Nursing Facility Benchmark Generator provides Medicare benchmarks so you can compare your performance to that of your peers across an array of financial and utilization benchmarks. Providers can customize a cohort to compare their own performance to others in the same market or to SNFs with similar characteristics in other markets.

Contact us at programinquiries@advisory.com or visit advisory.com/pacc to learn more.

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