VOICES

Ian Juliano, CEO, Trella Health

In this Voices interview, Home Health Care News sits down with Trella Health CEO Ian Juliano to get his take on today's market challenges for home health and hospice providers, why coordinated care is well within reach, and how providers can use data to prove their value and grow their businesses.

What would you classify as the top three challenges home health care providers today are facing during your experience as Trella CEO? How has the operating environment for home health agencies changed and how has the environment for health care technologies changed?

Ian Juliano: The No. 1 challenge is home health agencies capturing the value they create in this new world of value-based care. I like to tell a story about a hospital-admitted Medicare patient, who required a heart transplant, but the hospital had only been paid for three days by CMS. The hospital now had an acute, complex patient on their dime, and after several months this patient was singularly putting a dent in the hospital's income statement. A home health agency went to the hospital and said, "We think we can develop a plan to stabilize this patient at home until the organ arrives." Together, the home health agency and hospital worked out an elaborate care plan for home health. For several months they stabilized the patient at home and when the organ arrived, the patient had a successful transplant. It's pretty incredible when you think about it and has a lot of ramifications in its own right. My question for the home health agency was: "Please tell me you found a way to capture some of the hundreds of thousands of dollars you saved the hospital during that time." They hadn't. They were just collecting the standard [reimbursement]. It just doesn't make sense. If you're doing that much work and providing that much value, you must capture it.

> "The No. 1 challenge is home health agencies capturing the value they create in this new world of value-based care."

No. 2 is the episodic structure, which is not right for home health. In many states, when comparing 30-day hospitalization rates versus 90-day hospitalization rates for high acuity circulatory and respiratory patients, you'll see in those first 30 days, about 20% of patients were hospitalized or re-hospitalized. These are very sick patients, and most of these cases were unavoidable. However, when you extend that, the 90-day hospitalization rate can exceed 60%, as much as three times what it was in 30 days.

Since the average home health episode is 40 to 45 days long and a “care vacuum” is being created; we don’t think that other 40% is happening in that 10- to 15-day timeframe. We think it’s happening post the home health episode, when that care vacuum is created. When you talk to home health agencies, it’s clear they don’t have enough nurses and they have to be mindful of a potential audit for stacking too many episodes, even if the patients clearly need it. If you do the math, with the severity of the patient, the high costs of a hospital, and then the explosion of professional claims that go with it, you could be talking about a $50,000 readmission. I don’t think most hospital execs would argue that. Compare that to getting those patients an additional $4,000 home health episode, which would outlast that period. That’s a no brainer because a lot of those patients won’t go back to the hospital in that scenario. When you look at the huge ramp that’s created in a home health care vacuum, it’s just endemic of this issue we have with the episodic structure, which isn’t right for home health.

The third challenge is the nursing shortage. There are a lot of reasons for the shortage, but I think the biggest one is that basic economics don’t support it. The overall margins of most home health agencies are very slim, even though most agencies run pretty lean. Little to no margins naturally suppresses wages across the board, and with other career options, the nurses go elsewhere. In fact, one could argue that most of the medical profession doesn’t pay nurses enough, and due to the shortage, they are overworked, which leads to turnover. Until home health agencies start capturing more of the value nurses create, it’s going to continue to be very difficult to attract and retain nurses. The other big cause is the episodic mentality, which encourages “cranking” through as many patients as possible as quickly as possible. This isn’t why most caregivers (including doctors) entered the medical profession. [Today] they can’t spend adequate time with their patients, and they are under constant pressure.

Where can providers find opportunity in today’s market relative to all the challenges?

Juliano: I think a lot of it involves thinking outside the box. The opportunities come from changing your ratio of community versus institutional care and focusing where you have historically performed well, while being able to demonstrate value. I think the future is not only finding ways to demonstrate value but finding ways to take risks. One example is a provider that’s very innovative and has large institutional backing. They go to hospital systems and say “As a system, you paid X last year for all of your home care. We’ll do it for Y if you let us handle the discharge process.” They’ve done phenomenally well, because they know they can do a better job than the hospital can. As a matter of fact, the hospitals came to them and said, “Hey, can you take our SNF business too, please?”

Another example is a client of ours who acquired a special needs plan, a SNP. They now own an insurance plan. They’ve been in the home health business for many years and they said, “We can care for these rural high-acuity patients much better than the average Medicare Advantage plan.” As a

“When you think about the cost of a home health episode versus going back in the hospital ... it’s a no brainer.”

matter of fact, the beauty is now they’ve completely moved away from an episodic structure. They use a very different model, based on care planning. They determine if it makes economic sense to send a home health nurse on an ongoing schedule. If the numbers and results support sending a nurse every other day, they’ll go every other day. It’s their money and if it’s paying off and keeping that patient out of the hospital, it works for them.

There’s increasing focus on care coordination in this push toward value-based care. How can providers ensure they’re developing the right referral partnerships to provide the best outcomes?

Juliano: I have to say our data. We have data on home health, hospice, SNF, and hospitals, and we break it down by diagnostic category, acuity level and results. It’s not just the 30-day readmission rates; it’s hospitalization rates, and more importantly, the total cost of care over any timeline that allows them to see the outcomes.

It comes down to care plans. We looked at two skilled nursing facilities, A and B. They both take patients from Grady, a safety net hospital in downtown Atlanta. Risk adjusted through the CMS HCC scoring model, what we find is that A’s patients, over the course of a year, consume approximately $26,000 less in total healthcare consumption than B. You tell this to an insurer and their eyes pop out of their head.

Why is A doing so much better than B? A is doing better care plans. They use a factor of almost five times more home health on average than B. They use more skilled nursing as well. When you think about the cost of a home health episode versus going back in the hospital for these types of patients, it’s a no brainer. They each have about 50 high-acuity patients, and if you were to simply narrow the performance gap between B and A, you can save $1.4 million a year just in fee for service.
There are hundreds of opportunities like that across the state of Georgia and there are thousands of opportunities like that across the U.S., but it takes coordination.

We have three of the top 10 SNFs now as clients with our SNF product, which we rolled out a few months back, and one of them said point-blank: “We have to understand home health better, because we’re being held accountable. We need to be selective about who we pick and we need to coordinate tightly.” What we tell the flip side, the home health and hospices is: “SNFs are in worse financial shape than you guys in terms of making money. Their 30-day hospitalization rates are astronomical; some of them are as high as 40% or more, and as such they risk being cut out of the hospital networks. They are sending hospice- or home health-appropriate patients to the hospital, or home without

home care, and they're ending up at the hospital. SNFs are understaffed and are not always very good at determining appropriateness for hospice or home health care. Go do it for them. Free up their overworked nurses and improve their hospitalization rates, while gaining a valuable stream of patients. If you have the data (via our solution) on SNF performance, it's only a matter of time before the hospitals have it too."

We've had home health and hospices just knock it out of the park, because they've gone to the SNFs and said, "We'll improve your hospitalization metrics and make you a more viable player in this hospital network, while taking a difficult process off your hands." SNFs love it.

Given this increasingly coordinated care environment, do you see providers staying in their lanes moving forward or expanding into other post-acute channels?

Juliano: What you'll start to see is very tightly integrated partnerships beyond just handing off patients. There will be assessments and care coordination coming from both sides. Those hospice and home health agencies with our data are able to go in and see details on SNF performance. They're able to say, "Here's how we think you could be better leveraging home health and hospice to meet your goals and become a much better performer." That's informal but still integration.

I don't know how much we'll see hospitals increase their ownership of post-acute, but we'll see a lot more integration or ownership of different post-acute settings and very tight partnerships and more risk assumption. You'll also see payers starting to acquire assets very strategically on the provider side.

Lastly, there are signs that data exchange across caregivers in different care settings is finally beginning to pick up steam.

Teamwork is obviously an important part of business today. How are teams using systems and the Trella platform today to grow their businesses and make them more efficient?

Juliano: Enterprises are making huge investments in data-driven growth. Clinicians have to partner with the sales and marketing execs to provide a highly technical, consultative sale. You can't rely on relationships anymore. What we see time and time again, is how our data helps them prepare for hospital meetings. The hospitals are just blown away.

Our clients get meetings with the heads of discharge planning, and even the C-suite to say, "You've got certain objectives you need to meet. Here's what's happening to your patients and here's how you can leverage post-acute care strategies much, much better." It's a highly technical sale involving senior

management, the head of sales and marketing, the reps, and the clinicians. They have to develop a comprehensive story.

A perfect example we noticed countrywide was around a $2.5 billion a year lost revenue opportunity for the home health industry. Almost 40% of patients that were given very clear inpatient discharge instructions to enter home health never did. Those patients were more than 50% more likely to be readmitted in the next 30 days and their costs curves go way up. This was one of the earliest ways that we could help home health agencies prove their value and make the sales call a source of value for the referral partners.

> **“You can’t rely on relationships anymore. What we see time and time again, is how our data helps [enterprises] prepare for hospital meetings. The hospitals are just blown away.”**

They would say, “Something’s broken here. It is not that all these patients don’t qualify for home health or are refusing. We need to take another look at the overall referral process and figure out a way to move these numbers up.” The hospital would say, “Hallelujah. Somebody is finally giving me data on ways to move the needle on my performance metrics. If I’m going to partner with someone, it’s going to be these guys.” The rep couldn’t do that on their own. It took the entire company to make that type of sale.

We love it when our clients have licenses for clinicians as well. We chose not to charge per user to allow everyone in the organization to have access to the data. When you see the clinicians getting involved with the data and the sale, we know that it’s going to be phenomenal. We highly encourage everyone to get involved in understanding the solution. Our solution shows more than where they outperform their peers, and where they can focus and have a natural advantage. It also goes down into individual operating metrics, both on the sales and business development side, as well as the clinical side.

Why is a platform like Trella particularly useful for sales and marketing teams in light of the changing payment landscape?

Juliano: For the Patient-Driven Payment Model (PDGM), it’s more important than ever that home health agencies understand which patients they are uniquely suited to care for. It allows them to identify and target the high potential referral sources that align with their agency’s competitive differentiators in the market.

Regarding fee for service, we felt that focusing on the right type of patients from the right referral sources would allow better management of PDGM and avoid issues stemming from changing the patient source mix.

For risk-bearing referral partners and Medicare Advantage plans, being able to map out and demonstrate a superior longer-term patient cost and outcomes trajectory by agency will be critical. For example, if a high acuity circulatory patient enters Agency A or Agency B, what are the respective projected hospitalizations for that diagnostic profile, what are the rates of other adverse events, and what is the total healthcare cost that patient will incur over the next year (or any other timeframe) if they enter Agency A or B, risk-adjusted and based on historical performance?

Being able to demonstrate your value with irrefutable, highly compelling data is critical. It will be important for fee for service as well, because when the hospital is fighting for lucrative commercial patients, your ability to provide data to a hospital that says, "We provide outstanding cardiac care, and no one's better suited to deliver better outcomes at lower costs for your coveted commercial patients. We are the perfect combination to dominate this market," is a huge advantage.

Utilizing the data to show where an agency really has an advantage, utilizing it to know which referral sources to go to and then being able to demonstrate value so the agency can obtain reasonable, sustainable contracts and participate in the upside, is the key to winning in this new paradigm of value-based care.

Can you talk a little bit about some of the things that you're working on at Trella that will help providers become more efficient in their operations?

Juliano: We've spent over a year working on a new solution for home health and hospice agencies which will be generally available later this year. I think it is one of the coolest things in health care technology today, and it's coming to home health and hospice first! I started this company to empower post-acute providers, because I felt they have historically been underserved from a technology standpoint. When I first started looking at this industry seven years ago, I noticed that for every dollar that was spent in hospital IT, you were lucky if 10 cents were spent in post-acute. I saw the opportunity to bring innovation to a growing industry that is massively underinvested in and underserved. We developed our current marketing intelligence solution, which provides data to answer the critical questions required to succeed in value-based care.

In our newest solution for home health and hospice, we set out to design a system that helps guide sales, marketing and business development reps through their critical workflows more efficiently and more effectively. It takes our current solution that is somewhat interactive today, but still a data source, and turns it into a valuable workload driver that goes beyond any CRM out there.

The sales reps, managers and senior leadership in our new solution will have the power to manipulate and customize the data while collaborating across internal and external teams in an entirely new way.

> “You can’t rely on relationships anymore. What we see time and time again, is how our data helps [enterprises] prepare for hospital meetings. The hospitals are just blown away.”

It’s called Marketscape for Home Health and Hospice, and it’s a continuation of the transformation that we’re enabling for our post-acute providers.

I just can’t tell you how incredibly flexible it is. It’s extremely customizable for each individual user.

It allows management and the end-user to collaborate on where to target, how to target, what to say and how to get there.

Anything we launch has been practically co-designed with our end users. We’ve had a large number of users that have been using our market intelligence solution almost from day one involved in the new Marketscape solution. I can’t tell you how grateful we are to all of our beta partners who have been very involved in this process from a very early stage.

Can you tell me a little bit about the name change from Excel to Trella? What was the thinking behind it?

Juliano: One of the problems with “Excel” was its association with spreadsheets and reports. While our solution is built on the industry’s most complete claims data from CMS, we do so much more than provide raw data. We wanted to find a name that really signified our passion for making a difference in health care and for helping our clients meet their missions.

We’re excited to now be Trella Health. The name Trella comes from the word trellis, which is a strong, reliable support system that promotes growth. For us, this represents supporting our customers’ growth by helping them gain more patients, connect with the right partners, and form new networks.

Editor’s note: This interview has been edited for length and clarity.

Trella Health (formerly Excel Health) is a data-driven technology solution that empowers post-acute care providers and their referral sources to work together across the care continuum. Learn more at www.trellahealth.com.