

McKnight's panel: A brighter future for SNFs

By Tim Mullaney

Long-term care providers can harness healthcare reform to become more profitable and competitive than ever, but success is not guaranteed. Proactive organizations with advanced technology tools already are separating themselves from those without them, some of the sector's most esteemed leaders asserted at a recent *McKnight's* panel discussion in Dallas.

Titled "Managing from inside the storm: How to get your facility safely from where it is to where it needs to be," the discussion acknowledged that providers truly are in the midst of a violent storm. Threats and challenges appear from all angles.

New payment systems have providers especially concerned — and it's easy to see why, said Mark Parkinson, president and CEO of the American Health Care Association/National Center for Assisted Living. The industry-wide profit margin is about 1.8%, the leader of the nation's largest long-term care provider association said.

Parkinson praised how providers adapted to past payment pressures by adding Medicare-covered rehabilitation services. The shift helped compensate for "dramatic" Medicaid underpayments. But he cautioned that the rehab dollars are not secure. Entities that increasingly are controlling provider payments see the Medicare margin as a "business opportunity," he explained.

"Whether it's managed care or accountable care organizations or you-name-it, they're going to take some money out of that system for themselves, to the detriment of our residents and operators," Parkinson predicted. "The marketplace is cruelly efficient."

However, all is not bleak. The sector is "not in a horrible position" but "needs to get through the next iteration" of payment reform to keep thriving, Parkin-



Photos: Rick Dalton

son said. He and the other panelists shared their advice to help providers thrive.

McKnight's Editorial Director John O'Connor and Editor James M. Berklan moderated the discussion, which was a part of Symposium 2014, American HealthTech's annual user conference.

Managed care scare

The push toward managed care has been gaining steam, panelists observed. However, many providers have been able to stick with more traditional payment methods. Even some "huge chains" still rely exclusively on basic fee-for-service, and the sector's general unfamiliarity with managed care is "pretty scary," said Susie Mix.

As president of Mix Solutions, she has helped guide many providers into the managed care world, where health maintenance organizations and similar entities have contracted with states to administer Medicaid and Medicare benefits. To achieve the efficiencies

Top row (left to right):

Josh Luke, Ph.D.
Founder, National
Readmission Prevention
Collaborative

Mark Parkinson
President & CEO, American
Health Care Association/
National Center for Assisted
Living

Bottom row, left to right:

Susie Mix
CEO, Mix Solutions

Terry Sullivan, M.D.
Chief Medical Officer,
COMS Interactive

Teresa Chase
President, American
HealthTech





needed to make money, managed care organizations “bother us every day,” Mix joked.

True to their name, they in fact are hands-on because they “manage” their contracted providers, Mix said. But tracking and delivering the metrics that are so important to MCOs, and coping with the pressure to treat patients more quickly and cheaply, are not the only managed care challenges. Slower cash flow is another, Mix warned. She has seen facilities take out lines of credit to meet payroll while waiting on managed care dollars.

American HealthTech President Teresa Chase also zeroed in on this issue. Managed care organizations will have “a huge impact on the revenue cycle” of providers, she said. Savvy long-term care leaders should be seek-

ing technology solutions to help with revenue cycle management, and this is a major emerging focus of AHT, she noted. Providers can gain a distinct advantage by asking themselves “how do we use tech to get out ahead” of possible payment snafus and other managed care turmoil.

Chase encouraged a confident approach to managed care. It’s not a new concept, and MCOs “are not cutting edge,” she said, so providers shouldn’t be intimidated when approaching them.

Partnerships for value

Of course, managed care is not the only game in town. The Affordable Care Act created a variety of new models, such as accountable care organizations. Like managed care organizations, ACOs and similar initiatives are changing

incentives, panelists noted. They are seeking to reward providers for integrating services across the continuum to treat people at the lowest appropriate care level and in a patient-centered way, summed up Josh Luke, Ph.D., FACHE, founder of the National Readmission Prevention Collaborative.

The new and largely untested payment systems might create anxiety for providers, but they also hold enormous promise, several panelists emphasized.

“It’s a very positive, exciting time because we’re reforming a very broken system,” said Terry Sullivan, M.D., chief medical

officer at COMS Interactive. He cited an Institute of Medicine study that found about 30% of care delivered by the U.S. health-care system is basically of no value.

“We’re seeing the benefits of what happens when we collaborate and come together,” added Chase.

Skilled nursing facilities should actively be seeking out partnerships with hospitals and other organizations, so that the SNFs are preferred providers in the integrated healthcare systems forming around the country, the panelists all agreed.

Some SNFs still have their “head in the sand,” and they will be the losers in the future, Luke said. He shared the example of a California hospital that narrowed its SNF network from eight to three facilities. The excluded facilities did not make any changes after the hospital said they were “not good enough,” Luke said.

SNF initiative needed

They should have seen “it’s time to panic.” Luke imagines some nursing homes could be converted exclusively to custodial care and given a nominal Medicaid boost to keep their doors open. These “have-nots” will be the “needed but not preferred” facilities, he predicted. It would be similar to the existing situation in the hospital sector, he noted.

To avoid becoming a “have-not,” SNFs and other post-acute providers need to be highly proactive, Luke stressed. They should consider remote monitoring, genetic testing and other specialized services, should upgrade software and innovate, he urged.



“If you wait until you’re excluded from the network, you’re too late. The party’s probably over.”

Mark Parkinson
American Health Care Association/National Center for Assisted Living

Parkinson was even more blunt: “If you wait until you’re excluded from the network, you’re too late. The party’s probably over.”

Technology’s role in helping long-term care providers forge these partnerships goes beyond simply having robust software in place, Chase explained. Providers need to have a mindset of “pushing the envelope” with what information they share, and they need to do more than give

data to prospective partners, she said. Rather, they should determine what is valuable to a hospital and focus on using data to craft a relevant message. That is, long-term care providers increasingly will need to have analytics capabilities to turn data into “valuable statistics,” and then use those stats to “tell their story over and over again” to prospective partners,





she explained. This persistence will pay off when the hospital recognizes that it indeed does have needs that the SNF can address. To aid in this, nursing homes should consider hiring a health information management professional who can “mine for some of the gold” that facility systems already have captured, Chase said.

Readmissions realities

Hospital executives currently might not care much about how a skilled nursing facility could help reduce the hospital's readmission rate, Luke said. However, he believes that hospitals ultimately will see how the readmissions issue is a central component of the ACA's efforts to alter payment incentives. So preventing avoidable rehospitalizations should be a “top priority” for SNFs.

Another reason to prioritize readmissions: Managed care organizations are highly focused on this metric, Mix said.

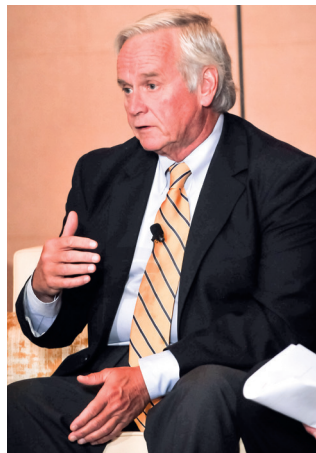
While skilled nursing facilities should promote good readmissions stats to hospitals and other partners, Chase thinks they also have to look within. Administrators should sit down with nursing staff and talk through outcomes reports, sharing data to drive better outcomes. And leadership should reward staff for improved performance.

“This is an area where we can build metrics that are not only connected to patient care but what staff members are doing,” she said.

Coping with shorter LOS

The need to reduce hospital readmissions is only one effect of the push for more efficient care — SNFs also are under pressure to get short-term rehab patients in and out faster.

“Length of stay is the major issue that the sector faces,” Parkinson declared. “Can we keep that decline at a reasonable rate and will increased patient volume make up for that reduction?”



“It’s a very positive, exciting time because we’re reforming a very broken system.”

Terry Sullivan, M.D.
COMS Interactive

Parkinson wants to see more data on how shorter length of stay affects patient outcomes. He

doesn't believe that all discharge decisions are “necessarily made on clinical grounds,” and he said anecdotal evidence suggests many people could do better with a few extra days of therapy.

“I’m not just being a shill for the industry,” he asserted, saying that he was thinking back to when he and his wife ran their own facilities in Kansas and Missouri.

Sullivan was more bullish on shortening length-of-stay. The practice of keeping patients for exactly as long as a particular payment system allows suggests that there is inefficiency to be rooted out, he argued. For example, in one facility he described, a Medicare patient would be admitted for 40 days and a patient in the Kaiser Permanente managed care system would be out in 15 — and Sullivan believes that their outcomes were comparable.

Part of Kaiser's approach is to have integrated points of care, including in the community, to keep services flowing while enabling people to move more swiftly through the continuum. Beefing up technology could allow a post-acute company to be a “virtual Kaiser,” Sullivan proposed.

“How much technology? Everything possible,” he said. “I’ve got to have an EMR, a disease management clinical capability, an analytic capability, to be connected to everybody both upstream and downstream. I’ve got to talk to my insurance com-

panies, be part of networks. I’ve got to do it all, because this is all changing so quickly. I know the world is going to look like Kaiser ... it’s not going to look like 40 days.”

From a big-picture standpoint, Sullivan is not as concerned with rehab LOS, but rather the fact that these patients generally are declining in their final years and account for a huge proportion of the nation's total healthcare costs. A key to reducing this cost is keeping these people out of the hospital in their last three years, and long-term care providers are front-and-center in this effort. For this reason, he thinks “post-acute for seniors is going to be the solution” for improving the inefficient U.S. healthcare system.

“There’s absolutely no reason nursing homes can’t take charge and manage that population that’s costing all the money,” he said.

More complexity to come

The discussion showed that long-term care providers already are grappling with highly complicated situations, and the panelists suggested there is more complexity to come. For instance, Parkinson thinks other metrics will gain the same prominence as readmissions. Increasingly sophisticated managed care organizations will begin to look at “difficult things like staff turnover and resident satisfaction,” he predicted.

The good news is that providers will be able to rely on, and help drive the development of, more advanced technology. Interoperability is “the next frontier,” Chase said. But operators need to keep informing technology providers about evolving needs, she added: “We want to know what you’re facing and what we need to do and do differently.”

So while the operating climate may get rougher, Sullivan said he believes that surviving organizations ultimately will be stronger for weathering the storm.

“We have the patients, the capability, the tools,” he said. “I’m very optimistic as to where this is all heading.” ■