Transitions of Care: Charting a Course to Better Health, Better Interoperability and Better Business

An Executive Roundtable of Key Post-Acute and Senior Living Executives

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Bob Van Dyk
President & CEO
Van Dyk Health Care

Executive Summary

The Challenge

There is a new dynamic between acute, post-acute care and senior living providers. Attention to accountability in quality reporting and payment (i.e., value-based purchasing) has incentivized hospitals and health systems to ensure that care coordination for discharged patients continues long after patients leave their setting. At the same time, post-acute care providers – facing their own payment and practice reforms – must manage communication and data exchange with acute care and other community providers to reduce avoidable hospital readmissions and provide quality care. Add in senior living communities, which are caring for frailer patients while needing to ensure safe and effective care transitions both inside and outside their walls.

It feels like a perfect storm is brewing.

In October of 2016, 14 key executives from various segments of the post-acute care and senior living industry met in a roundtable discussion at the American Health Care Association/National Center for Assisted Living (AHCA/NCAL) Annual Convention & Expo in Nashville, TN for a Provider Executive Roundtable to share their observations, challenges and innovations surrounding increasingly complex care transitions.

The Bottom Line

Acute, post-acute and senior living providers are in the middle of a revolution on how healthcare is delivered. The most significant includes regulatory and financing changes and new collaborations between acute care, post-acute care providers, senior living providers, new payer entities, and the trend toward home and community-based post-acute care services. This new complexity, coupled with mandates brought on by the Affordable Care Act (ACA), makes transitions between care settings more important – *and more challenging* – than ever.

The Takeaway

Providers have a choice: They can either be the disrupted or be the disruptors by implementing new, innovative care transition models – *and scaling them effectively* – to not only change their own organizations but to revolutionize the entire healthcare delivery model.

Roundtable Participants

Scott Adkins	CFO, Magnolia Manor
Fred Benjamin	President, Skilled Nursing Division, Lexington Health Network
Matthew Cannon	Vice President, Business Development, COMS Interactive
Teresa Chase	President, American HealthTech
Peggy Connorton	Director, Skilled Nursing Operations, Covenant Retirement
Boyd Douglas	President & CEO, CPSI
Hill Fort	COO, Magnolia Manor
Brandi Meadows	Administrator, Annandale Village
Matt Moore	COO, Southwest LTC
Ronald Payne	CEO, Southwest LTC
Neil Pruitt	CEO, Pruitt Health Care
John Shafaee	President, Medtelligent
Bob Van Dyk	President & CEO, Van Dyk Health Care, Inc.

Moderators

Charles (Chuck) Czarnik	Vice President, HIT Strategy and Support, Brookdale Senior Living
Joanne Erickson	Editor-In-Chief, Provider magazine

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>
> Neil Pruitt
> CEO
> Pruitt Health Care

Introduction and Background

The post-acute and senior living care continuum has undergone a dramatic transformation since the implementation of the Affordable Care Act. There is now a national trend toward fewer and shorter inpatient hospital and post-acute facility stays, and increased discharges to home with home health or other community-based services.

In recent years, greater attention has been focused on improving the patient experience of care; improving the health of populations; and reducing the cost of care. Traditional post-acute care settings generally include skilled nursing facilities (SNFs), inpatient rehabilitation facilities, assisted living and independent living communities, and home with home health services.

As new models and settings emerge, driven in part by regulatory and financing changes, and growing support for community-based alternatives, new challenges and opportunities arise in ensuring smooth transitions of care between previously "siloed" care settings. In response to the changing landscape, post-acute and senior living providers are working with hospital and healthcare systems, as well as payers, to ensure care transitions flexibly meet the needs of patients and residents across the care continuum.

One area that holds promise for synergies between the various providers are care transitions, or the movement of patients from one healthcare practitioner or setting to another as their conditions and care needs change. These may include transitions from hospitals or nursing homes to assisted living, independent living communities or home.

This year's executive roundtable once again gathered top executives and leaders in the post-acute and senior living industry to discuss the state of the industry, this time focusing on the opportunities and challenges of care transitions. The consensus is that there are three

fundamental areas that impact care transitions in both post-acute and senior living settings:

Better Interoperability Leading to Collaboration and Communication

As people, funding, and resources move more fluidly between disparate groups of providers, the care systems can potentially align to support the shared mission of providing the right care, at the right place, at the right time. In order to improve care transitions from the hospital to other settings and reducing readmissions, many healthcare providers recognize the value of working together with their community partners to coordinate better care transitions.

Better Care Leading to Quality Outcomes

The ACA includes strategies promoting quality of care across the health care continuum, including acute, post-acute and senior living care. This dynamic shift is consistent with the goals of the Triple Aim to focus models on achieving quality outcomes, no matter where the patient is in the continuum.

Better Business Leading to Technology, Financial and Risk Implications

The Affordable Care Act (ACA) accelerated a shift away from traditional volume-driven health care services to value-based payment models that encourage providers to focus on quality, outcomes and cost containment. This includes care and follow-up provided as patients move between care settings, requiring that post-acute and senior living providers take on more risk and become more innovative about care models during the care transition process.

Let’s look at what this group of 14 executive leaders has to say about these and other topics in detail, as they discuss the key opportunities and challenges associated with transitions of care for 2016 and beyond.

Better Interoperability

The roundtable discussion opened with participants sharing how interoperability plays a significant part in transitions of care, and it didn't take long for the challenges – *and opportunities* – to surface.

According to Ron Payne, CEO of Southwest LTC, he questioned how providers follow patients when they're discharged from a post-acute facility.

"How do we follow the patient when they discharge from us, whether it's back to the community, back home or back to an assisted living facility and not get penalized with rehospitalization if they decline at home without our knowledge? There is a unique program in Oklahoma whereby CMS reimburses us to monitor patients when they go back home. When they leave our facility, we have a good baseline of where they are and we can send a nurse or aide to their home to assess how they're doing post-discharge. If we notice a decline, CMS will pay us to bring them back to our facility for 24 hours to stabilize them with the goal of getting them back home. It enables us to continue to monitor our patients' care while also enhancing our position in the community."

Neil Pruitt, CEO of Pruitt Health Care agreed and spoke of an innovative model whereby they deploy a nurse navigator to the bedside in acute care settings. The nurse navigator does an assessment and then recommends placement in the appropriate care setting. "This model enables us to meet with the hospital, the patient and the family and set expectations. We agree upon a common goal to achieve and communicate with physician, payer and family to put us all on level footing. This builds a trusting relationship."

Matt Moore, COO of Southwest LTC, concurred. "Hospitals have systems that if we could access, it would help with admissions. On the discharge side, our biggest weakness is staying in touch with the 40 patients we discharge each month, and also how we interact with managed care. They own the life. They take control and determine if the patient is better-suited for the community or home health or our facility. So this is just another piece of the puzzle we have to navigate now."

Bob Van Dyk, President & CEO of Van Dyk Health Care brought a different perspective to the discussion: competition. "The first half of the challenge is how do I get patients through my doors; the second half is following-up with them so they don't go back through the hospital's doors."

Van Dyk explained that he operates in a highly competitive market – one of 13 facilities that hospitals in its northern New Jersey region can choose from.

“We’re all in the hospital vying for the next patient; but once we get past that, the bigger challenge is the discharge home. We have a nurse educator and a full-time nurse practitioner and can discharge more quickly. This has made us a preferred provider because hospitals want to know who is getting patients out most quickly with low readmissions and good outcomes.”

Better Care and Yardsticks for Success

Roundtable moderator, Chuck Czarnik, pivoted the discussion to issues of care quality and the tools to measure them. He asked,

“Are rehospitalizations rates, Five-Star, total cost of care the right yardsticks for measuring the services we deliver to our consumers?”

It didn’t take the panel long to weigh-in, starting with Neil Pruitt, who suggested that total cost of care is a good measure for his services. “It takes in the totality of one’s care and the costs associated with that. So where we can partner with other institutions and have a seamless care plan, it works beautifully. For example, if a patient is with us in our SNF and later discharged to our home health agency, they’ll have a better experience at a lesser cost because we can manage their care and cost the whole way through.”

Bob Van Dyk then raised an issue on every provider’s mind. He said, “The one piece we don’t talk about is the change in the entire health care delivery model. This will lead to a compression of acute care beds and LTC beds. We won’t have as many beds 10, 5 or even 3 years from now. The way to get total cost of care down is fewer days in post-acute or acute and more days in home care. So this boils down to two scenarios: either go out of business or find another use for those beds. We need to specialize to become more efficient. But we can’t lose sight of the fact that this is a whole different way of delivering care.

Better Business Leading to Technology, Financial and Risk Implications

Fred Benjamin made the connection between better care and better business. He said it’s not about filling beds anymore. Rather, providers have to see the world in terms of managing lives across the continuum and get in front of the payment stream.

“We have to be problem-solvers,” he said. “When Managed Medicaid came to Kansas, our organization was partnering with one of the three ACOs in the market. There were 12 service titles in the Medicaid program and 102 counties they needed to serve. But they couldn’t establish an affordable distribution model. So we stepped up and asked, ‘What can we help you with?’ We offered to provide Meals on Wheels and set-

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Fred Benjamin
President
Lexington Health Network (Skilled Nursing Division)

up a women's health clinic. The point is, we have empty space and we need to re-conceptualize how we operate. In rural communities, we can become the center of the health care delivery model. We're the low-cost providers and can work with the county health department and be the integrating element. That's a huge opportunity."

Chuck Czarnik suggested that a provider's ability to offer new and agile solutions largely depends upon the technology and management of quality data to share with key partners.

According to Neil Pruitt, "We use the same assessments and technologies that insurance companies use and this enables us to better target interventions and prevent patients from going back to the hospital. But interoperability just doesn't occur right now. We don't have access to the hospital system so our data is with our AHT EHR. And there's more data in a therapy system and a home health system and a pharmacy system and so on. This isn't efficient. We have to get to a consistent data set that makes sense for our patients. We're in data overload."

Hill Fort added that providers are often judged on data that doesn't match their data. "We met with a hospital recently and demonstrated our readmission rate and had a great discussion; however, their data was much different than what we had. We're collecting a lot of data but I don't know who has the right data. It's just not apples to apples yet."

According to Matthew Connor, Vice President of Business Development for COMS Interactive, "Data is crucial. Having the ability to know exactly what your data is on ALOS, mortality and readmissions is beyond important. Your partners may have their own data set and even if yours differs, creating that discussion is huge. We switched the way we count readmissions along the lines of how CMS is looking at things and we evolve this to make it as parallel as possible."

Teresa Chase, President of American HealthTech, pointed out that, while the data is critical, it's also the clinical protocol or the pathway that the nurses are following that holds the key to consistency. "Hospitals have very standard protocols across settings. We're working with our providers to be more standard in their clinical processes because the data – and the results – will then be more standard. It's about the practice.

“The providers who are still hoping that CMS will go away if they ignore them long enough are the providers who keep me up at night. The reason being, they’re not keeping up and when that happens, the public notices and the government makes more changes. That’s a problem for all providers.”

Hill Fort
COO
Magnolia Manor

Providers on the front-end should continue to push protocols for every disease state. The data will follow, putting you on a more even playing field.”

Moderator Chuck Czarnik acknowledged there are challenges and asked a tough follow-up question:

How do we fix it and who solves the problem?

Fred Benjamin offered a perspective using Medicare Advantage plans and ISNIPS as an example. “It’s all about perspective,” he said. “When you look at this through the lens of population management as opposed to through the lens of knitting together a bunch of systems that don’t talk to each other, ISNIP gives you a model of care across the entire system. You don’t spend time and effort trying to connect disparate systems that really aren’t going to connect anyway.”

Neil Pruitt built on Benjamin’s perspective. “We’re going to bear the risk. Whether ISNIP or ACO, we’re responsible for risk. The regulatory bodies gave us the framework to work within, but we are managing the totality of care for all patients. As we bear risk, the rationalization of care will be solved by us.”

Bob Van Dyk added that strong partnerships are also vital to the solution. “The hospitals and health systems don’t have all the answers. They’re looking to us for answers, too. We all need greater consistency because until everyone is on the same page, we’ll always have different stories to tell. We need to come together to find solutions.”

Chuck Czarnik suggested the industry needs a Wikipedia. “I’ve got markets where we’re doing really innovative partnerships with hospitals and health systems. But we need to come together to learn how to scale these solutions because I agree that this is driving the hospitals crazy, too.”

Ron Payne added, “The bottom line is that the money controls. We’re the solution but we don’t control the money. The hospitals, health system, ACO or physicians look to us as the problem-solvers and our focus has to remain on what benefits our residents. That needs to be first and foremost for all of us.”

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COMS Interactive

John Shafaee, president of Medtelligent brought in the senior living market perspective and questioned how these same challenges affect them. “From our experience, the dynamics aren’t really that much different in CCRC’s and ALs,” he said. “The residents are there and shift between services so these organizations have the same challenges managing care transitions under their own roofs.”

Peggy Connorton, Director of Skilled Nursing Operations for Covenant Retirement, concurred. “We’re seeing frailer people moving into our IL, AL and skilled facilities. When an AL or IL patient has to go to the SNF side and then returns back to their apartment or the hospital, it’s tough to manage and track. We have to communicate throughout the whole campus to ensure we’re providing the right care and also billing for the right services.”

According to Hill Fort, “Our assisted living communities have the same issues as our SNF facilities. And data collection in assisted living is just as important as it is in SNFs. We’re just doing it in paper right now, which is why we’re now working with AHT’s senior living solution powered by ALIS to demonstrate the same data points across all facilities.”

Future Considerations and Concluding Insights

There is little doubt that the post-acute industry has had to weather many storms, many opportunities and many challenges to provide the best care for its patients, while meeting the mandates of health care reform. But there is a lot of optimism among these leaders.

Moderator Chuck Czarnik liked the agility from providers to repurpose an asset that may be over-sized for a market that’s shrinking is innovative. “That kind of thinking provides opportunity,” he observed. But he asked the panelists,

“What’s the biggest challenge keeping you up at night, and what does the future hold?”

Nearly all of the panelists said that what they worry most about are the providers who don’t go to conferences and aren’t futuristic.

According to Hill Fort, “The providers who are still hoping that CMS will go away if they ignore them long enough are the providers who keep me up at night. The reason being, they’re not keeping up and when that happens, the public notices and the government makes more changes. That’s a problem for all providers.”

Neil Pruitt shared that his organization’s services are blending. “We’re so accustomed to thinking about service lines but we have to re-evaluate that strategy. The services are converging and we’ll be site-agnostic eventually. It comes down to what’s best for the patient so we need to deliver a single way to care for them.”

Bob Van Dyk thinks the industry will see fewer and fewer independents. “We’re at a point where smaller operators don’t have the resources to manage through all of these changes, so I think many will eventually sell to private REITs. So I see smaller operators giving way to more concentration of larger operators.”

The one thing all providers agreed on is industry resilience. Neil Pruitt summarized it best. “We’re post-acute providers; we’ll figure out a way. There have been storms in the past and we survived; for this one, I see a huge amount of opportunity. We’ll figure out a way to care for our patients and succeed in this environment. That’s what we do and have always done.”

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