McKnight's Roundtable: Prescription for change

When top long-term care executives and physicians meet, visions for a new future of long-term care technology, care processes and payment mechanisms soon follow

Photos: John Merkle

Top row, left to right:

Chris Masterson
Greystone Healthcare Management

Keith Moss, M.D.
Riverside HealthCare

Charles Rogers, M.D.
HealthMEDX

Pamela Pure
HealthMEDX

Thomas Triantafillou, M.D.
Covenant Retirement Community

Michael Mutterer
Riverside HealthCare

Ed Smolevitz, M.D.
ITEX Company

Hassan Alkhatib, M.D.
Greystone Healthcare Management

Bottom row, left to right:

Mark Fritz
Remington Medical Resorts

Bruce Robertson
Sentara Life Care

Diane Kane, M.D.
St. Ann's Community

By Tim Mullaney

Leading long-term and post-acute providers are responding to unprecedented challenges with a variety of innovative care models. Prominent executives and clinicians discussed and debated these at a recent McKnight's Roundtable Forum.

New technologies are a linchpin of many of these efforts, and the speakers emphasized the value of solutions that both fit their particular approaches and objectives that support communication and goals across the whole continuum of care.

Participants gathered in the Chicago suburb of Rosemont in late April. *McKnight's* Editorial Director John O'Connor and Editor James M. Berklan moderated the event, which was sponsored by HealthMEDX.

The topic of post-acute versus long-term residents came up early in the discussion and got at some of the most basic, yet critical, issues in play: Who is in the facilities and who is caring for them?

New reality

The rise of facilities offering diversified, Medicare-reimbursed services means that traditional long-term care residents risk getting scant attention as providers look toward the future, warned some of the physicians.

"There are so many different things we're doing in these facilities, the long-term piece of this, we [are liable to] forget about it," warned Keith Moss, M.D., vice president and chief medical officer for Kankakee, IL-based Riverside HealthCare.

Frail elders generally are spending less time in long-term care now than in the past, and this is a positive development, Moss said; however, providers still have a responsibility to "take care of them in the best way possible"

once the long-term care facility becomes their home. To achieve this, providers must be equipped to take care of issues that once would have led to hospitalization, he argued.

Diane Kane, M.D., CMO at St. Ann's Community in Rochester, NY, agreed. She advocated for creating long-term care facilities with hospital-level capabilities. This would benefit elders and hospitals, which should see fewer long-term residents in the emergency room, she said.

"The reason that we have an 8% readmission rate even for frail elders in the nursing home is several-fold," she said. "We can do all labs and X-rays right in the room of the nursing home resident or in the room of the transitional care patient."

Time to split?

Other participants had a different take: Rather than thinking of post-acute and long-term care under a single umbrella, it might be time to more radically distinguish them.

"I think we have to look at skilled nursing a little differently than we have in the past," said Mark Fritz, founder of Remington Medical Resorts in Texas. "We're trying to keep these two segments that are very different married. At some point, we have to really look at them differently."

Remington has taken the long-term care patient out of the equation by focusing exclusively on rehabilitation and transitional care, observed Chris Masterson, Tampa-based senior vice president of clinical operations for Greystone Healthcare Management Company. Greystone also has developed centers devoted exclusively to transitional care, and the response to this move has been "tremendous," Masterson said.

"Transitional care is a different type of care setting that maybe didn't exist" in the past, and facilities dedicated to it have great appeal, he explained. They don't have the nursing home stigma, and patients seem to like that long-term residency is not an option, he added. This supports the model of having "two separate entities" for transitional and long-term residents.

Doctors needed

Providers serve different populations depending on their business model, location, for-profit status and other factors, but there was unanimous agreement that patient acuity has risen across the board.

"We're getting a much heavier acute patient into skilled nursing today than even five years ago," said Remington's Fritz. "It requires a doctor to be in that facility. So how do we get that?"

Community doctors are not likely to enter facilities in greater numbers, according to Ed Smolevitz, M.D., associate medical director of ITEX Company and a geriatrician affiliated with NorthShore Medical Group in Chicago. He estimated that about 40% of his work is in nursing homes, and a dwindling number of doctors have such commitment.

Also, because much of the work in SNFs involves new admissions and lab results arriving between 4 p.m. and 8 p.m., he thinks a new M.D. is more likely to become a hospital physician than one dedicated to a skilled nursing facility.

But tricky hours aren't the only impediment to recruiting so-called "SNFists."

"If you want to make a SNF more appealing to a doctor, it's about reimbursement," emphasized Hassan Alkhatib, M.D., medical director at Greystone. "A doctor doesn't get any reimbursement in palliative care or hospice. We spend hours with that patient and don't get any reimbursement."

Norfolk, VA-based Sentara Lifecare implemented a SNFist model, but poor reimbursement made it unsustainable, said President Bruce Robertson. The large, integrated healthcare system reverted to a community-based model. Robertson does not believe this is "the answer" in the long run, but any attempt to put together an in-house group of doctors must deal with the general scarcity of geriatricians and primary care physicians as well as having properly aligned incentives for reimbursement, he noted.

Providers are exploring various ways to achieve a SNFist model despite these challenges. One possibility is to partner with established hospitalist groups to see if they'll "come to the world" of skilled care, said Michael Mutterer, vice president of nursing and post-acute services at Riverside. And the robustness of the hospitalist sector might offer some clues about how to increase the number of SNFists. Perhaps unsurprisingly, it comes back to money.

The ranks of hospitalists surged only when hospitals recognized they needed dedicated doctors to improve efficiency, and increased

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payment rates, observed Charles Peter Rogers, M.D., MBA, FACC, medical director at HealthMEDX.

A new paradigm

The hospitalist example does not provide much comfort to post-acute providers.

"The problem with it, again, is we don't have the money the hospitals have," said Riverside's Moss.

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Rogers also referred to a paradigm shift. He believes that acute care providers and systems like

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One possible answer: outcome-based reimbursements for episodes of care, rather than the current paltry per diems, said Fritz. While Mutterer agreed in principle, he noted that healthcare reform so far has not brought this to fruition. Instead, hospital systems are the "big bully in the room," picking their preferred post-acute partners and dictating "cut-rate" payment deals while setting high bars for outcomes.

Kane and Moss struck more optimistic notes. SNFist subsidies would be more than justified by improved quality and prevention of readmissions, Moss said. And Kane believes that more stakeholders are looking beyond the bottom line at the other benefits of SNFists.

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Rogers also referred to a paradigm shift. He believes that acute care providers and systems like Kaiser are coming around to the notion of "taking care of people in the long-term" by setting achievable goals and continuing to support and manage care in the post acute setting.

Tailored technology

Despite the diverse models of care they are building, panelists had similar visions of an ideal electronic health records system. Mobility, robust access to records and interoperability all are crucial for long-term and post-acute

settings providing more complex care. As HealthMEDX CEO Pam Pure summed up, "As the care delivery model evolves, physicians will be managing patients with higher acuity. Full access to the complete electronic record will be critical to safe, efficient care in the LTPAC setting. Order sets and streamlined documentation are becoming critical components of the LTPAC technology suite enabling physicians to drive care online. Mobility will be a critical factor in physician adoption."

There are features that might be considered unique to the LTPAC physician. Over time, these systems might highlight conditions dominating care, because clinicians at the bedside often have to rediscover the main reasons a patient is there, said Thomas Triantafillou, M.D., director of geriatrics at Covenant Retirement Community in Glenview, IL.

Citing the American Geriatrics Society's guide to EHR components for geriatrics providers, Triantafillou pointed out that they must meet the needs of many people besides doctors — such as to cover "all the things you need for reimbursement." And even the best IT product will not solve problems caused by unaddressed inefficient workflow prior to adoption of electronic tools, he added.

But if electronic records are not a cure-all for workflow problems, they certainly transform processes for the better — for instance, through user-friendly tools that resolve administrative headaches and mitigate health risks associated with care transitions. As Pure said, "These systems must be easy to use, configurable to support the workflow variances that occur as physicians and patients transition through the continuum of care."

For example, Greystone partnered with HealthMEDX to push the envelope and equip their physicians with a mobile platform that includes an electronic chart and iPad-based ordering and documentation. In addition, they plan to provide hospital partners with access to critical patient information. The firm is committed to coordinating care and electronically supporting care transitions. They want "the SNFist to see the hospital record and the ER doc and hospitalist to see the LTC record," Masterson said.

Other participants described their own impressive tech initiatives. Like the discussion as a whole, this part of the conversation was nuanced and frank about challenges, but the ultimate takeaways were straightforward and positive. These thought-leaders agreed that in today's complex healthcare system, technology is simplifying processes, enabling them to take action and ensure the highest quality care for everyone who comes through the door. ■