LTC expert panel: Cautious optimism for SNFs

By Elizabeth Newman

As 2014 drew to a close, long-term care providers had reason to pat themselves on the back. Successes over the past year included a significant reduction in off-label use of antipsychotics, improvements in quality measurements and a November election that put Republicans in control of the House and Senate.

"In general I feel pretty darn good about things," said American Health Care Association/National Center for Assisted Living President and CEO Mark Parkinson at a symposium for long-term care providers hosted by PharMerica in December.

He added, however, that "there is risk every time Congress is in session," especially as policymakers consider funding cuts.

Overall, however, Parkinson and fellow panelists were upbeat at the *McKnight's* panel discussion at the PharMerica first annual long-term care executive educational conference.

"The House is essentially the same, and that's great for us," Parkinson explained. "Republican leadership under Speaker [John] Boehner has been very good for the sector. The committee leadership with Paul Ryan, we think, will be very good, very policy-oriented. We certainly have their ear to give them good ideas."

Politics lingered during the star-studded panel discussion, which also included Bruce Vladeck, Ph.D., former administrator of what is now the Centers for Medicare & Medicaid Services and a senior advisor to Nexera Inc.; Stephen Guillard, former executive vice president at HCRManorCare; and Fred Benjamin, COO at Medicalodges. Moderating the mid-December event in Orlando were *McKnight's* Editorial Director John O'Connor and Editor James M. Berklan.

Subjects dominating the session included managed care, specifically regarding Medicaid beneficiaries, the Five Star nursing home rating system, and relationships with hospitals, physicians and other potential partners.

While cautiously sharing Parkinson's optimism, the group warned about uncertainty ahead, especially when navigating bundled payments.

Photos: A Nectar Production

Left to right:

Bruce Vladeck, Ph.D.
Senior Advisor
Nexera Inc.

Stephen Guillard
Former executive vice president
HCR ManorCare

Mark Parkinson
President and CEO
AHCA/NCAL

Fred Benjamin
COO
Medicalodges

Managing managed care

With managed care, everything old is new again, said Vladeck. He's worried about what the arrival of more managed care means, not just in terms of the volume for providers and how they are paid, but in how care is delivered.

"One of the advantages or disadvantages of being my age is you've kind of seen everything before," he said. He recalled that a fully capitated Medicare/Medicaid long-term care benefit in the 1980s was "a total flop."

Guillard, who sits on the board of post-acute care management company naviHealth, says he often helps executives better understand long-term care machinations. In

discussions with officers at managed care companies, he says he was "always impressed with how eloquent, how knowledgeable, how smart they were and how focused they were on understanding the metrics" of long-term care.

"That said," he added, "they lacked an appreciation of the struggles that the providers have, and the dynamics of how the business is working, and the pressures that are hitting the companies."

Industry leaders must encourage dialogue and strive for more mutual understanding, he explained.

"Things are moving and they are moving at faster speed than many providers realize and managed care companies realize," he observed. "Witness the demos on bundling, and the speed at which they are gathering data and aggregating results."

Payment models are changing based on the market, the group noted. Texas is moving to Medicaid managed care March 1, while Kansas has had three managed care organizations over a five-year contract. So far, they've lost nearly $200 million, according to Benjamin, who is the head of the Kansas Health Care Association.

"I want to keep our members in business, especially in rural areas," he said. "We are trying to make a transition from putting out fires to being in a more proactive planning mode."

'No validity'

Guillard is a staunch critic of the CMS's Five Star rating system for nursing homes, largely because the data is "horribly flawed."

People need a nursing home and want the assurance that they will get better and go home, he said, which relates to the provision of therapy services they are receiving. Yet therapists' time is not included in staffing calculation for Five Star.

"To me, there is no validity, there is no demonstrated reliability," he stressed. When he talked to CMS years ago about data being wrong regarding staffing and the attempts to fix it, he said he was told there was no interest.

Benjamin added that while he is in "violent agreement" over Five Star's flaws, "the reality, of course, is we have to live with it."

"The other reality to me is that our profession has not been doing this, i.e. measuring things or managing to measurement," he said. "There is a lot of low-hanging fruit there, there's a lot of opportunity to improve quality."

He noted AHCA's quality efforts, and Medicalodges' efforts related to the Baldrige Performance Excellence Program criteria. The best way to improve quality is to examine direct care, he said.

"We have 30 or 40 different variables that we meet on, on a monthly basis and empower teams at the bedside to move the dials. To me that's where the rubber meets the road."

Vladeck observed, however, that maintaining quality is a "complicated process." Most nursing homes are relatively small enterprises, which means quality can suffer for months if one nursing director leaves. There need to be meaningful comparisons, but Five Star drives the industry away from that, he said. The point of quality improvement is not to give out "gold stars" but to have meaningful clinical measures that allow facilities to compare themselves to each other, he asserted.

"Quality is multi-dimensional. You can go to one of the top hospitals in the United States but if you have a problem that requires a gastroenterologist, they [could be] weak in gastroenterology," he noted. "I think it's true of a large number of nursing homes, as well, where we are really good with taking care of these kinds of patients but we don't have the control, we don't have the freedom to pick and choose on the front end of who we are admitting in order to match with what our relative capabilities are."

Anticipating changes

Parkinson noted "there are some real challenges" in proposed changes to Five Star, specifically related to using payroll-based staffing data. In 2015, CMS is scheduled to start auditing back to payrolls to verify staffing levels.

But "the Five Star system is going to stay," Parkinson agreed. "In fact, CMS is going to double down and start to utilize it for other sectors. And I would be disingenuous if I didn't say that we're aligned on this. Modern management techniques, which I think have sort of revolutionized American business, require measurement, require accountability. It is only when we measure things that we can improve them.

"The challenge with Five Star is that they aren't measuring the right things," he concluded.

Just who should be LTC operators' new business partners?

It depends on the market, Parkinson said, but each facility or company would be wise to study metrics such as rehospitalization rates and staff turnover.

"You have to create an alliance with whoever is out there," he emphasized.

Vladeck countered, however,

that decades of such efforts have brought mostly futility.

"For the last 30 years, we have tried to develop real relationships between hospitals and nursing homes, and if I listed the things that I have been involved in with my career, that is far and away the one in which there has been the least progress.

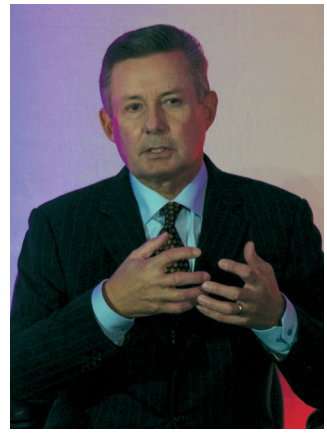
"From the viewpoint of nursing homes or long-term care providers more generally, my perception is the least helpful partners to have are hospitals," he said.

Meaningful relationships with referring hospitals are critical, Parkinson asserted. But Vladeck pushed back on what a good relationship means.

"[Hospitals are] supplying and keeping your beds filled to meet their needs, but they're not doing anything for you other than getting rid of patients they don't want any longer, and you're there to catch them," Vladeck said. "There are a whole lot of opportunities and a few instances in which there are real reciprocal collaborative relationships between hospitals and long-term care facilities. But I haven't seen a whole lot of them."

Vladeck said physicians might be the secret weapon in maximizing reimbursement.

"You can run a healthcare system without hospitals or a lot fewer hospitals than you have, but you can't run it without doctors, even with all the nurse practitioners in the world," he said. "Again, historically they have been nowhere in terms of understanding. They're now really organizing because they want to be on top of the food chain in a world of risk and not be subservient to the hospitals. Depending on the community, that's another potential ally. If the docs and you guys are together, then no one else can touch you."



"Things are moving and they are moving at faster speed than many providers realize and managed care companies realize."

Stephen Guillard
naviHealth

Guillard agreed, noting physicians are fragmented, but "we probably benefit if docs are in control because they are judicious buyers ... and they are incentivized."

Investigating integrations

Benjamin, a former hospital administrator, said his company is focused on horizontal and vertical integration, noting he wants to make sure it is not "cut out, frankly, by the hospitals or others that might get to the trough before I do."

"I want to create my own post-acute system, which involves home care, which we are already very involved in, and probably hospice care down the road," he added. He mentioned a recent meeting with a hospice provider executive in his area.

"She was going at the same thing that I was from a different direction. She was thinking about building assisted living and being more brick-and-mortar oriented. We both agreed together that we wanted to make sure that we got there before hospitals did, to the degree that we can," Benjamin said. "If we have the quality and cost a lot less than the hospitals do — and we do — then we are in a pretty good position."

Optimistic future

Changing demographics are good news for operators, said Guillard, who believes the length-of-stay window for beneficiaries will plateau.

Vladeck said he's concerned about policymakers who have become "so infatuated with the home- and community-service sector and so negative in their views about nursing homes."

"When the baby boomer demographics really hit in 10 to 12 years, we are not going to have enough beds," Vladeck said. "It's really going to mean that only the most difficult, expensive, long-term patients are going to have beds. In large parts of the Northeast, this is imminent."

But he's optimistic about the IMPACT Act, and says the "ideological warfare that has infected public policy process in Washington and seems to get worse every week seems to have largely skipped over the post-acute and long-term care sector."

Benjamin and Guillard agreed the best way for nursing homes to move forward in 2015 is to embrace quality management, with Guillard emphasizing outcomes must be tracked within a system.

Vladeck encouraged conversation, with everyone from physician groups to community health centers to competitors.

Parkinson urged operators to refinance since interest rates are at historic lows. He also repeatedly stressed the importance of quality measurements.

"The use of data and metrics, and using them to achieve results and to incentivize people and to create outcomes is as important as a revolutionary change to American business as, say, the Internet is to communication," he said.

"There is a huge difference in your likelihood of success if you make decisions based on anecdotes as opposed to if you make decisions based on real data." ■