Transitions and quality command center stage as experts examine post-acute care's future

By John Hall

Few will dispute the value of ensuring patients are optimally treated and attended to as they move across care settings. The payoff includes fewer complications, shorter stays and lower rates of costly re-hospitalizations.

Yet shifting payer rules and regulations leave most providers in the post-acute space scrambling to understand and grapple with this new order as they seek ways to ensure business continuity while staying at or above an ever-rising quality bar.

Disciplined care transitions and care coordination are more important than ever to accomplish overall quality improvement, better care delivery and reduced costs — for all types of providers. Knowing what care partners along the continuum are thinking and doing will be essential for success.

Those who remain in silos or work in a vacuum will never thrive amid all of this change, experts agreed at a recent *McKnight's* panel discussion sponsored by Medline.

Photos: Tim Carlson

Top row (L to R):
Chris Mason, Senior Housing Managers LLC

Brandon Ballew, Kindred at Home

Todd Stern,
Seasons Hospice & Palliative Care

Fred Benjamin,
Lexington Health Network

Bottom row:
Shawn Scott, Medline

Sandra Bailey, Methodist Health System

The big uneasy

Many said competitive marketplace pressures and tight revenues give them staffing heartburn.

Chris Mason, president and CEO of Senior Housing Managers LLC, said a workforce dominated by millennials makes him worry about not having "the right people at the right place at the right time."

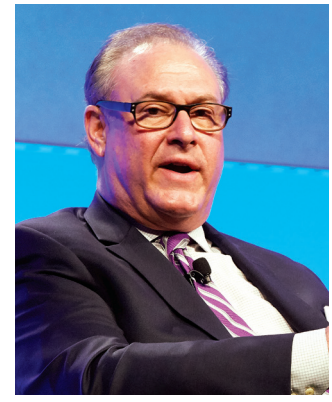
It doesn't help that the feds are constantly trimming reimbursements. MedPAC, for example, recommended elimination of the payment update for skilled nursing facilities for fiscal years 2018 and 2019.

"On the cost side, everyone wants a raise every year," noted Fred Benjamin, president of Lexington Health Network's skilled nursing division. He noted that the Centers for Medicare & Medicaid Services "just announced they're going to give us a great increase of 1% next year. How many of you would be happy with a 1% salary increase next year? Not many. That's the reality we have to deal with right now."

Compensation issues are just as hard outside the skilled nursing space, argued Brandon Ballew, COO of Kindred at Home.

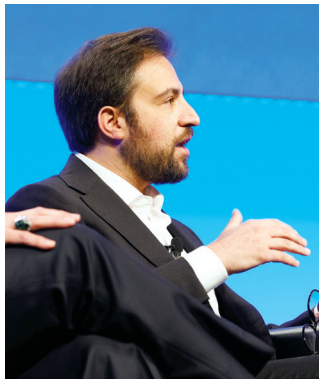
"At the end of the day, we have to have clinicians to do our service," he said. "I'm not in the bricks and mortar business like some of my colleagues. We need clinicians and nurses and therapists, and what can we do to make sure they come and stay with us as a company?"

The concept of continuity refers to much more than care transitions, and it's sorely lacking in places where it's most needed, believes Todd Stern, CEO of Seasons Hospice & Palliative Care. "I've grown up around grandparents who built the second nursing home in Illinois in 1963," he said. "What makes healthcare success-



"Quality is about metrics."

Fred Benjamin
Lexington Health Network



"The problem is sometimes they cut the wrong wire."

Todd Stern
Seasons Hospice & Palliative Care

ful is continuity and in the current environment and pace we live, people are always looking and jumping. It's challenging to operate a business with a certain level of quality."

Sandra Bailey, vice president of care transition services for Methodist Health System, told the audience that emerging models of care are raising many questions about the kinds of partnerships that are needed.

Costs keep many executives awake at night, too. Mason asserted that rising acuity and lessening affordability in assisted living are challenging for resources, particularly for so many baby boomers "who've spent down already."

More than anything, government policy — the sheer volume of it and the pace at which it's changing — is daunting.

The emergence of value-based purchasing is creating real concerns about keeping pace with quality mandates, believes Shawn Scott, senior vice president of Corporate Sales for Medline. As the company looks out at the varied post-acute landscape of its customers, the narrative often reverts to helping them understand the regulatory changes while "remaining prosperous and keeping their doors open."

Benjamin thinks government policy's impact on length of stay has put incredible pressures on providers to do more with less money and time — about 40% less revenues and a 30% paid length-of-stay drop since the switch from cost-plus to prospective payment.

"When I was a hospital administrator, we had 35 hospitals within a five-mile radius of downtown Chicago. Today, there are about 10," he said. "Where did those other 25 go? Well, today they're basically condos." Value-based purchasing "basically throws everything up for grabs," he added.

All too often, regulatory tweaks are unwittingly misguided, he added.

"The problem is sometimes they cut the wrong wire," said Stern, referring to the near disaster that happened when home health precertification rules went awry several years ago, and more recently when the government tried to tweak Medicare Part D rules on medications for hospice providers.

Quality mandates fallout

No one disputes or refutes the emerging emphasis on quality outcomes. But for post-acute providers, the journey there will be costly and in some cases, not without significant challenges.

Developing protocols and partners are two that occupy Bailey and Ballew more than anything. Pressures to develop care pathways are challenging both internally and beyond for hospital systems such as Methodist Health.

"As hospitals are responsible for 30 days post-discharge in the readmission category, what we want to know is if we hand off the patient to a post-acute provider, what quality of care are they going to get in that facility and if they're discharged from that facility, are they going home with home care?" Bailey posed to the panel. "We're looking at the full continuum now and want to have high quality partners that will continue the care paths that we place patients on in the hospitals into the skilled facility or into the home."

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Brandon Ballew
Kindred at Home

Ballew lauds efforts to develop pathways as one way to break down the silos that have dogged the post-acute setting for years. Yet, "this is where collaboration is a little creaky," he said.

"Your care pathways and protocols are important because it's not just in the setting you're in today or you're going to be tomorrow. It's what am I doing today in the acute setting," he said.

In other words, it's critical that patients are put on the best possible path the moment they're admitted because financial resources in the post-acute side are likely to be thinner than ever. This will force every player along the continuum to be as efficient as possible, he added. Hospice and home care providers "are at the end of the totem pole. It's a good and bad spot to be," Ballew concluded.

The push for quality will bring an equal, if not greater, demand for accountability. And that's where measurements will matter.

"The issue in quality is not something you can talk about in general terms," Benjamin said. "Quality is about metrics. It's about understanding the length of stay, how many falls you're having, what's your off-label use of antipsychotics and a whole coterie of other things. When we talk

with our hospital partners today, that's what those meetings are all about."

All panelists agreed that care coordination is critical to ensuring quality — something that isn't exactly a cakewalk when dealing with hospitals, as evidenced during one brief, light-hearted exchange.

"I noticed Sandra didn't mention assisted living in her last comment [on care pathways]," observed Mason.

"We don't think about assisted living," Bailey responded.

"Five years from now, you will be saying 'assisted living' in the same breath as you say skilled nursing," Mason added. "Yes, as Fred said, we're looking at metrics. We're measuring, which means we're using QAPI to set quality standards within our communities. We're monitoring. We never did that in the past. Assisted living was a social model. Today, it's a medical model with a social conscience.

"We're doing a lot of the same things today in assisted living that skilled nursing did 10 years ago, and I don't say that lightly. We're putting primary care clinics inside our assisted living communities. I don't know that that's the answer, but it's working and we're reducing rehospitalizations. We're able to track that information, where five years ago we didn't have a clue.

"I'm a baby boomer, so I have certain expectations," Mason added. "I don't just have needs. I have wants. And from a quality standpoint, you have to meet my wants as well as my needs. So for me, being a Red Sox fan, I want my Starbucks coffee in the morning, I want my paper delivered to my apartment with a rose, ball scores circled, and if the Red Sox lost, break it to me gently. It's that simple."

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All of this is not to say providers bristle at the push for quality.

"I think some of the stuff that we've all been subjected to has actually led to good outcomes and better appreciation for what each of us provides in a positive way," Stern said.

That said, hospice providers face special challenges. Hospices had an estimated 2.1% increase, or $350 million, in Medicare payments for FY 2017. But CMS also finalized changes to the hospice quality reporting program, including new quality measures.

Requirements such as reassessments for certifications in hospice can be onerous, Stern said.

"We also see the 30-day readmission type penalties, the carrots and sticks, are creating uncomfortable conversations [with terminally ill patients]," Stern said. "But now because of carrots and sticks, they've either got a share in it or accountability for a bad outcome that's forcing those conversations."

Responding to challenges

One of the major "calls to action" for all post-acute providers is understanding the important role each plays, and that hasn't always been easy for executives to admit until now.

"Some years back, someone on the hospital side created this term called 'systemness.' And what that means is getting all the boys and girls to play together in this same sandbox, like having a post-acute and hospital division," said Benjamin. "What we're trying to do now is break down those silos and create a seamless continuum, what I'd call a 'plug-and-play' capability." But that also means everyone needs to prepare themselves as much for competition as for collaboration, he added.

Meanwhile, assisted living and home care both seem poised as prominent players in the post-acute space, according to panelists. It also means those players should brace for more regulatory scrutiny.

"We really believe assisted living should be regulated at the state level," Mason said. "That's critical. It also provides great opportunities because when it is regulated at the state level, you have the opportunity for all these new models of care you wouldn't otherwise have. If you look at states that are well along in the assisted living continuum, they've already achieved a lot of the acuity levels that we would see in what we used to consider nursing facilities."

Hospital systems such as Methodist Health are also working now to develop strong home care partnerships.

"Eighty percent of our readmissions come from home," Bailey said. "And so we are really working now at developing really high-quality home care partners. We're beginning to expand our vision somewhat and understand the value of each of those segments in the community." ■