Finding residents' suite spot

A partnership between Grace Lutheran Communities and the Marshfield Clinic in west-central Wisconsin is a creative example of the way the federal government wants providers to form non-traditional linkages to improve care and lower costs. Grace Lutheran runs small skilled nursing units added onto three Marshfield buildings, cutting hospitals out of the chain of care for numerous conditions. The two-year-old collaboration has expanded in two additional directions, Grace Lutheran Foundation's COO Randy Bestul told *McKnight's* Editor James M. Berklan.

Photos: Marisa Wojcik

Q: What's the aim of these "comfort and recovery suites"?

A: They started out to be a recovery site for people having a subset of operating room procedures, many of them orthopedic-related — total knees, total hips, shoulders. The goal was to perform the surgeries on an outpatient basis and have rehab adjacent to the surgery centers. The patients would be good to go home in one to three days, reducing costs.

Q: What was most important when setting up?

A: We wanted to make sure the physicians and patients using them saw this as comparable to a hospital but different. It works without all the overhead hospitals have. A third-party payer, commercial insurance or Medicare Advantage, contracts with Marshfield Clinic for a case rate. We have a contract with Marshfield based on a formula and agreement.

Q: How did your companies come upon partnering?

A: Our business plan called for a few more beds. We were in contact with the administrator of a local facility that was closing — which is the only way to get beds in the state. He said another party was interested, and we were able to get the name, Marshfield Clinic.

Our CEO contacted them and since they had never operated a nursing home, the state (ultimately) told them they should probably find a partner. They were looking to build four small skilled nursing facilities physically attached to surgery centers in their main markets. They wanted help designing and building them, and lowering costs. We were told what appealed to them was we were local, Wisconsin-based and not-for-profit. We wound up with two 12-bed units and one 20-bed, in Marshfield, Eau Claire and Wausau.

Q: What were the core considerations?

A: Number one, it had to be relatively low risk. Two, in our ideal situation, it was to develop strong relationships with one of the area systems.

I feel very strongly we have to have a good relationship with the hospital system and physicians. This is a good way to it.

Q: How does this play out?

A: The patient room is designed to look like a hospital, with suction machines, hospital beds — all that a nurse needs. The patient's own shower, furniture recommended for post-hip and -knee recuperation, a sleeper couch. Some really nice stuff for recovery.

The units are designed with a common area that looks like the lobby of a hotel. There's a very nice kitchen that serves meals. If you want to come to the bistro, you can, but it's essentially room service.

Q: How do you staff it?

A: We basically have one nurse to four patients. They'll get pretty intensive care. The typical hospital is probably one to six. We're looking for hospital or surgical nurses. We were able to get them up and trained two weeks prior to opening.

We started with registered nurses, but as we became better at predicting volume, we do use CNAs. It's not uncommon if census is down to have one nurse and one CNA.

Q: How does therapy fit in?

A: The physical therapy lag time is 0.32 days. That means there's a therapist seeing you at the minimum of eight hours after surgery. That was important to our orthopedic doctors. We've been very good about that. Health plans expect patients to be seen within 0.66 days.

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Overall, satisfaction is almost hitting perfection, like 4.96 out of 5. People go there and really like it. Who wouldn't? They're getting pampered, great meals, keeping busy and going home.

A hospital executive was pretty certain we were going to fail and all these people were going to wind up back in the hospital. But we were right. We made it work for these patients.

Q: How have you reacted to bumps in the road?

A: The reality is the volumes are not what were originally forecast.

We originally thought some people would be one to three days, but the norm is a one-night stay. We've been forced to add onto [the program]. We're diverting people out of the hospital. We began that about a year ago.

The goal is catching people before they get too sick and wind up in the ER or hospital. They use our comfort and recovery suites or a short-term stabilization stay, one to three days probably, for a tune-up.

Q: What's in the future?

A: It's even morphed some more. We'd been in business 17 months and gone from just an orthopedic project to the hospital diversion and more in the last several months.

Marshfield Clinic has purchased a hospital in Marshfield, and they're building one in Eau Claire.

What they're really looking to do with these long-term care beds, or short-term care beds, is work with the hospital system as well to maximize bed usage in each of these markets.

I'm certain what we're going to wind up seeing is a referral pattern that is beneficial to the hospital portion of operations and seeing much more stable census in these skilled facilities.

Q: What's pleasantly surprised you about this effort?

A: The whole survey process. We met with the regional director of the survey teams to give them an idea of what would happen.

In essence, we're taking hospital patients and putting them into a nursing home. We got certified by the same surveyors who do our other buildings.

The surveys have been very positive. We have two buildings that are five stars and one is four stars. They (surveyors) still scratch their heads at it. They don't look like traditional buildings. Things like home-like and resident rights, the regulations don't fit well for a place like this. At the same time, I think we're doing a good job of hitting intent.

There's been $6 million-plus of new revenue, and a lot of that's probably been taken out of the hospitals.

Q: What advice do you have for others trying this?

A: You have to have common goals and values, in this case excellent quality care and the lower cost. You have to look across the system and not just your little baby.

We weren't in a position to take on a lot of risk, and partly because of that and partly because it was such a new idea, we negotiated what amounts to a cost-based contract. We have a little bit of risk in overhead, but we become, in essence, a cost center for the clinic.

It's still profitable and probably what's more important is developing those inroads for working with a larger healthcare system. We've gotten insights into what's important to them. Down the road, those ACOs and will become much more proactive. Conceptually, that's what we're doing — getting ourselves ready for them. ■