A ‘super’ approach to care

Recent regulatory and reimbursement changes led Symphony Post Acute Care Network to develop a “Super SNF” care model. Serving higher-acuity residents and lavishing them with fuller personal services during the past two years has worked well for the firm, which has 28 facilities in the Midwest, seven of them Super SNFs. So well, in fact, Tim Fields, the executive at the front of the company’s efforts, has decided to venture out on his own, consulting and making plans for a new company focused entirely on Super SNFs. Fields discussed the model’s past, present and future with *McKnight’s* Editor James M. Berklan.

Q: How did you first get into the Super SNF concept?

A: We really started the model in collaboration with trying to launch new Northwest Indiana facilities, in Dyer, Crown Point and Chesterton. We were coming to a new market with new physical plants, but we also wanted to deliver a new model for partnerships with hospitals, physician groups and others.

The industry is shifting toward the model where the SNF provider has to take higher acuity, lower length of stay and costs of care, and then deal with lower admission rates.

We were trying to figure out how to stand out from the pack and differentiate ourselves.

Q: How did it evolve?

A: During strategic planning, we saw the writing on the wall, and the need to change how we do business to better align ourselves with the hospitals, physician groups and managed care payers.

The future’s not going to be a big phonebook list of where [post-acute patients] can go but rather a fine-tuned list of who’s doing the best. We want to be on that list.

We improved volume while improving customer services — there was great improvement on scores. So we improved relationships and improved margins.

As an example, we took over a facility in Evanston (IL) from a nonprofit, renovated it, improved amenities and aesthetics, put in a Super SNF program and had clinical and customer service upgrades.

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We went from not even being on the map with those hospitals to becoming the premier provider. It was almost a complete turnaround from way into the red to way into the black. It took time to do — it was a 12- to 18-month project.

Q: What's the key to making this work?

A: Number one for me is culture and staffing. You have to have a culture from staff who want to do this and move it. Not a conservative, risk-averse culture that does not want to move in this direction.

A lot of skilled nursing work is about regulatory compliance and playing defense instead of playing offense. I'm a believer in playing offense, not defense.

You need clinicians who figure out how to take this patient population and manage it, rather than see the reasons to avoid it and deny it. A good example is non-invasive ventilators. They're high-acuity. Super SNFs figure out how to do it. We get training and tell the hospitals how we can take care of this.

Finding staff with a certain perspective and background is important. We actually hired a lot of people from hospitality and we have one former ER manager.

Q: How do doctors fit in?

A: You need doctors who want to be in this model — engaged and present. We've built models with physicians and sub-specialties and nurse practitioners.

For heart failure and COPD patients, they're seeing cardiologists, pulmonologists and primary care doctors. You get this team of people working like in a hospital.

You have to find doctors with the right personality. I'm not an expert in physician billing but there's a way Medicare allows you to be able to take care of these patients. If, for example, you have 20 patients, four times a week and $80 per consultation, you can make it work. It's finding doctors who are willing to do it and then have the time and energy to do it.

> *We were trying to stand out from the pack.*

The other piece of that is building clinical programming. You need really good physicians and nurses. They can say here's the best way to take care of a CHF patient, from admissions to discharge and post-discharge. Program is important.

I'm also a big believer in the INTERACT program — the [Centers for Medicare & Medicaid Services] grant project with tools and pathways for how to manage patients.

Q: What's technology's role?

A: We want to understand the data and live in real time. This is a model where people are coming in and out quickly.

You need to understand the triggers and if things are moving in a different direction. You're making fast decisions, constantly looking at adjusting the medical record to help better analyze patients and better understand wound care and calling patients after they go home, for example.

Q: Don't hospitals get mad about encroachment?

A: No, because Medicare still requires the three-night hospital stay. They come to us after that. With managed care, we're seeing hospital-diversion strategies. Managed care companies like this because the most expensive piece is hospitals.

We work in a couple of hospital systems in Chicago and Indiana. They're definitely more concerned with avoiding having that person go to the ER and the total cost of care.

You have to work with the hospital and health system and sometimes say no, you can't take every patient.

Q: What's a possible negative of the Super SNF?

A: Staffing is something you have to work at every day. You're constantly tinkering with staffing. No matter what the market is, we still think we can get more sophisticated RNs. You never have enough in the labor pool. Staffing is always a concern that goes through ebbs and flows.

Q: How do you handle risks?

A: In general, you have to recognize and respect risk, but you have to play offense. Good facilities with good care don't get sued very much. Our Super SNF buildings are all four- or five-star buildings.

Q: How does enhanced customer service work?

A: We have a dedicated director of customer experience in every building. Our goal is to follow "Surprise and Delight" from our High Note Hospitality Program. That can mean helping them Skype with their grandchildren or bringing a chocolate shake from McDonald's.

We benchmark against 4- and 5-star hotels and often our facilities have a better score.

Q: What about the future?

A: I'm very bullish on things like new development. If you can raise new buildings and position them in markets where this type of model is advantageous, whether it's Pittsburgh or Charleston or Des Moines, there are probably certain areas that don't have providers sophisticated enough to get this model together.

The question about markets is, can you get the right staffing and the right culture? Not necessarily everyone can do it. ■