Regional Roundtable I October 2011

Executive Summary

LTC 100 Regional Roundtables are designed to provide an intimate forum for long term care leaders to share best practices and strategies, giving equal emphasis to short- and long-term areas of focus.

This past September in San Francisco, ten long term care C-level executives, from seven states (UT, CA, CO, TX, WA, NY, AZ), participated in the second of three roundtables. Their discussions centered on adapting to the changing future of long term care. The group talked about the challenges they face as well as steps being taken to address these issues. The main topics addressed were:

- Handling Medicaid and Medicare Cuts
- Financial Markets
- Creating Partnerships
- Preparing for Healthcare IT

We've organized this Executive Summary to present the key discussion points and leverage the experiences and knowledge of thought leaders in the long term care community.
Please note: names have not been attributed to specific quotes to protect the candor of the roundtable.

What are the Implications of the October 1 Medicare Cuts?

Among the providers at the meeting, the assessment of the impact varied based upon patient mix. Particularly hard hit are providers focused on transitional care and rehabilitation. One provider estimated that the effective reimbursement rate hit was closer to 14%.

While many providers are responding by looking at ways to cut costs, the reality is that SNFs have historically run fairly lean operations and that while everyone needs to watch their expenditures and look for ways to save, there is no way to recoup the lost revenue strictly through cuts. As one executive stated, "***providers that just slash will end up burning***. We still need to stay the course, focusing on quality and outcomes."

One executive acknowledged that "the way providers deliver care hasn't really changed over the years. We added more rehab and more nurses. But in order to adapt, processes will need to be re-engineered."

Strategies for Increasing Revenue

Extending length of stay:

Among the providers present, many are well below the average length of stay in their states. Part of the rationale mentioned by one provider is that patients improve the most in the last seven days of their stay. By extending the length of stay by 3 or 4 days, and using that time for additional care and education on how to take care of themselves, patients will have easier transitions and even better outcomes.

There are several barriers to extending length of stay. First, care plans will need to be adjusted, and should include an accurate and measurable benchmark that includes FIM scores. Also, the therapists and staff need to be educated about communicating why the patient should remain in the facility after they have been discharged from therapy services.

Co-pays also present a barrier. Providers indicated that they hit a barrier around day 20. One executive has dealt with this by establishing a "flex pay plan" where patients provide credit card information and are set up on a 15-month payment plan right away – billing credit card. This helps get over the 20 day hump.

One executive was more cautious about extending length of stay. "Be careful – HMOs like Kaiser are discharging in 10 days, not 21 or 41. Obama is looking at the Kaiser model."

Improving Documentation:

Focusing on improved methods for capturing what services are actually being delivered can increase reimbursement. One participant who has made several acquisitions of troubled facilities stated that ***improved documentation alone has caused these facilities to go from losing $30,000 per month to earning $30,000 per month***.

Training has to be a key component of improved documentation. Staff will need to be trained thoroughly on accurate MDS and ADL coding, and how to capture the information in the system.

There is still opportunity to move further upstream into treating more acute patients to obtain higher RUG rates – like caring for trachs. This will require a commitment to training and developing staff. One provider has addressed the challenge of developing staff by paying CNAs to train to become LPNs, and LPNs to become RNs. This program has reduced turnover from 32% to 2%. This same provider partners with a vocational college, and offers scholarships at local community colleges and nursing schools. The scholarships don't require students to work for them, but many do.

For those looking for ways to increase efficiency, below are some of the ideas recommended by roundtable participants:

- Working to partner with vendors, trying to share the pain. You can get a little through cost cutting but not enough.
- Stricter labor management can help – make sure you run the budget to PPDs.
- Implementing smart IT solutions to automate processes can save 4-5%.
- Listen to employees, get down in the trenches. Front line managers are a great source of ideas - listen to them.
- Make sure you provide the data front-line managers need to manage effectively. Also take a look at paper-based data capture. Staff spends hours a day collecting data on key metrics. There are "buckets of money" to be saved in documentation. It's possible to cut 10 hours of work per week by automating documentation.
- Make sure you are selective about key metrics. Some organizations spend half a month collecting data for a large number of key metrics, and then by the time you get it, it's out of date.

How are the Financial Markets Viewing Long Term Care?

Generally speaking, providers see opportunities. Investors seem to feel like the market is bottoming out, and that as providers really begin to feel the impact as the rate cut takes effect, a buyer's market will be created. There are several reasons for this:

"Reimbursement Cut Fatigue": Independent facility owners who are not up to the challenge of restructuring their business again after the latest cuts and will opt to sell.

Impending Facility Expense: Owners of older facilities that are facing necessary remodeling and upgrade projects with look to sell rather than take on new debt for development projects. Even an investment in EMR technology has to be considered within the context of the age of the building and the need for other investments.

Non-liquidity: Underperforming facilities that have been struggling to reach profitability will sell rather than attempt to refinance.

The challenge for larger, more sophisticated companies will be greater. Since they are already running very efficiently, they are limited in terms of actions they can take. Census will be the most important lever for them.

As an industry, SNFs need to educate people and lobby better about value, convincing the public that SNFs can be the community hospitals of the future. It was noted that hospitals and physicians don't want Medicare. SNFs can differentiate themselves by saying, "yes, we want it." Historically, SNFs did not work with very high end nursing patients, but that's changing.

How can Long Term Care Create Partnerships with Physicians & Hospitals?

When it comes to building relationships with hospitals, the consensus is that ***you need to get to the top and take discharge planners out of the loop***. The reality of penalties for readmissions is top of mind for senior executives, but not to the discharge planners. You have to build the relationship at the C-suite. Hospital executives get it. You need to understand their strategic plan to see if it aligns with your organization. Where are their pain points? Are they different in different markets?

One provider was able to make a strong case to a hospital CEO based on outcomes, and now the CEO monitors discharge planners to confirm that patients are being discharged to SNFs.

Building stronger relationships with physicians, and reducing readmissions, requires improved information exchange. When contacting a physician about a change in patient condition, nurses must be prepared with the appropriate information and be able to deliver it in a clear and concise manner. To ensure this happens, one provider has developed a form that requires all the salient information required to have a productive efficient call with a physician. Nurses are not permitted to make the call unless they have all the information on the case.

Another important factor in preventing weekend admissions is to be proactive. As one executive stated, "most of the conditions that require weekend readmissions don't crop up overnight. Most have been developing over several days." Restructuring rounds on Wednesday and Thursday to identify these developing conditions is a great way to prevent weekend readmissions.

Augmenting staff so that there is an NP or an RN on-site 24/7 is another way to reduce readmissions.

Several providers noted some disturbing trends in the behavior by hospitals. Some hospitals are classifying stays as observation and are not fully admitting the patients, and can go on for several days. While they get paid a lower rate for observation, they feel that it is worth it when compared to the financial impact of a readmission. Another noted that a local hospital wanted to charge a SNF for sending physicians to make rounds.

How can Long Term Care Overcome the Hurdles to EMR and Automation?

There are many hurdles to full-fledged EMR and the ability to share and update data. Each system is different, with similar data and no common format. Another issue is that most SNFs don't have EMR systems. Several executives feel that the adoption of EMR rests with hospitals. They will need to be willing to share information, and allow it to be updated. To get there, they'll have to find a way to share data while protecting it.

There are some promising things happening in the area of data sharing and automation. In the area of data sharing, some providers are seeing progress through Regional Healthcare Information Organizations (RHIOs). A RHIO creates a means to share diagnostic data on a patient, meaning that there are fewer redundant tests, which cuts down on costs. SNFs have the ability to access the data, but do not receive discharge notes and they are unable to change it.

Other opportunities to use technology to enhance productivity include: medication integration and pharmacy; ADL capture to improve documentation, and providing portals into SNF systems to physicians so they are able to sign off on orders.

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