United Methodist Communities

JOURNEY

TO A VALUE PROPOSITION

By Dr. Carol McKinley

INTRODUCTION

Gone are the days when referrals were coming readily to our communities and our beds were full and overflowing. Although healthcare has always been ever changing, most of us have not seen this much volatility in such a short period. We have witnessed a heightened number of mergers and acquisition, and an increase in hospital and nursing home closures throughout the nation. What was already a very complex system has become more arduous and to many of us, intimidating.

Unfortunately, the long-term care environment continues to combat multiple poor perceptions. No wonder, it appears that hospital systems, Accountable Care Organizations (ACOs), and insurance carriers want to disregard us in the post-acute strategy process. The truth is we have an important place at the table with value to share. That value does not demand huge amounts of additional costs or capital expenditures. It does mean that you have to understand what is important to your partners and how you demonstrate your value to them.

A first major step in this process is recognizing that care delivery has changed. People are experiencing shorter hospitals stays and going to nursing homes in much sicker states. In sub-acute nursing homes, rehabilitation is required to be brief; therefore, persons are going home not fully recovered.

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Person-directed care is an expectation, not just a fleeting philosophy. Data collection is the focus for how care is driven. Long-term care measures include length of stay, return to hospital rates, five-star quality ratings, resident satisfaction, and staffing ratios. Technology has given rise to electronic medical and pharmacy records and opportunities for health system portals. The federal government is executing new long-term care regulations.

Finally, newly implemented payer models promote effectiveness of care, but in an efficient process. Understanding Value Based Purchasing, Managed Medicaid, Managed Medicare, Accountable Care Organizations, hospital system expansion, and insurance companies is essential to navigating these entities. In their attempts to manage decreased financial resources, long-term care organizations are "narrowing the networks" with whom they wish to do business.

Ultimately, our value comes down to proving effectiveness of our care and services in an efficient manner, reflecting stewardship with financial resources. In an environment of many industry stakeholders, the requirements to prove your merit can be many. Consistency amongst the stakeholders seems to hold true in the following three areas: quality outcomes, return to hospital (RTH) rates, and length of stay (LOS) benchmarks. Each having a set standard defined by the various stakeholders in the healthcare and senior care industries. Creating an overall value proposition is complex.

United Methodist Communities (UMC), a senior care system located in New Jersey, understands this environment well. They consist of nine communities (five affordable housing and four full service communities offering independent, assisted living, memory care, and skilled nursing care); a home care company; and a central corporate office. With a 110-year plus history in senior living services, they have weathered well its many changes.

Over the last several years, they have accepted the care delivery changes noted above, worked to tackle these new challenges, and pushed to demonstrate the value they offer. They have utilized multifarious approaches to build their value proposition. Their story provides a living example of the development of a value proposition. Their journey has been broken down into the following sections:

1. Evaluating and Responding to the External Environment
2. Reviewing Their Internal Environment
3. Taking Risk and Expanding into New Territories

EVALUATING AND RESPONDING TO THE EXTERNAL ENVIRONMENT

The external environment has expected much of all healthcare providers. In most recent years, hospital lengths of stay (LOS) and return to hospital rates (RTH) have been a major focus. In assessing the external environment, UMC saw these areas as opportunities for them to enhance their visibility and demonstrate their worth.

UMC recognized that hospitals were financially suffering from extended lengths of stay beyond the expected DRG timeframe. Utilizing med-par analysis, UMC determined what specific Diagnosis-related Groups (DRG) with which the hospitals were struggling. Armed with this knowledge, their leadership was able to have meaningful conversations with hospital CEOs and CMOs on the topic of niche development to impact length of stay.

For example, a hospital with an average five day extended LOS in congestive heart failure, incurs on the average a $2,000 a day financial loss, giving rise to a total of $10,000. Multiplied by the number of extended hospital care stays yearly, the losses for an individual hospital can be in the millions. UMC worked collaboratively with the hospital teams to bridge care pathways around these significant DRG losses. The overall goal has been to shorten the hospital length of stay. UMC has implemented niches' in their full service communities; two evolving around cardiac needs and two developed around respiratory care.

Investment in this level of skilled care has required a modulation in staffing expertise, physician integration, and clinical tools. UMC has moved to an all registered nurse (RN) staffing model; added a respiratory therapist to the interdisciplinary team; replaced their EMR with one more robust; requested physicians become more invested in technology, including active documentation in the electronic medical record; and purchased various clinical instruments to enhance outcomes (i.e. bladder scanner, EKG machines, etc.).

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A critical aspect of this process is sustaining the hospital relationship over time. Change that comes with mergers and closures also typically means the evolution of the influencers within a system (i.e. CEOs, CMOs, CNOs). UMC's leadership persistently shares their story with hospital systems to ensure "a seat at the table" and that their work remains relevant.

Niche development was UMC's first step into value development. The second focused on the return to hospital (RTH) rates as defined by the federal government's readmissions program, started under the Affordable Care Act. Just like the extended length of stay in hospitals created financial issues for acute care facilities, so did this readmissions program. Hospitals with too high readmission rates saw their Medicare payments docked. Demonstrating low readmission rates is very important to our hospital partners. UMC has actively worked to reduce readmissions to the hospitals in multiple ways.

First, they focused on the in-patient side of sub-acute care. This emphasis encompasses improving quality outcomes by implementing a proactive, vigorous multi-daily clinical assessment process. Assessments completed twice a day help to uncover potential health complications before they worsen, allow for faster intervention and ultimately, prevent the need for admitting a resident to the hospital. UMC has accomplished this through an innovative software product called Daylight IQ, which provides the framework for in-depth health assessments of its sub-acute residents, focusing on those with multi-comorbidities who often quickly decline and

require re-hospitalization.Additionally, the software generates real time data on readmission rates. This enables the interdisciplinary teams to complete a root cause analysis for re-hospitalized residents. It identifies weaknesses, prompting adjustments in the care processes. Improving the assessment process as well as tracking readmissions from real time data, has made a significant difference to the organization as a whole. Historical double-digit readmission rates of 35 to 39% have shifted significantly to single digits of 5 to 6% corporate wide real time RTH.

Secondly, UMC has concentrated on the experience of residents once they return to their homes in the greater community. Noting the correlation between sustaining health post discharge within the home environment, UMC has created the *Transitions to Home* program. A UMC registered nurse completes a home visit within 24 hours after discharge from a UMC sub-acute stay. The nurse reviews discharge plans, confirms referrals and contact made with each, conducts medication reconciliation, and verifies re-connection between the primary care physician and the patient.

Beyond clinical concerns, the nurse also evaluates many of the psychosocial and environmental aspects, which prove more problematic to staying healthy. The physical environment assessment includes a review of the home for safety and accessibility, evaluation of transportation options for medical appointments, presence of nutritious food in the kitchen, and discussion with the client regarding their support network. Although discharge planners work diligently to gather this information, the home visit helps realize clients' additional needs. Supplying an additional safeguard also validates contact from the home health provider and the timely arrival and functioning of any durable medical equipment.

Since UMC's *Transitions to Home* program has started, various client issues have arisen, triggering health issues and a potential return to the hospital, including:

- Referred providers not making timely connections
- Transportation and support networks not strong as identified by the client
- The home lacks appropriate food supplies
- Multiple, questionable medications present in the home
- Durable medical equipment is wrong or not functioning properly

UMC has developed a strong downstream provider network of partners who among other things well understand the importance of controlling readmissions to hospitals.

Personnel collect and track metrics to determine success of the program in conjunction with readmission rates. After the home visit, the RN continues to make weekly phone calls to the client to substantiate progress.

Thirdly, through claims analysis, UMC discovered referral sources downstream impacted readmission rates post discharge from sub-acute care. Therefore, in seeking some level of readmissions control, UMC created a more formal provider network for downstream referral sources. Modeling hospital systems' preferred networks with nursing homes and rehabilitation hospitals, UMC has created their own preferred provider network.

Additionally, they have solidified this network through selected participants signing a preferred provider agreement. This creates transparency between home health providers and UMC that includes metrics regarding quality, readmission rates, and lengths of episodes. It also requests they prioritize UMC as the first contact when a client needs help, thus averting a hospitalization or emergency room if the client comes back to a UMC community. UMC has developed a strong downstream provider network of partners who among other things well understand the importance of controlling readmissions to hospitals. Recent claims analysis demonstrates a positive impact on decreasing readmissions.

As another step focusing on return to hospitals, UMC is integrating the preferred providers with the interdisciplinary team through a formal process, identified as the *Transition Council*. Held weekly at each community, their overall purpose is to support advanced discharge planning starting upon admission to a UMC community. Any partners involved in the care of the client upon discharge have a voice at the council. In light of much shorter sub-acute stays, early discharge planning conversations are key and better prepare residents and families for the next steps.

Finally, UMC understands the importance of connecting with elders before they even require inpatient health services. UMC, through developing senior resource hubs at nine different locations, provides a forum for the well elderly. Known as Senior Space, they promote opportunities for socialization, education, and case management through a variety of programming such as exercise, lectures and discussion groups, as well as professional resource connections. Most importantly, seniors in the greater community can engage, yielding opportunities for UMC's staff to gain awareness of those individuals. These early connections can potentially preempt an issue leading to hospitalization.

REVIEWING THE INTERNAL ENVIRONMENT

New Jersey has been moving to Managed Medicaid with state and national insurance providers, which are also evaluating Medicare Advantage programs. ACOs are proliferating across the state as physician groups and hospital systems begin to develop an understanding of functioning in this healthcare environment. They are beginning to put together preferred provider lists.

UMC knows they need to be assertive in these arenas. They have felt strongly about the value they bring through the niche development and their readmission rate metrics. However, is it enough in a very competitive market? At this point, is it worth considering that bringing value is not all about creating and implementation? It is also about understanding your value. It is about taking stock of what you do well and identifying what is important to potential partners. UMC, with its 110-year history and rich culture of care and services to their residents and clients, identified a great deal as merit worthy.

Metrics such as resident satisfaction, quality measures, risk management statistics, staffing ratios and mix, and five star ratings indicate service standards. To this, UMC has added niche specialties, readmission rates, Transition Councils and Transitions to Home. They have identified other programs that enrich their residents' care and services. This has included their deliberate move to a person directed care model; expanding rehabilitation through additions of biometrics, e-stem and ultra sound; and formalizing long-term wellness programs through partnering with SeniorFITness, a proven program that helps seniors achieve and maintain their functional potential and stay more independent longer. Furthermore, they offer these programs and services beyond their walls through Senior Space, which focuses on social engagement and case management. Likewise, the various types of residences within UMC's communities support the changing needs of aging seniors.

By taking stock of this internal environment, UMC discovered they have much to offer that is desirable to pertinent stakeholders. One example and historic organization-wide resource, assisted living, has brought long-term living arrangements to seniors, and met their overall needs through services and direct care. The amenities include registered nurse oversight, licensed practical nursing, certified aide support, dining and building services, and activity programs. Evaluations of this setting note that sub-acute residents often transfer to respite stays in assisted living before making their final transitions home.

With this in mind, UMC created the *Transitions* service line. Beyond a typical respite stay, the overall goal is to identify and work with the senior around very specific goals to prepare them for a successful transition to home. The completely private pay program's per diem rate covers room, board, very detailed physical and clinical care plans, and social engagement. People may stay up to six weeks, and longer if necessary, with executive leadership approval.

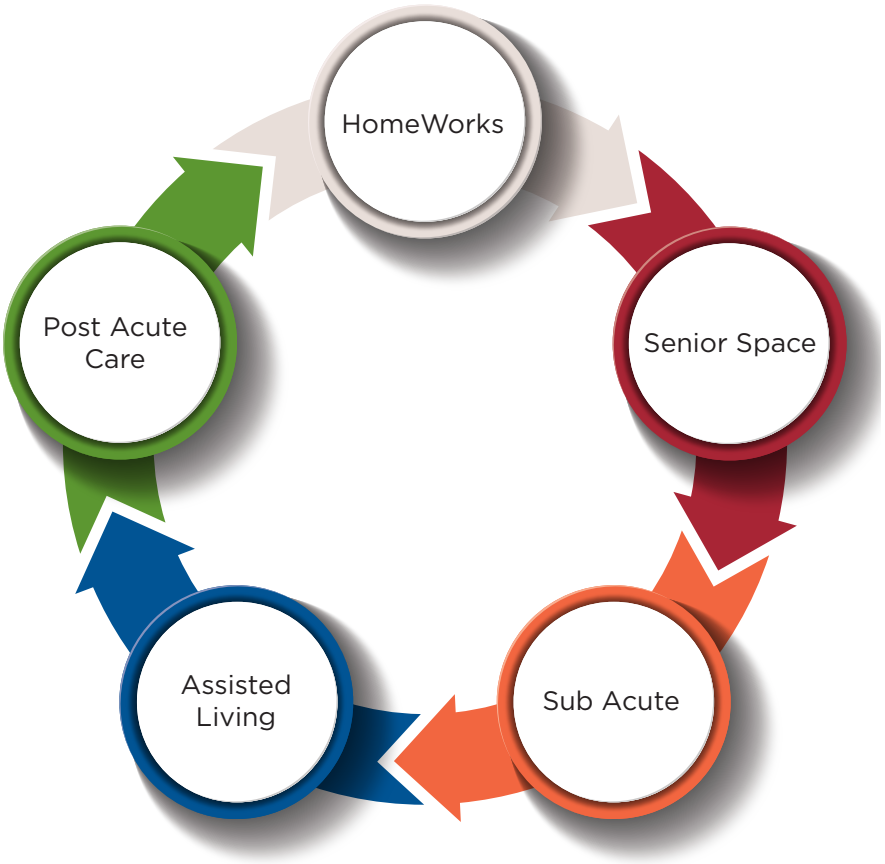
Any elder, elder's family member, or other referral source may request admission to a *Transitions* apartment. UMC has found this program helps bridge the gap in care. The admission might come from a sub-acute, a hospital discharge planner who finds a nursing home admission inappropriate, a home health provider who determines home care inadequate, and so forth. With shorter lengths of stays in hospitals and in sub-acute communities, *Transitions* has become an important alternative to returning home too soon. It has supported the prevention of re-hospitalization and emergency room utilization.

TAKING RISK AND EXPANDING INTO NEW TERRITORIES

In 2014, UMC took a risk and applied for acceptance into CMS's pilot study of the Bundled Payment for Care Improvement initiative (BPCI). The thought process of doing so was the idea that they could practice a process that pledged to be both a promising and lasting Medicare payer method. They became an active participant in this pilot study in 2015 with the support of a convener. The convener had the responsibility of completing a significant data analysis so that UMC could select its bundles.

During that process and among the learning, UMC realized if they did nothing to overall operations, they would still be successful in the BPCI initiative. This knowledge affirmed UMC's successful work in the areas of return to hospital rates and lengths of stay. The actual data analysis proved UMC's initiatives are both effective and efficient. As UMC continued their activity, they have worked to tighten their operations on both the quality and financial platforms. They learned the program very effectively promotes the state and federal goals of quality and financial stewardship. These processes all parallel the overall Affordable Health Care Act initiatives.

Finally, up until this point, UMC has always focused on institutionalized care. With the strong national push to help elders stay at home, UMC made the strategic decision to step into home and community based services. Reaching beyond their walls, UMC opened up HomeWorks, a home care agency offering home healthcare, certified nursing aide service and respite care. This initiative closes the loop of a very in-depth system of care UMC offers, from Senior Space pre-population participation, in-house opportunities, to the optimal outcome of successful discharge to home with the support of homecare with HomeWorks. While a huge endeavor on their part, it adds further value to UMC's overall picture.



THE VALUE PROPOSITION

UMC's journey defining their worth culminated in developing a strong value proposition. They have taken and assembled their merits in the form of a Triple Aim Score Card. The Triple Aim approach, modeled after the federal government's healthcare initiatives, includes Improving the Experience of the Resident, Creating More Affordable Health Care, and Improving Health of the Greater Population.

TRIPLE AIM SCORECARD
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Improving the Experience of the Resident

Psychosocial	Data Source
Person Centered Cared	Survey
Permanent Assignment	Schedule
Short Term Satisfaction	Survey
Clinical	
Continence Improvement	ACP
Patterned Electrical Neuromuscular Stim.	ACP
Therapeutic Ultrasound	ACP
Quality Measures CMS	
Pain	
Pressure Ulcer	
Antipsychotic Use	
Flu Vaccine	
Pneumovax	
Medication Management	EMR
Safety	
Risk Management	Claims

Creating More Affordable Health Care

Sub-Acute	Data Source
Length of Stay	Alliance Rehab
Readmission Rates	COMS
24/7 Admission Policy	Admission Stats
Model 3 Bundle Payment	Remedy Stats
Medical Specialty	Med Par
Cardiac	
Pulmonary	

Improving Health of Population

Community	Data Source
Post Sub Acute Transitional Care	Stats
Wellness Programs	Stats
Senior Fit	
Nutrition	
Education	
Home and Community Based Services *	Stats
Senior Resource Hubs	
Family/Friend Connectivity (Skype)	
Education	
Meal Program	
HomeWorks	
Care Management	
Medication Management	
Vital Monitoring/Telehealth	
Direct Care Support	

The Triple Aim process identifies the multiple levels of programming highlighted in this paper as well as the necessary statistical sources to demonstrate quality outcomes. It has become an important tool to utilize in communications with hospital systems, insurance companies, and ACOs.

SUMMARY

UMC's journey positioning themselves with a strong value proposition has taken several years. These efforts have required UMC to be creative, nimble, flexible, vocal, and assertive. They accepted a changing world and their need to change along with it. They strategically determined their direction through evaluating their external and internal environments, and their willingness to take risks. A team approach driven by a robust strategic plan, accomplished the work.

The Triple Aim Score Card summarizes their value proposition. The data it yields, leads to constructive and meaningful conversations. Overall, outcomes have been positive. All UMC's communities are established preferred providers. They are active throughout the state in collaborative, creative work with hospital systems and ACOs. Overall, UMC is a renowned leader in post-acute strategy and care.

Hospitals, ACOs, and insurance companies continue to evolve and establish preferred provider networks. It is in their best interest to work with aligned partners capable of meeting the new care standards, defined by effectiveness and efficiency, and providing value. United Methodist Communities has not waited for an invitation to join these conversations. Their proactive work in this volatile environment will help them build a solid future. They will continue to modify their value proposition as conditions warrant. Through these efforts, they will forge ahead to be a leading provider in this post-acute care arena. They are a living example of creating a value proposition.

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Dr. Carol McKinley is the Vice President of Operations for United Methodist Communities, a retirement system located in Neptune, New Jersey. She is a veteran licensed nursing home administrator, serving in an array of health care and aging services for over 30 years. Her academic credentials include a Doctorate in Administration and Leadership from The Indiana University of Pennsylvania; a Master of Social Work specializing in health care and gerontology from Boston University; and a Bachelor of Arts in Social Work with a health care focus from West Virginia Wesleyan College.

Dr. McKinley has devoted much of her education and career to the care of older adults. She is committed to elders having quality lives, being treated and respected as adults, and receiving the care and services they need to live to their full potential. The current health care arena creates difficulty in all of these areas.

Motivated by this challenging environment, her overall goals are using creativity with available resources and finding ways in which elders can continue to be honored. She vigorously participates in streamlining care pathways through appropriate collaboration and partnership, including post-acute strategy, value based care programming, value proposition development, and advancing partnership development. This proactivity has helped to place United Methodist Communities in a positive position within a very complex industry.

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