

MATCHING PATIENT NEEDS TO PROVIDER SERVICES

Providers seek referrals one influencer at a time.

Patrick Connole

The new world of long term care marketing has expanded the boundaries of where and from whom skilled nursing facilities (SNFs) and assisted living facilities (ALFs) seek referrals, from the old days of working only with discharge planners and social workers at hospitals to the 2010 version, where marketing targets practically anyone influencing seniors' post-acute care decisions.

The federal government says the goal of discharge planning is a "smooth move" to the next care setting, but making that happen oftentimes pivots on provider marketing.

Matching the needs of an exiting hospital patient or senior looking to move from home with the care capabilities of a post-acute care provider involves many factors and has seen many new trends emerge in recent times.

Marketing, both "inside" the industry and related settings of care and "outside" to the general public, can involve a slew of different strategies for providers to pursue, from physically having a representative working

in a hospital with case managers and discharge planners, to tracking data on potential residents via electronic health record management systems, to working on advertising and other outreach campaigns for bolstering the brand and boosting occupancy.

Everyone in the post-acute care business knows that hospitals need to move people out as quickly as is feasible, and long term care settings, in turn, need to gauge, sometimes quickly, how a discharged patient best fits into the continuum of care they provide.

Caregivers and patients, along with the discharge planning staff at a hospital, all have ideas on what qualifies as a "smooth move." And, for seniors looking to transition out of their homes and into an ALF, the decision relates as well to what their next residence will do for quality of life.

Reaching All Points Of Access

Seeking access to all sorts of influencers—the people who live with, provide services to, or simply know potential residents—is a growing trend in provider marketing, be it before or during the discharge planning cycle.

In addition to senior centers, post-acute providers promote their services among themselves (home care, hospice, rehabilitation, SNF, ALF) and to those influencing seniors: estate planners, clergy, ophthalmologists, Meals on Wheels volunteers, pharmacists, paramedics, and many more stakeholders, says Rhoda Weiss, an international consultant, writer, and educator based in Santa Monica, Calif. "As the numbers of people needing post-acute care moves from seniors to younger generations suffering heart attacks, strokes, orthopedic issues, uncontrolled diabetes, asthma, trauma, and more, the SNFs, rehab facilities, home care, and other providers are expanding their marketing and rethinking strategies, tactics, and techniques," she says, tapping into her experience as past national chair of the American Hospital Association Society for Healthcare Strategy & Market Development and ex-chief executive officer of the Public Relations Society of America.

Weiss relates that her 93-year-old father, who volunteers weekly at a center offering programs for seniors, understands how important referrals are to SNFs.

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“He sees scores of SNF personnel stopping by with information and goodies in quest for recognition, positioning, and, hopefully, referrals to their facilities,” she says.

Patricia Cokington, senior sales trainer for Sikeston, Mo.-based ALF provider Americare, agrees that the old days of SNFs simply making weekly visits to a hospital are over, and for ALFs the net is cast just as wide. “You are definitely seeing more referrals from different people,” she says. “You



Blaise Mercadante

see lots of influencers in church. The clergy know when one of their elderly worshippers can no longer come to services. Overall, they are very receptive.”

The main role clergy fulfill is, of course, as spiritual guides, making any work they do as a conduit to a

provider an informal task, says Father Kevin Walsh, pastor of Saint Anthony of Padua Catholic church in Falls Church, Va.

While tending to the elderly in his parish, he occasionally recommends programs he sees that work well for his parishioners. “There is a hospice that has done very good work, so informally I recommend them,” he says.

Besides an increase in the number of people receiving at least part-time home care, Walsh says in his 18 years as a priest, the main goal of families continues to be in trying to keep their loved ones with them, or in their own homes, as long as possible.

The key for provider marketing and sales staff is to reach out into the community, especially in rural America, Cokington says, noting Americare does most of its business outside of metropolitan areas.

While increasing the focus on non-traditional sources of referrals, the best place for provider marketing remains the hospital, be it by placing a representative within the hospital walls or a computer linkup for word on the latest prospective residents.

Physicians Receive Attention

Inside the hospitals, providers have tried more aggressive and straightforward approaches to let doctors treating their potential future clients know that their long term care facilities can offer patients a second professional home.

Blaise Mercadante, chief development and marketing officer for Miami Jewish Health Systems, says doctors are tops on their list. “We talk to physicians, and we talk to case managers and discharge planners. Part of our sales force meets with physicians and holds these events in their offices,” he says.

The goal is to make the doctor a partner in the future care of their existing patients and others.

“We really want them to feel comfortable,” Mercadante says. “The key message is that their patients will be cared for. We respect the role of doctors, and we will provide the service they feel comfortable with. If they want calls at 3:00 in the morning about their patients, we will do that.”

The next level is to work with case managers “to smooth discharges,” which also includes automated links with the nearby Aventura Hospital and Medical Center, he adds.

Kindred Healthcare, which has instituted a new marketing campaign under its Continue the Care program (www.continuethecare.com) in Cleveland and Indianapolis (with more target cities coming soon), says amongst all of its varied efforts, the communication with physicians is one of its chief marketing priorities.

“We really tell them that they can build a practice [at our facilities]. We make the economic case to the doctors by making the physician aware of the quality outcomes we provide and that we care for them,” says Kindred’s Benjamin Breier, executive vice president and president of the hospital division, as well as the incoming chief operating officer (COO) for the company.

No ‘Bounce-backs’

Dan Benson, COO of Indianapolis-based American Senior Communities (ASC), says his company has personnel right in the hospital “helping to be part of the solution” for discharge planners and hospital administrators, because

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assessing where to place patients is not as easy as looking up the nearest long term care facility and getting the elderly person there.

He says that especially today providers must be savvy in finding appropriate care for discharged patients, to prevent “bounce-backs” from the long term care setting to hospital. “Information gathering about patients really helps to prevent bounce-backs, a negative for reimbursement purposes as well as for patient care,” Benson says. “It is much better to coordinate care with the hospital, to cover the patient’s drug regime and all aspects of their care.”

ASC hires nurse liaisons to work at nursing stations to best gauge where potential residents stand in terms of needs, even working on transportation issues. “We go into a marketplace and find the sharpest discharge planners and case managers and have them become employees of ours,” Benson says.

Once a possible match for an ASC facility is discovered, the team works back to the facility level to make sure the care can actually be satisfied, he says.

“We ask if we can care for this person, are we able to meet this person’s needs,” Benson says, including physical layout of the SNF or appropriate machinery such as ventilators.

“It is the folks at the building level that have to be able to focus and see if we can make a good decision.”

In the old days, he notes, the decision by families to place a loved one in an SNF might take a day or two to sort out, but today it is usually accomplished in a few hours, with the policy emphasis on moving patients along the care continuum and competition for space.

Families can get a jump on research by looking at the Internet, but also viewing marketing materials, like virtual tours, provided by the long term care provider.

Critical To The Care Process

Weiss says as hospitals face higher costs, lower reimbursement, shorter stays, and growing post-acute community resources, discharge planning has become even more of a top priority. This importance translates into more collaboration and partnership with case management and utilization review programs.

“The role of discharge planning is growing in importance and respect as a critical part of the hospital’s medical and financial future and its ability to safely and effectively discharge patients to the appropriate post-acute provider, reduce re-admissions, increase patient and family satisfaction, and help lead the critical work of comprehensive continuity of care in their communities,” Weiss says.

During the past decade, Weiss says she and others have witnessed an explosion in best practice medicine that involves physicians leading teams of clinicians and support staff who compile, share, and implement best practice plans for scores of medical conditions.

“During the last few years, we are seeing more of these best practice care plans integrating discharge planning and discharge planners into the best practice plans,” she says.

Technology In Play

In years past, discharge planners would spend hours upon hours playing phone tag with multiple referral sources to place patients with the most appropriate after-hospital provider that had the time, space, and staff to accommodate the patient. Now, referrals are increasingly made electronically, securely, safely, and more efficiently, thanks to electronic referral management.

This benefits the hospital that can match patient needs to the capabilities, availability, and services of the referral source as well as safely and electronically share secured patient information with the after-hospital provider.

One of the main players in the electronic health records (EHRs) business is PointClickCare (www.pointclickcare.com), which bills itself as the market leader in long term care software-as-a-service (SaaS). At the start of this year, some 5,000 long term care centers in Canada and the United States used the company’s software for tracking demographics; managing current, historical, and waiting list clients; and maintaining a physician registry for all care professionals such as attending physicians, dentists, therapists, and consultants.

Mike Wessinger, PointClickCare president, says the EHR helps track bed availability and pre-booking assessments in a real-time fashion for often quickly developing discharge scenarios. PointClickCare’s software does this by allowing hospitals to capture critical information on the abilities, capabilities, and resources available from post-acute providers.

“It benefits after-hospital providers with easier and quicker access to patient information, which speeds referrals and patient transfers,” Wessinger says.

Marketing To The Public

There is another kind of marketing of course, and that is marketing to the public through media and other avenues, which is what providers of assisted living and independent seniors housing focus on more than in the discharge planning process.

Linda Dickson, marketing director for Redstone Highlands Senior Living Communities in Pennsylvania, says efforts to attract clients for her company’s housing options cover a number of traditional avenues, like direct mail and newspaper ads, as well as new social media like Facebook and Twitter.

“Direct mail is one of our best producers,” she says, noting that unlike SNFs, people looking at assisted living are making lifestyle choices rather than “needs-based” decisions.

Even through the tough economy, she says, Redstone's stable of apartments, villa homes, and memory impairment and skilled accommodations have been well-occupied, "95 to 96 percent sold and 93 to 95 percent occupied."

Dickson says one of her marketing successes has been the use of billboards, strategically placed to catch the eye of seniors driving in cars. "I was sort of laughed at when we first did it, but now I think people are envious of our billboards," Dickson says.

She notes that despite the forays into social media, Redstone's target audience is still newspaper readers, so they do a lot of advertising in that medium. In the end, however, direct marketing brings in the most business.

"Direct marketing helped us to zero in on the group of people we are hoping to see more of," she says.

The Kindred Campaign

At Kindred, the Continue the Care campaign has boosted business in the Indianapolis and Cleveland markets where the program has first been rolled out, Breier says.

Besides marketing to hospitals and doctors inside the hospital, he says the two pilot markets have seen an initial round of saturation advertising through print ads, direct mail, aggressive social media, and other outlets to first raise recognition.

"The content of the campaign is to build the brand," Breier says. It seems to be working, as he points to double-digit growth in the pilot markets as a result of the marketing campaigns in what is a "pretty tough market out there."

Kindred plans to expand the Continue the Care strategy to 20 markets in total, gradually rolling out to more

cities in 2011. Breier said the company did its homework before embarking on the campaign and stresses that it is important to remember that pre-planning is critical.

"The lessons are you can't be all things to everyone at once. Be careful on what and where you spend the dollars. I mean, we didn't decide to roll out to 40 states," he says.

At www.continuethecare.com, the public can access information about Kindred facilities across the country, covering long term and acute care, skilled nursing, assisted living, inpatient rehab, home health care, outpatient rehab, and hospice.

There are also click-throughs to refer patients, receive a newsletter, and even find employment, with one of the provider's goals being to attract new and skilled talent through the marketing program, Breier says.

Remember The 'Smooth' Goal

Through all of the various ways providers seek to manage their end of the discharge planning process, it is important to remember the factors in play and sometimes in conflict.

Discharge planning demands a continual balance between the needs of patients and their families and pressures of managed care and health plans for timely discharge from a hospital—often causing conflicts among nurses, social workers, and professionals who are part of the utilization review and discharge planning process; physicians responsible for each patient's care; health plans; employers; and post-acute care providers.

Medicare defines discharge planning as "a process used to decide what a patient needs for a smooth move from one level of care to another." But, Weiss notes, discharge planning is not an isolated event—it starts prior to hos-

pitalization once the patient is referred to and/or admitted to the hospital or at admission for unplanned medical events.

"The goal is to ensure patients can function appropriately and safely following a hospital stay," Weiss says. The objectives are to conduct a patient-centered, comprehensive assessment with the most complete data, resulting in the best possible decision making for patient placement. Whether the decision is to send the patient back home or to post-acute care, appropriate and safe reductions in lengths of stay and quick transfers are imperative.

It's A Team Event

Providers note that discharge planning demands close working relationships among all members of the health care team, from both the hospital and post-acute provider.

"Discharge planning is a comprehensive activity involving not only medical and physical needs, but psychological; spiritual; financial; and practical and family needs, capabilities, and available resources," she says.

The process is data- and labor-intensive and requires comprehensive knowledge by the discharge planning team of available community resources that best match patient needs and knowledge of how to make the best connections for patients and loved ones.

Discharge planners often know as much as primary care physicians about patients as they are typically involved in that care prior to or at hospitalization through hospital discharge to a post-acute provider and follow up, Weiss adds.

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The challenge for discharge planners, and why providers seek to help in the process or are connected to the process via electronic means, are many, from the hospital and its maze of clinicians, support and back office staff, primary and secondary physicians, and the many parts of a puzzle that comprise such a facility.

Weiss says these challenges also have been exacerbated greatly by higher hospital costs, inadequate reimbursement from government payers and health plans that often are lower than the cost of care provided, and enormous pressures from health plans and payers for short stays and early discharges.

“Another challenge is identifying an appropriate post-acute provider that matches the patient’s continuing health care needs, requirements for medical equipment, single or multiple diagnoses, the patient’s insurance plan, ability to pay, family budget and availability and age of caregivers, along with their capabilities to care for a loved one at home,” Weiss says. “The emotional distress of the family as well as their ability to accept different levels of post-acute care also play a key role.” ■



Thousands of long term care, post-acute, and assisted living providers utilize tracking and maintenance software to boost referrals from hospitals.

PRE-BOOKING FOR ELECTIVE SURGERIES

Another way that providers have made marketing inroads with families, patients, and physicians to secure new business in the rehabilitation space is by pre-booking people who have scheduled elective procedures in a hospital. Carol Spedaliere, administrator of the Port Chester Nursing & Rehabilitation Centre in Port Chester, N.Y., says pre-booking has proven to be a huge success and taken some of the confusion and worry out of the discharge planning process.

“People are very selective about choosing their doctor and their hospital, but many get left out of a rehab facility because they just don’t know,” she says.

To remedy the situation, the Port Chester team gives good information to patients and their doctors—

many of whom are orthopedists for elective surgeries—about their short-stay rehabilitation offerings, “eliminating anxiety” when the time comes to leave the hospital, she notes. The reception for pre-

‘HOSPITAL DIS- CHARGE PLANNERS ARE RESERVING SPACE BEFORE THE PATIENT ENTERS THE HOSPITAL.’

bookings, which the facility has done for around six months, has been excellent, with “patients and doctors really liking the idea of one care plan” covering pre-hospital, hospital, and post-surgery, Spedaliere says.

Weiss sees this trend as well, saying in many communities there is a waiting list for patients to get into an appropriate SNF.

“Hospital discharge planners are reserving space before the patient even enters the hospital,” say for spine surgery, Weiss notes. “A number of hospitals are also contracting with SNFs to secure a number of SNF beds exclusively for their patients.”

Since many of the rehab patients are in their 60s or early 70s, the time they spend at Port Chester can act as another tool for marketing in case the short-stay resident needs SNF care down the road.

“Absolutely, the 60-something-year-old can begin to look at what long term care can be when they are in their 80s or 90s,” Spedaliere adds.

WHAT PATIENTS ARE BEING TOLD

It is important for providers to understand the potential resident's perspective during and even before the discharge planning process and what caregiving organization guidelines are communicating to the public at large.

All patients are assessed in terms of health, functional, and social care needs, at or before admission, and these needs are continually reviewed during the hospital stay.

This includes documentation and decision making to determine when it is appropriate and safe for a patient to leave the hospital, as well as establishing policies, procedures, and criteria for that discharge and establishing a discharge plan for every patient that is recorded in the patient's record.

Rhoda Weiss, an international consultant, writer, and educator based in Santa Monica, Calif., says patients are typically educated on the projected length of their hospital stays and the plans for post-hospitalization before planned hospital stays or shortly

after becoming a hospital patient for unplanned stays.

"Even if the patient does not need any post-acute care from a provider, that patient—whether discharged from a hospital, outpatient setting, or emergency department—still requires education, information, lifestyle hints, risk-lowering health skills, prevention techniques, and referrals," she says.

Here is a sample of the kind of information potential residents are being told by caregiving organizations and what to expect before and during the discharge planning process.

BE PROACTIVE

As soon as a loved one enters the hospital, ask the attending physician how long they expect the patient will remain there. Tell the physician and the hospital unit secretary a meeting with a discharge planner/case manager is needed as soon as possible, so arrangements can be made for whatever continued care is necessary. Discharge planners and case managers find their time consumed with patients who are leaving the hospital "that day." By asking for a consult right away, caregivers and

patients can become a partner in the discharge process.

FIND OUT ABOUT INSURANCE

The discharge planner can help find out what a loved one is entitled to under their insurance. Specific medical criteria must be met in order for a nursing facility stay to be covered. The same goes for coverage of various home health aides and durable medical equipment. Let the discharge planner make these calls, so a caregiver can concentrate on the more important decisions.

It is also important to talk to a discharge planner about whether or not ambulance transport is needed. Depending on the insurance, this service may or may not be covered.

Many families are shocked to receive a bill, which can run into the hundreds of dollars.

SHARE INFORMATION

Be prepared to inform the discharge planner about a loved one's health history. In addition, the discharge planner will want to know about a loved one's activities before the hospitalization in order to better assess what services

and/or equipment that may be needed to help in caregiving.

Often, a patient will have more needs upon discharge from the hospital. For instance, before the hospitalization, he/she may have been able to stand and pivot during transfers. After the hospitalization, full assistance may be needed. If the house or apartment where a patient is headed to has narrow doorways or steep, curving stairways, a hospital bed or other durable medical equipment may not fit. Make sure discharge planners know about these barriers.

HOME-BASED AGENCIES

Home health agencies offer a variety of services, including certified nurse assistants, licensed practical and registered nurses, physical therapists, occupational therapists, speech therapists, dietitians, and sitters.

MAKE A LIST

Put together a list of any skilled nursing (rehabilitation) facilities (SNFs) or home health care agencies used for previous stays, and discuss which ones worked and why. For many patients, discharge from the hospital does not mean an immediate trip home. Today, a SNF is an extension of the hospital and is often the next step in

recovery. The discharge planner will provide a list of Medicare- and Medicaid-approved SNFs or home health agencies in the surrounding area. The planner will also contact the facilities to determine which ones have openings and/or available equipment and staff.

DO RESEARCH IMMEDIATELY

Check out area facilities or agencies before the day of discharge so there is not a rush into making a decision. Talk to family members and friends, and arrange to tour several facilities while a loved one is still in the hospital. Have a backup choice in case the first pick is full.

Talk to a physician about who will be providing care at the facility. Many physicians don't make rounds at nursing facilities, so a patient will most likely be seen by another physician while there. But, sometimes they do have connections to a SNF or other facility.

If a doctor does not visit a particular facility, this shouldn't be a problem if it is a short-term placement. Some hospitals run their own SNFs within the hospital complex. The discharge planner will note if a hospital does and if these beds are available.

Keep in mind that before any transfer, the physician providing

care in the hospital is responsible for preparing a discharge summary. The discharge summary should include a description of the hospital course of treatment, a list of medical problems and medications, and rehabilitation instructions. Ask the discharge planner for a copy of this document. Make sure to understand what is being asked and whether or not the care plan is doable.

ASK FOR HELP

It is natural to feel a patient is being discharged before they are ready. Remember, hospital stays are much shorter than they used to be.

It is also likely that a patient will have special medical needs that will continue beyond the hospitalization. The discharge planner is there to help make all the necessary arrangements for transfer to a SNF, for the use of home health equipment, or for health aides.

The day someone enters the hospital is usually not the time to be thinking about discharge. But in this era when the hospital is viewed as just the first stop in the healing process, it's never too early to begin planning for the next one.

Source: Rhoda Weiss and caregiving tips online

TECHNOLOGY HELPS REFERRAL PROCESS

A case example of how a Web-based referral management system can build census and increase revenue is the experience of Greystone Healthcare Management of Tampa, Fla. The provider sought out Patient

Placement Systems' (PPS) Referral Management System for its 25 skilled nursing facilities (SNFs) and has seen positive results from the purchase of PPS software.

Greystone said the system roll-out was swift, as the firm wanted to automate and accelerate marketing, admissions, and business intelligence to boost results for its dozens of users in Florida, Indiana, and Ohio as quickly as possible.

"The system has driven clear growth in census, up 5 percent in the first half of 2010 in comparison to the same period in 2009 when they were not using it," says Doug Walker, PPS vice president and general manager.

Greystone says the Web-based system has resulted in a 73 percent improvement in referral response times, with the improved efficiency

enabling admissions coordinators to focus more on customer service, such as greeting patients and families, preregistering patients, and ensuring that rooms are ready well in advance of admissions.

Walker says a large number of long term care providers, even large skilled nursing facility chains, are not using new technology to speed referrals.

SCRAPPING THE FAX

"You'd be surprised at how many use manually based processes that are very time-consuming and very inefficient," he says.

"There is some resistance in health care, particularly long term care, to new technology, but sometimes it is not even the technology that raises fear but the lack of interest in adopting new processes in general."

By scrapping the fax machine and phone call, Greystone has improved response times to referral tips to eight minutes from 30 minutes. "What you see is more efficiency," Walker says. Once staff see how quick the learning curve is for the new software, and the corresponding results, it is easy to win them over, he adds.

This echoes what the provider said early in 2010 when it chose PPS. "We had a strong business need for a comprehensive system to automate referral and admission processes across all of our facilities," says Connie Bessler, CEO of Greystone.

"Without the system, we were spending a huge amount of time and manual effort to capture the business intelligence we use to effectively market our services and maintain exceptional census performance," Bessler says.

PPS said its product is especially helpful for multi-location nursing facility operators as executive managers get new visibility into sales and admissions performance, with reports on win-loss, marketing effectiveness, referral source analysis, admissions, and conversion rates.

"The solution tracks the life of the referral and all associated data and documentation, arming Greystone with analysis and information that provides a true competitive edge in our census," Bessler says.

Greystone notes that 71 percent of its admissions are Medicare or Medicare HMO programs.