Project Healthcare Designing Integrative Care Models that Work

Maria Nadelstumph:

So, good morning. Welcome to Project Healthcare. This is a unique program that we've put together for you today. My name is Maria Nadelstumph with Brandywine Living. I'm your emcee for today. How many people here have seen the show Project Runway? Oh, quite a few. Okay. Let me just see those hands one more time. Where are you at? Okay, perfect, perfect. So we have a little bit of something different for you today in terms of how we're going to deliver information. And the content here that we're going to talk about about integrative healthcare is what we do know is we take care of people. And what we don't know is also on trend is what type of healthcare services are we putting into our communities, and our organizations, and our business to take care of people that are keeping them healthy and happy at home in senior housing? And really, what is the right fit for you?

Maria Nadelstumph:

So what we came up with today is to give you an idea of three different designers who are going to come up and talk about three different healthcare models that are working for them. It may be a good fit for you, it may not be a good fit for you. And what you'll have in front of you is a fit guide to give you some identification to say, "You know what? Maybe this works for me, maybe this doesn't work for me." Take some notes, jot down some questions, and as we go through this program today, you'll learn a little bit about care coordination, you'll learn a little bit about healthcare information. You'll also learn a little bit about services that are co-located as well.

Maria Nadelstumph:

And our three designers today represent different types of business, and we also have three advisors with us today, too, who are going to help dig a little bit deeper into the different designs, ask some questions, talk about implementation, and strategy, and value. And then we ask you to also participate at the latter end to say what other questions that you have to see if this is a good fit for you as well. So we have three designers, three advisors. I'd like to do a quick introduction of who our group is today. Our designers are Patricia McBride, who is the vice president of clinical and compliance with Christian Living Communities. We also have Sarah Walmsley with Bayada, who is the national director of strategic partnerships for senior living solutions. We also have Dennis, and Dennis is with SRI Management, and he's the chief information officer.

Maria Nadelstumph:

We also have three advisors who are sitting up here front and center who are going to be questioning our designers and really making them sweat up here as they walk the runway. Right, ladies, gentlemen? Okay. And our advisors are Ben Firestone with Blueprint Healthcare Real Estate Advisors. And we also have Phil Fogg, president and CEO of Marquis Companies, and we also have Amy Kaszak, who is the president of special needs plans for AllyAlign Health and is also the co-planner for this particular program today. So welcome, advisors. Welcome, designers. Welcome, audience. So let's get started. Our first designer coming to the runway today is Pat.

Patricia McBride:

Thank you, Maria.

Maria Nadelstumph:

Mm-hmm (affirmative).

Patricia McBride:

So good morning. I'm Pat McBride, I work with Christian Living Communities and Cappella Living Solutions. We are headquartered out of Denver, Colorado, and we serve... we manage and serve 24 communities in seven states currently.

Speaker 3:

So, I just have a really big problem. I'm so busy at home, my husband lost his job, I got to work two jobs, I've got kids at home.

Speaker 4:

Oh, my goodness.

Speaker 3:

And I have to do this lab work, get this lab work on my mom every week for her INR. And I just don't know how I can keep coming here and taking her to the lab, and it's just so much. I'm just overwhelmed. I just don't know what I can do, what else I can do.

Speaker 4:

Well, I think we can help you with that. In my role as the medical concierge, I can take care of the lab work that needs to get done every week for your mom so that you're a little less frazzled and torn in so many directions.

Speaker 3:

Oh, that would be so great. What a relief. That would be so great. I didn't know you did that here in independent living. That's really great-

Speaker 4:

We do that.

Speaker 3:

That you do have something like that.

Speaker 4:

Absolutely, absolutely. We have a lab, we've contracted with a lab. They come here once a week. I put in the... or, as many times a week as I need them. I put in the orders, I have her doctor's information. I might need to tweak that a little bit more with maybe her cardiologist information so that we can get orders and see if we can't take that off your plate for you.

Speaker 3:

Oh, that would be so great. What a relief.

Speaker 4:

Okay. Good.

Speaker 3:

Thank you.

Speaker 4:

Oh, no worries.

Patricia McBride:

So [inaudible 00:04:31]. That's kind of what we hear in all of our communities, right? Those adult daughters who have to take care of all this care coordination. So this isn't anything new. So I want to talk to you about our program called a medical concierge program. So it's much like when you go to a new city in a nice hotel, you go to the concierge and you ask them what not to miss in the city, and how to get around, and what's the recommendation for dinner. Our medical concierge kind of serve the same purpose. They are the care coordinator of all healthcare in our community, so they help get referrals, they help make sure people are assessed for certain things, they communicate to the daughter, they're able to find that lab work and that chest x-ray. They are kind of the quarterback of our healthcare system.

Patricia McBride:

We have medical concierge in all of our communities, in our three life plan communities, and those serve both residential living, independent living, and skilled nursing, and all payer mixes. So let me tell you how this works. So this is Dottie and her daughter Linda. Dottie lives in our assisted living community for about six years now. And Dottie was down talking to... getting a blood pressure exam during a clinic with our medical concierge Isabelle. And Isabelle noticed that Dottie had a cough and said, "Dottie, how long has your cough been going on?" Dottie said about five days. So Isabelle, the medical concierge, was able to make an appointment for Dottie to get her... go to a nurse practitioner in our clinic to get checked out. She called Dottie the morning of to make sure she knew of her appointment.

Patricia McBride:

During the appointment in the clinic, Isabelle, the medical concierge, took her vital signs, made sure she was comfortable. When an antibiotic was ordered, Isabelle, the medical concierge, called the pharmacy, had it delivered to the community. Isabelle then delivered it to Dottie in her apartment, making sure Dottie knew to take her pills every single day until they were gone, and also arranged to have Dottie's dog walked until Dottie was back on her feet. So this allows Linda to be... to fill the most important and the most fulfilling job that she has, which is that of being a daughter, not a healthcare coordinator.

Patricia McBride:

So we talked about... I talked about the high touch of our medical concierge. They're also some high tech. So our medical concierge set up all kinds of assessments and educational programs to help people deal with their medical conditions that they're living in. So this is a picture of Jack. Jack lives in our independent living, and he came to one of our fall assessment testing that we have. His medical concierge's name is Gabby. And so, Jack was tested, we used high technology. We use this company called VirtuSense. Has anybody used VirtuSense? It's a great technology that assesses people's potential for falls within the next six months. It assesses their gait speed, their ability... if one leg is a little shorter than the other when they walk, all these kind of things, and it spits out a probability of someone falling within the next certain amount of time.

Patricia McBride:

And Jack unfortunately scored pretty moderately high risk of having a fall, and falls are a big morbidity and mortality issue for us in our business. So his medical concierge, Gabby, printed off some good exercises for him to use, to do in his own home, set him up for a very specialized exercise class that we have in our community, as well as called his physician and got a nice order for a physical therapy outpatient rehab. And I'm happy to say that Jack tested about six months later and really reduced his chance for falls. So it was a very good success story.

Patricia McBride:

So we feel there's a triple benefit to a medical concierge. So number one is coordination of care. The whole purpose of this position is to coordinate all the different people that touch our seniors and make sure that everybody knows what the other one is doing, and everyone is charting in the same electronic health record. So that definitely has an impact on quality of care and efficiency of care. And this allows us to identify problems when they're subtle, before they become a 911 situation. So we were able to identify Dottie having a little bronchitis, not necessarily pneumonia, which would have been a 911 call. So we're able to reduce our hospital/rehospitalization rates, which is very important to our healthcare partners.

Patricia McBride:

The other benefit is we influence population health. So with all the screening and the programming that our medical concierge coordinate, we allow the seniors to take control of their own healthcare. And empowering the seniors to do something much like Jack did with his fall risk really creates a better environment for them to be able to stay in their level of care longer and more successfully, therefore closing the back door. And third, improve customer satisfaction. All of our seniors and their families, as well as the team members who come in touch with medical concierges, are just thrilled. They love the service. And having good customer satisfaction is everything on making sure you have occupancy. It also creates a new market niche that could help differentiate you in a crowded market. A good customer service, of course, increases your occupancy, which gives you a good return on your investment. Thank you.

Maria Nadelstumph:

Thank you, Pat. So hold on to that clicker. We're going to pass it around. We should probably get some hand sanitizer up there, now that I think about it, right? We're passing that back and forth to one another. Coming up here to our advisors, who have obviously some questions. I see a lot of head nodding. So, Amy, why don't you kick us off? What's the questions you have for Pat?

Amy Kaszak:

So, Pat, my first question is I'd like to know a little bit more about the medical concierge. So what type of person is this?

Patricia McBride:

So we've been very fortunate and successful by using CNAs and medical assistants in our medical concierge role. They're very cost effective, and I think the best characteristic of a really good medical concierge is the medical assistant who runs a really busy doctor's office, that really organized person that is very autonomous, that can be a really good problem solver, someone that doesn't allow loose ends. They make sure everything is covered, and they're very good communicators. So the best charac...

This isn't somebody that has to run by all their changes to their supervisor all the time. This is somebody that has to really be quick on their feet, and autonomous, and a good problem solver.

Amy Kaszak:

So I've got a follow-on now. So is this truly a new role, or would you use one of your nurses or social workers?

Patricia McBride:

We do not use our nurses and social workers. First of all, they're very expensive. Our nurses, and it depends on where you live, but ours are about 37 to $40 an hour. Medical concierge, we pay about $17 an hour average. So this person is... medical concierge is someone that will find that lab work for you, call the doctor's office, make sure it's in the chart at $17 an hour. And we would like our nurses at around 38 to $40 an hour to interpret the laboratory report, much better and effective use of a position.

Ben Firestone:

Pat, the question everyone in the audience is asking themselves right now, how do you measure the return on this investment?

Patricia McBride:

Well, we measure it mostly by customer satisfaction and occupancy rates, and as well as rehospitalization rates. We've really kept our rehospitalization rates low and our... And then, again, it's a market niche. It's something very different that can drive up your occupancy.

Phil Fogg:

Is there a charge for this service in addition to your monthly?

Patricia McBride:

There is not. No.

Phil Fogg:

So it's buried into your monthly rates?

Patricia McBride:

Right.

Phil Fogg:

And I'm curious. Do you have an EMR in your communities? Or how do you gather the data-

Patricia McBride:

We do.

Phil Fogg:

To be able to demonstrate the value?

Patricia McBride:

We have an EHR. And from there, everything is into the electronic health record. So it's all coordinated.

Phil Fogg:

And can I ask you, are there... You mentioned hospital readmissions. I could definitely see how this helps people live the best rest of their lives. Are there other population health factors that you measure beyond customer satisfaction and hospital readmissions?

Patricia McBride:

Well, yes. We measure how long people can live in their current level of care before they have to move out into another level of care. We measure all kinds of medical indicators: hospitalization, ER visits, how many antibiotics they are on, certain medications. We track all those clinical indicators.

Amy Kaszak:

Great. Okay, thank you, Pat.

Patricia McBride:

Thank you.

Amy Kaszak:

I don't think we have any more questions.

Maria Nadelstumph:

Thank you, Pat. I'm actually taking some notes myself, and I feel like it's a fit for us when I think about our company. How many people think it's a fit for them, that type of role and that position in your organization? Anybody? No, nobody? No fit? Oh, we got one. We got one in the back. Thank you very much. And I think... Yes, of course, it's a fit back there. So let's move forward, and I thank you, Pat, for sharing that information. I think it's a very helpful, unique role. It's not just the clinical coordination, but there's a relationship component to it as well, so fining the right individual for that role is a critical piece, too. So, excellent. I'm going to ask Dennis. Come on up, Dennis, and present your design.

Dennis McCarthy:

Hi. My name is Dennis McCarthy. I'm the chief information officer with SRI Management. We're a small management company based out of Tallahassee, Florida. When we started this project three years ago, we had 14 properties. We're at 31 today, with six more coming out of the ground this year. So we're kind of growing, blowing and growing, as I like to say, and trying to keep things moving forward. We went to a very highly integrated model to try and do what we wanted to do with providing care to residents, proving care to the families because they're every bit as important as what we do. And we like the idea of putting all the information available in one basket. This allows everybody that we need to see information see all the information we want them to see.

Dennis McCarthy:

It gives us a lot of flexibility and a lot of power in the little things like reporting. We can pop a report out that can show you who in the last 30 days has fallen, missed meds, is late on her payment, and had the maintenance guy show up in her apartment to fix something that had to be taken care of. The ability to

do that is a really powerful ability to us, putting all that data in one stop, putting it all in one place gives us a lot of power in flowing information. The information flows from sales to care in one system and everywhere in between. All of the financials are in there, all of the care pieces are in there, all of the information collected in sales.

Dennis McCarthy:

We had a situation not too long ago where a resident who needed to be... or, the resident family member needed to be contacted, we found out that the mobile number had not been updated anywhere in the system. But the new nurse got the number, put it in the system, and instantly everybody across the entire spectrum had the same phone number. It was just as quick as pressing a button. It's really powerful to have all of that in one place. Staff maintains visibility anywhere at any time. We're spread out. We've got divisional directors of nursing that live in Pensacola, Panama City Beach, Clermont, down in the Sarasota area. Every one of them can see every resident all the time. In fact, if I was really up to it, I could go log in and show you all of our residents in one shot. It doesn't take much to be able to do that. But that visibility is pretty powerful. It gives us a lot of flexibility in where people are in getting help to the source when it's needed.

Dennis McCarthy:

What we generate from our system are care plans. We have an electronic health record. The electronic health record includes an assessment piece that's done. As the assessment's done, it generates a care plan. As the care plan gets generated, staff members, as they're doing things, are checking stuff off. They're all working off a mobile device, and there's a lot of advantages to having people working off the mobile device. There's a few things that we've learned to manage better because we've got that in people's hands. But it's a really, really powerful way to be able to get everybody on board. This means everybody. Everybody from the business office manager to the housekeeper to the LPN to the caregiver, whoever, they've all got the information they need.

Dennis McCarthy:

The ability to update that information anytime, anywhere is really, really important to us. As I mentioned, the phone number issue that somebody found, I think it was about 7:30 at night they needed to get a hold of a resident family member. Once they finally got the number and put it into the system, the next day, the ED was able to follow up, the sales director was able to follow up, everybody had that information. One of the other really powerful things that we gain from this is some offline charting capabilities. The system is designed so that you're going to get a network hiccup. Welcome to Florida, the power goes out, right? The ability to offline chart for a period of time has been really good for us. It's really helped us a lot.

Dennis McCarthy:

And again, I can't overstress that ability to do everything with the resident from the time they get out of bed in the morning to the time they go back to bed in the morning, and everybody across the entire spectrum can see everything that's going on with that resident. It's a real powerful piece that I think really gives us a lot of flexibility in taking care of residents. There we go. Whoops. I think I got to go back one. All right. The expected result, full team collaboration. This is really, really important. One of the unexpected benefits we got out of this is we suddenly elevated some people that maybe typically feel like they're, "Okay, we're here. We do our job, but we're not really part of taking care of the resident.

We just do our piece." We elevated everybody to one good, solid team because they're all looking at one good, solid piece of data in one database in one place all the time.

Dennis McCarthy:

The ability to build out a custom solution, I would recommend that if you're looking for something, look for something that you can customize. We use the Yardi platform, been very, very happy with Yardi. We can customize it from one end of the spectrum to the other. We can customize the way the guest card looks when we bring somebody into the building. We can customize the assessment. We can add and delete assessments literally on the fly. We can customize the way the record looks in the system. We can customize who can see what. We have some external users, for instance, pharmacy users. We've given them the ability to log in and look at this, but we can also highly restrict what they can do when they get in the system. We've given some physicians the ability to get into the system.

Dennis McCarthy:

Believe it or not, we like to kind of restrict what the physicians can do, too. They would probably like to get in there and go crazy. We'd rather they didn't do that. And the... training the staff staff... I would probably like to mention one other piece that we brought along with this, and that is the Yardi e-learning piece. We were able to build out a solid e-learning piece that every single user that goes into the system has to go through. And not only do they then get all this training, they see everything that we want them to see, the way we want them to see it, how we want them to see it, how we want them to do it, but we're documenting that now, too. So we can say, "Look, you were trained to do this this way. Oh, you did do it? Okay, very good." And it all works out pretty well. Full team collaboration. They've got the information at their fingertips in the accurate and timely documentation.

Dennis McCarthy:

Another piece, decision making, when and where it needs to happen. We live in Florida. Welcome to Florida, you're going to have a hurricane. It's going to happen, you can't avoid that. We had to evacuate one of our buildings last year. Instead of boxing up a hundred and... I think it was 103 or 104 medical records and shipping them with the residents, we boxed up seven iPads, put them in a box, and sent them 250 miles away with the residents. Before they got there, we were able to get into the system, set the system up so that nurses at both of those communities could see all of those residents simply by logging into the system. So now we've combined teams 250 miles away, combined residents 250 miles away with a simple... It took me less than five minutes to set the system up so that every user at both buildings could see every one of those residents and know exactly what was going on with those residents.

Dennis McCarthy:

What are we in this for? We're in this to take care of people. I'm a technology guy. I've been a technology guy for over 30 years. I enjoy playing with computers. I probably enjoyed taking things apart when I was a little boy, who knows. But the bottom line is, I'm a technology guy. But we're not in this as a technology business. We're in the care business. Our job is to take care of people. Our job is to make sure that the residents are taken care of. I get the pleasure of providing the technology to help make that happen. But resident satisfaction and family satisfaction is really critical to us. One of the pieces that we have is called RENTCafé. A family member can log in through the RENTCafé portal, can see what's going on with the resident, can see the care that's been given, can see the bill, the whole nine yards. Everybody can see everything. I think that's what I've got.

Maria Nadelstumph:

Thank you, Dennis. That's a great job. Thank you. Let's hear from advisors. I know there's a lot of questions about strategy, too. I could feel it. How about you, Ben?

Ben Firestone:

Dennis, what are the must-haves for implementation of this system?

Dennis McCarthy:

You know, it's interesting. The very first thing I think of when you say that is you must have a network. You've got to have a good, solid, strong network. But one of the benefits that we've found with our Yardi implementation is the ability to offline chart. So I would say network, make sure your network infrastructure's solid and sound, don't be afraid if it fails that you can do what you need to do. But network is the number one thing that I think that you really have to have. You've got to have a solid network. You've got to have an infrastructure that can support it.

Amy Kaszak:

So, Dennis, I am not a technology girl. And so, as I'm listening to you talk, it sounds like this is a pretty big undertaking. There's a lot of pieces. So my first question is, for the audience, is this something that other providers can actually replicate? And as you're answering that, if you could also say is this something that can be... Can you do it in pieces or a little bit at a time? Or are you doing it all at once?

Dennis McCarthy:

That's a great question. I appreciate that. Number one, yes. Anybody can do this. There's no reason why any provider could not put in what... we refer to it generically as the electronic health record, but there's a lot that goes with that. But the answer's, yeah, any provider can do this. There's no reason why they can't. Your second question regarding stages, we actually did it in stages. When we started, we had 14 properties. You're looking at 14 caregiver staffs, 14 properties that have to be configured, 14 properties that have to have all this stuff built out in there.

Dennis McCarthy:

What we did was we had already done assessments on the EHR platform, so we just rolled that right in. We had kind of already done incident reports on the platform, so we rolled that in. We took on the big boy next. Instead of taking on the little things like charting, we took on the EMR next. We made our next step putting the medical... the passing of meds as our next big piece out there. And once we had everybody at the same piece, then we were able to start rolling forward with different pieces, different parts of the electronic health record. So the answer's yes and yes.

Phil Fogg:

Dennis, probably almost 100% of this skilled nursing facility environment has embraced a Saas, cloud- based EHR solution.

Dennis McCarthy:

I'm sorry. My hearing's shot.

Phil Fogg:

That's all right. About 100% of the SNF operators in America have adopted a Saas-based, cloud-based model.

Dennis McCarthy:

Right.

Phil Fogg:

What do you think's the primary barrier for ALF or senior living communities to embrace the EHR?

Dennis McCarthy:

Probably I would say you're going to have some people either in some leaderships roles that are going to look at this and question it. "What am I going to get out of this? Why are we doing this? What are we spending this money for?" Yeah, I honestly believe that that's the number one and maybe the only barrier that you're going to see. And I'll give you an example. At our Ocala Hills building in Ocala, Florida, I was concerned about that building. It was... I'm going to offend somebody here. I'm not PC, what can I tell you?

Dennis McCarthy:

The director of nursing there was an older woman. She liked hiring people more her age, so we had a pretty... we had kind of an older care staff there. And I'm thinking, "I'm going to put an iPad in the hands of a bunch of grandmas here." Worked out like a champ. They took right to it, they handled it well, everything went great. I don't think you're going to see barriers at staff levels. I don't see... You're not going to see barriers at director levels. You could see somebody that's going to question, "Why are we doing this?" And you got to get past that question because the benefits once you do get past that are phenomenal benefits, they really are.

Phil Fogg:

Follow-up question. You mentioned what I would think of as a family portal.

Dennis McCarthy:

Right.

Phil Fogg:

That enables them to get into the EHR. I'm just curious, A, what kind of engagement are you seeing from families? Because I'm a believer that we have to begin to get transparent with our information and kind of evolve. I think that's where we've lagged behind other professions. So what kind of engagement, and are you getting resistance from providers with being transparent with care plans, and progress notes, or treatment plans?

Dennis McCarthy:

First, no. We're not getting resistance. Another surprise to us was how well the family members took to the Rent... to the portal, to the what we call RENTCafé, the family member portal. Again, remember my discussion about customization. I can limit specifically what they can see, when they can see it. We're not just letting them go look at the health record and say, "Oh, Mom took losartan this morning at 3:15." They're not seeing that kind of stuff. But they can see an assessment, they can see progress notes

if we're releasing those progress notes. And they can see things like the bill, charges that are rolling up, stuff like that.

Dennis McCarthy:

But we've seen zero resistance to that. The only places where we've probably not really pushed that out into the caregivers, into the families, and things like that are simply because the local property are still struggling with, "How do I present this? How do I make this as part of my sales pitch?" So to speak, things like that. But it's been a... That product's been a very good product. The son changes his cell phone, he can log into the portal, put in a new cell phone number, and, boom, everybody's got it instantly, just like that. So that's a really, really powerful thing to be able to provide people.

Amy Kaszak:

Thank you. I think that's all of our questions.

Maria Nadelstumph:

Thank you, Dennis. Nice job.

Dennis McCarthy:

Thanks.

Maria Nadelstumph:

So I have to say one thing from Dennis' presentation. Next year, new title, new tagline, "iPads in the hands of grandmas." Love that. I love that. Next session, next year, technology, "iPads in the hands of grandmas." Sarah, come on up.

Sarah Walmsley:

Thank you. I'm Sarah Walmsley. I work for Bayada Home Healthcare, and I'm excited to bring my design for you all today. Our model is based off of bringing an integrative care model that we can stand up in your communities. It's called senior living solutions, and we developed it about 10 years ago because we really wanted to be able to bring these services in house, these healthcare services to your residents. As they age in place, these are the services that you're going to need to be able to also unload the burden of managed care off of your wellness team. And so, under senior living solutions, this model brings home health services, which is skilled nursing and outpatient therapy... or, excuse me, therapies. And then our teams are also certified to treat under the Medicare B certification and bring to you therapy services, we bring fitness classes in house. We also develop wellness programming and staff education designed to really raise the health IQ of your entire community. And then if needed, at end of life, we have hospice services.

Sarah Walmsley:

But all this is run by the same dedicated clinical team. They get to know your residents, they know how to collaborate with your wellness team and with their primary care physicians to really bring a true coordinated care. Complicated design? So today I'm going to break out and just talk about therapy services. You may know therapy services on site as your outpatient therapy team, or it might be known as rehabilitation. But the hallmark features of it, it is multi-disciplinary. You'll have physical therapists,

speech language pathologists, and then occupational therapists that are designing treatment plans that will enhance your residents who need its function.

Sarah Walmsley:

There's a strong emphasis on proactive health and preventative medicine. As a therapist myself, it's my job to reduce the need for pain medication, unnecessary surgeries, reduce their risk for falls, ER visits, and hospitalizations. And how is that done? It's done by really getting to know your residents, running health clinics, balance screenings, fall programming, developed specifically to meet their unique needs and to keep them healthier longer. There is a strong emphasis on developing a culture around wellness, so when you bring therapy services in on site, they might be renting a clinic space. It's usually a very vibrant experience for your residents to engage in because we want to not only optimize the function of the residents that we are working with or any therapy company is working with, but also increase the function of all the residents in your community.

Sarah Walmsley:

Now, what is the strategy? How do we implement this? How do you implement this? It is as easy as selecting the right partner. We hear a lot about selecting the right partner, and you may already have a therapy company on site right now, but I think we have to talk about how to evaluate what is the right partner. You're providing them a very captive customer base. They are going to be interacting with your residents, their families, your wellness team, your professional referral sources, hopefully for many years. They're a representation of your brand, so does your mission and values match? That's the number one question. Do they have outcome data that is benchmarked nationally that they can share with you on an ongoing basis to make sure that you are selecting a quality partner?

Sarah Walmsley:

Like I said, you're providing them an opportunity to have a business inside your community, so what are they providing for you? Are they available to be there to help you to consult for gym spaces, clinic spaces? If you have fitness equipment, can they evaluate to make sure that you're selecting the right equipment your seniors will use? Are they available for move-in screens? Will they take functional data of residents as they move in, and then look at them every quarter or every six months to see if there's a decline, and maybe get them on services sooner? How are they going to integrate with all the other healthcare entities that are in your community, whether it's a physician, or hospice services, or home care aides to make sure that throughout the journey of your residents' healthcare experience, that it's completely coordinated and there's strong collaboration? How are they going to be held accountable to that integration every month, every year?

Sarah Walmsley:

And co-marketing is something that you should ask them about. What are their experiences with bringing more exposure to communities, to your community specifically? What is their plan to get you in front of maybe healthcare systems? Are they a part of a larger post-acute network? Are they the preferred provider that can get you to the seat of the table and have discussions with maybe a hospital CFO or a skilled nursing facility administrator to develop more professional referral relationships? And the value of bringing therapy services in house with the right provider is, number one, it doesn't cost you anything. If anything, it might be a revenue generator. So I mentioned renting clinic space or gym space just to give you an idea because it is based off a fair market value to be in state and federal compliance. We're pretty heavy on the East Coast, most states, 13 states, and we also have offices in

Arizona and Colorado, so we rent a lot of spaces. And our average rental of a clinic space is about 355 square feet, and that's about 6,500 yearly revenue that can be brought to your community.

Sarah Walmsley:

We talked about co-marketing events as a value add. I talked about it at a professional level with healthcare systems and skilled nursing facilities, but let's talk about are they going to be hosting events in your community, can they bring speakers and continuing education, professional networks, events to your community to help bring exposure? Therapy clinicians are usually a very dynamic team, they're engaging your residents, they're able to get to know them on a very personal basis over a long period of time. That's a second pair of eyes on your residents. They're going to notice a decline very quickly and be able to proactively identify which services are appropriate for them to prevent a fall, to prevent a hospitalization. And it's easy access to care. So they can identify a need, call a physician, get an order, and start care most times in the same day.

Sarah Walmsley:

We know that low hospitalization rate is something that everybody is talking about. We know that that's very important. How do you take that number if you're achieving a low hospitalization rate and tell a meaningful story? I'll give you a little context of how that can happen. We are in partnership with Brandywine Living Communities. There's eight of them that are matching in our footprint. At any given time, we have 150 of their residents on either home health or outpatient therapy services. We have collectively a hospitalization rate that is nine percent. Why is that relevant and why is that good? Because the national rate is closer to 15, 15.5%. That's where it typically hangs out. So we're well below the national rate, and that is a savings when you can annualize this out and know how to tell the story to the healthcare system of over a million dollars.

Sarah Walmsley:

So who wants to hear that story? Hospital CFOs? Yes. Skilled nursing facility administrators? Absolutely, especially with PDPM, they're looking for partners who they know that they can trust to keep their patients, your residents potentially out of the hospital for 90 days so they don't have a hit to their revenue stream. So you can see that being able to provide this kind of data and get these results can open up a whole new way to even bring in new revenue sources and develop stronger relationships with your larger healthcare network. All of this, of course, is designed to help keep your residents aging in place til end of life in a very healthy, happy, and active way. Thank you.

Maria Nadelstumph:

Thank you, Sarah.

Phil Fogg:

Sarah, I've got three questions. I'm sorry.

Sarah Walmsley:

Shoot.

Phil Fogg:

The first is what kind of scale in terms of revenues do you need to see out of a community to make this work for you guys? Do you have a sense for that?

Sarah Walmsley:

Yeah. I would say that about 20 residents on service at any given time. Really, though, depending on the size of the community and the size of the clinic space if we're renting it, there are Medicare guidelines that we have to follow that if you don't have that amount of residents on service with you, then you actually would be considered in violation of an Anti-Kickback law.

Phil Fogg:

And then, did PDGM change that number at all, or do you not quite yet have your head around that yet?

Sarah Walmsley:

So for those of you that don't know, you're talking about PDGM for home health?

Phil Fogg:

Yep.

Sarah Walmsley:

Yeah. So PDGM affects our home health payment system, how we're paid is the largest change that we've seen in the last 20 years. And so, it is affecting us, and we've been well prepared. And actually, what we'll see is more utilization of Med B or outpatient therapy services in the future.

Phil Fogg:

And then, lastly, are you able to get the facility enterprise to pay for any part of your costs, or do you... You've got multiple revenue streams, probably some of the residents are paying, some Medicare, some Advantage care. Is the facility paying at all or contributing?

Sarah Walmsley:

No, the facility doesn't pay at all. It's reimbursable by their insurance. There might be some out of pocket... When we're talking about therapy services in particular, there might be some out-of-pocket cost depending upon your residents' insurance. Did they have co-insurance? When we're talking about the home health services, that's completely covered 100% under their Medicare A benefit.

Ben Firestone:

Sarah, what are the biggest challenges associated with not having your own facilities with your own amenities that you're familiar with?

Sarah Walmsley:

So expand upon that. Own facilities, like meaning having your own clinic inside a community?

Ben Firestone:

Exactly. So not having your own gym, your own-

Sarah Walmsley:

Got you.

Ben Firestone:

Your own equipment.

Sarah Walmsley:

Yeah, I think you don't have to have your own gym if you're bringing therapy in house. But I think that it adds a lot of validity to the services. It allows you to be more marketable with your differentiator. It provides a location for residents to come down and seek medical advice, interact with the clinicians and develop relationships with them so they trust them as a medical resource. And then you could host events and have a lot of branding opportunities inside the clinic as well.

Amy Kaszak:

Great. So, Sarah, I heard you talk some about integration. Now, I really like the idea of therapy being included as part of the entire care continuum and so, not just kind of hanging out over here by itself like it does sometimes. But to get real efficiencies, and improvements, and care, what needs to happen? What are the factors that providers should really consider?

Sarah Walmsley:

So this might be unpopular, but I think that you have to evaluate the existing vendors or agencies that are coming into your community now. And then after you've vetted them and you decided that they're the highest quality that deserve access into your community, then taking the time with your wellness team and your operators, even, and sitting down as a group, and really discussing what is coordination looking like. What touchpoints are we going to have? What data are we going to share with each other? At what times of the month are we going to meet to discuss future interventions that we can all work on? How are we going to interact with the skilled nursing facilities and the hospitals? If our residents... if your residents are out at a hospital stay, who's going to be tracking them with you to make sure that they come back? And then, can we bring the physician into these meetings to make sure that at least once a month we're all touching base and having conversations on your residents' healthcare experience?

Phil Fogg:

Sarah, are you measuring the functional status of the communities before or during/after your services commence that you get some sense for the impact you're having?

Sarah Walmsley:

Well, not my... The way we measure functional impact is upon the baseline data that if we are asked to collect on the residents as they move in. And so, we are able to collect that information and then evaluate that every quarter, every six months, or year. It really depends on the community's comfort level with us having access to being able to do these functional tests on them. But with a home health component, we are able to track multiple metrics every month, and be able to share that outcome data with the community, and use it to develop interventions so that if we see an uptick in UTIs, an uptick in hospitalizations due to falls, then we can create some collaborative programming to prevent it.

Maria Nadelstumph:

Thank you very much, Sarah.

Sarah Walmsley:

Mm-hmm (affirmative). Thank you.

Maria Nadelstumph:

So we could open up for questions from the audience. We have some time to do that. So our advisors asked a lot of great questions. Guys, thank you for that. I think there's probably a lot of questions that you asked they were thinking of, too. But any questions that the audience has for any of our designers?

Speaker 10:

For Dennis. Why did you have to do iPads when you can simply put it on the net?

Dennis McCarthy:

Well, you could... We actually have put some Chromebooks into play, too, a couple of laptops here and there. The iPads just make it very, very convenient. In addition to that, the software's written to be a mobile piece. 90% of their job is passing meds, and it's a mobile app that runs very well. It's just a matter of click, click, click, click, click, and they're moving on to the next resident. So why did we use iPads? They're very convenient. We have not used them at every single install... every property has a mix, really, of some laptops, and Chromebooks, and some iPads. It just makes it very easy for them to use it.

Speaker 10:

The question was why did you have to transport the iPads-

Dennis McCarthy:

Oh, I'm sorry.

Speaker 10:

When you could log onto your net?

Dennis McCarthy:

I'm sorry. I apologize. I missed your question there. The building that already had residents, they had all their nurses, and they were all using their iPads. The building that we evacuated and drove those residents 250 miles away, you needed more devices because you just doubled the size of the nursing staff in the building, and then they had to have something to work on. So ideally, probably really didn't need to do that, but it sure didn't hurt for them to have the additional equipment on hand to do the job. I apologize I missed your question.

Speaker 10:

That's okay. No problem.

Maria Nadelstumph:

Thank you. Questions? Yes. Won't use the mic.

James:

I enjoyed the presentations. I'd like to ask each one of you, what's the biggest mistake the way you deliver services to communities that communities make? Each one of you from your own experience, what's the biggest mistake that they are making or you're solving, however you want to phrase that question?

Maria Nadelstumph:

So the biggest mistake maybe operators are making with implementing these type of services? That make sense? Who wants to take the...

Dennis McCarthy:

Go ahead, Pat.

Patricia McBride:

I think one of the biggest mistakes is not really understanding the clinical complexities of our seniors that we're serving. The seniors that are in our skilled nursing right now are the ones that I used to take care of in the hospital. And the ones that are in skilled now look like our AL. And residential living looks like AL. So people are very complex out there. These are not people that are living successfully in their own homes. And so, we do have to really look at the whole picture and make sure that we're providing care in many different ways, including medical care. I know we talk about we don't care for people, but I've got to tell you, the real world out there is we are giving care to our seniors.

Dennis McCarthy:

I could add one thing to that, too. Strictly from the technology side, I do this almost innately. I underestimate the staff's ability to grab hold of this and do it and use it. In every single instance, they welcomed it, they opened it up, they went to work, and everything just smoothed right out. They were excited to see it. So I did... I probably underestimated the staff's ability to absorb it, to do it, to bring it in and make it work.

Patricia McBride:

And I have to tell you, nurses really need all the help they can get right now-

Dennis McCarthy:

Boy, no kidding.

Patricia McBride:

And technology is a great way to do it. They've very, very busy.

Dennis McCarthy:

Any nurses, we'll make you an offer. No, I'm just...

Patricia McBride:

Right.

Maria Nadelstumph:

Sarah.

Sarah Walmsley:

I think for therapy services or any healthcare provider that you have coming into your community, I think one of the greatest barriers and challenges is if they're not doing an outstanding job, not feeling comfortable asking them to not come into your community anymore or changing your preferred provider status with another agency. It's difficult because they develop relationships with your residents, but holding them accountable to quality metrics is the wave of the future. And I think that if you as operators start to feel more comfortable with your right to ask for quality metrics, demand accountability, demand being a true partner, I think that alleviates some of those barriers.

Maria Nadelstumph:

Good. James, good? All right. James is happy with those answers. And you're filming live, it sounds like. Excellent. Questions? Yes.

Speaker 12:

Go first, I don't [inaudible 00:48:01]. First, I thought everybody did an excellent job. Pat, quick question on the medical concierge model. I think it's a great service and a great value add. Are there any potential unintended consequences with respect to standard of care or liability for someone saying that you failed to schedule the appointment appropriately, or you didn't get back to me in time? Do you concern that you elevate the level of risk for your operations?

Patricia McBride:

I think having a medical concierge actually alleviates the risk. It creates a less-risk situation. Again, you've got to hire the right person, someone that doesn't have any loose ends, make sure that they have great follow through. But right now what we have without the medical concierge is a very busy nurse who will forget to set up transportation, or forget to call the family with the changing condition. That's probably more realistic than the medical concierge that can make the calls and reduce our liability and our risk.

Maria Nadelstumph:

Other questions? Yes.

Speaker 13:

For Sarah. Sarah, you talked about using outcome data for marketing. What successful initiatives have you had using the data to develop healthcare system relationships?

Sarah Walmsley:

There's many examples I can provide. I'll share one of the recent ones. We work with a company that has over 30 communities where we're the preferred provider, and we are showing them this great outcome data every month. And they wanted to work with us to develop a co-marketing campaign on how do we bring this outcome data to the hospital systems and to the skilled nursing facilities. And not only how do we bring it to them, but how do we educate the sales directors inside the communities on how to speak to these data points?

Sarah Walmsley:

And so, that's powerful in itself because I think sales directors are really comfortable selling to family members and to perspective new move-ins, but maybe not as comfortable selling to directors of population health management or administrators of skilled nursing facilities. And so, we've been able to use the outcome data for that. We've also used outcome data to be able to create fee-for-service contracts, directly linking healthcare systems to assisted livings for patients that they had living in their hospital needing just custodial care but costing the healthcare system a lot of money. And so, developing contracts was a key to have the outcome data present.

Maria Nadelstumph:

Thank you. Other questions? Quiet crowd. Anything, anything? Anyone? Nothing. So any final questions from our advisors to close up the afternoon?

Phil Fogg:

I've got one. Are you combining physician services or physician extender services in your communities that you have the medical concierge with? Did I hear you say that? You kind of referenced it

Patricia McBride:

We do. We have clinics in our planned communities, our CCRs, and those are staffed by nurse practitioners.

Phil Fogg:

And are they billing fee for service to Medicare and managed care, or are they just doing-

Patricia McBride:

It's kind of a step towards that, but right now it's through Redwood Healthcare Partners.

Phil Fogg:

Okay. And Sarah, are you gaining access to the EHRs of the assisted living or senior living communities? Are you getting access to their data?

Sarah Walmsley:

No, not at this point, we're not. Mm-mm (negative).

Amy Kaszak:

Okay. And Dennis, I have one last one for you. So tell me just a little bit about where do you get ROI for the investment of a... kind of the holy grail, right, of systems here? So where do you see that?

Dennis McCarthy:

The first piece, we've actually done a couple of studies. Having a solid payroll system has helped us considerably. First thing we did right out of the gate on almost day one is we took one full day out of nursing at every single property. That's a pretty significant savings over the course of a year. The second thing that we noticed, and it took us a little time to catch on to what was happening here, but because everything's in this electronic health record, because progress notes, doctors' notes, "Hey, Mrs. Jones

did this today," is in that, we started to notice that the shift-to-shift transfers of information were... the time was declining quickly.

Dennis McCarthy:

It used to be the seven to three shift would start clocking out at 20 after three, 3:30 because they're spending time filling in the three to 11 on what happened. Doesn't really happen anymore. When they're done, they hand over the iPad, they clock out, and they go home. So we've really seen a pretty significant drop in just in man hours alone. And I think in addition that man hour drop, having people feel more comfortable with what they're doing because it's right there in front of them in black and white, I'm almost... I would be hard to convince that that's a really measurable benefit, but it is truly a benefit.

Ben Firestone:

One more question for Sarah. What should developers and operators be thinking about when they're planning new communities with respect to your services?

Sarah Walmsley:

I think they would be wise to lock arms with a trusted partner early on because a quality company that is a good partner for you will help design gym space appropriately, can save you a lot of money by selecting the right equipment. We recently saved a large IL company $15,000 off of their exercise equipment package that they were bringing in. Where to put the gym, should it be... or the clinic? Should it be in a high-traffic location? But also, how are they going to help market new builds? Are they going to attend prospect lunches with you? These are the kind of things that you want out of a partner. Are they going to use their social media channels to help promote a new community opening and then support the occupancy as it comes in? So I think finding that partner and then moving forward with them for every new build is priceless.

Phil Fogg:

Dennis, one last question for you. So we alluded to the fact that skilled nursing facilities have adopted pretty much 100% EHRs. What year do you think it'll be when we come back this into environment and every assisted living facility in America has adopted EHR? And what do you think the driving force will be that will cause the tipping point of that?

Dennis McCarthy:

I think there's really two things. I honestly believe that the biggest future for technology in senior housing is going to be in interactivity, the ability for the resident and the staff to interact, the family member and the staff to interact, the provider to interact. And I think as those kinds of things come on board and people start to see that and see the benefits of that, it's going to start ramping up a little more quickly. If you ask me to predict when's everybody going to be on it, you're talking about a lot of different ALFs out there, smaller buildings that have a harder time justifying the cost, things like that. I believe that some form of all of this will be everywhere within 10 years. It honestly will. They may not have a full-blown EHR, but they're probably going to pass meds and be able to chart electronically somewhere, somehow.

Dennis McCarthy:

I had an interesting discussion earlier today. Why are we not all on one electronic health record nationwide, every hospital, every ALF, every SNF, the whole nine yards? Understand the difficulties of that. In our system, when someone checks off that they gave a med, it uses their initials and their personal PIN number, the PIN number that they've created, to document that. That little combination is not going to exist in all these other systems, so it's difficult to meld some details. But if we can meld charting, if we can meld the med pass, if we can meld some of those things, we'll probably get to a platform within about 10 years where everybody could be sharing data and seeing data across the spectrum of care.

Maria Nadelstumph:

We have one other question back here. James.

James:

I provide capital, so I can ask a stupid question, but... So the three of y'all have a really good message. Different, good message, but are you guys competitors? Are you friendly? Or can one facility-

Dennis McCarthy:

I don't even like her.

James:

Can one 150-bed IL, AL, memory care thing, split it up however you want, can they afford all three at the same time?

Sarah Walmsley:

Well, I'm no cost, so. And I represent no cost, but, yeah, I can see us working with both of these services interchangeably and in a great way to enhance. Like Pat was mentioning, she has technology that can recognize a fall risk, right? I could be coordinating with her to be able to get that resident she identified on services really quickly same day. And for the healthcare information, we could probably in the future sign agreements where we're able to access certain parts of it and be able to coordinate our care even better with physicians and with the coordin... with the wellness team inside. So high, high ability to coordinate with all of us, I think.

Dennis McCarthy:

I think that's a great answer. We already have external users, pharmacists, physicians, that have access to our database, could log in, see stuff. I would not... It wouldn't even bother me to have a therapy company come in and, "Hey, we want to have access to this." No problem. We'll set you up, we'll... We've got enough customization that we can give you exactly what you want to see and what we want you to see.

Sarah Walmsley:

What we can't see-

Dennis McCarthy:

And, boom, click, we're in business. So to me, competition boils down to collaboration more than competition.

Patricia McBride:

And we have all the different people that touch our seniors, including home care, rehab, all document in the same healthcare record. So they all have access, and that's really powerful because that way, everybody knows what the other one's doing. So many people touch our seniors that it's really important that we have one database where everybody can see what's going on and also to collect data to see if what we're doing is actually making an impact. And I'd also like to comment on I think a very important trend in our industry is to really look at your preferred providers that you work with. And that means narrowing who you are working with. We do use Bayada and a couple other home care and rehab companies, but you want to make sure you have trusted partners that can give you the data that you need to prove that they are making an impact. Because if you narrow your search or you narrow your network, you can hold each other more accountable. So I think that's a really important trend in our industry.

Dennis McCarthy:

That's an excellent point.

Maria Nadelstumph:

Great point, Pat. And thank you, James, for that final question. You kept holding my arm up in the air, too, James. I know you don't want to touch me in this surround. It's uncomfortable right now for all of us. I want to personally thank all three of the designers here today. I think you all made the finale. By the way, you all win Project Healthcare. Great job. You agree? Yeah? And thank you for your stories, and I do agree that we talk about healthcare and what we're doing today in senior housing is that we have to pay attention, we have to identify different services that are the fit for us.

Maria Nadelstumph:

It may not be a fit for everyone in this room in terms of technology, and medical concierge, and therapy services, but there might garner something from this session, a little bit of information that maybe will help you elevate services in your communities to keep people healthier. That's our goal. So fantastic job. Thank you for our advisors as well. And for next year as a final thought, any trends that we should be thinking about for Project Healthcare Part 2? Any of our advisors have any ideas of what other designers you would bring up to the stage next year?

Amy Kaszak:

Well, I was just going to say that I predict that Project Healthcare will have a second season at NIC. And I am very interested in seeing who's coming next, but maybe you have some more specifics.

Phil Fogg:

Yeah, I think the family portal and how we interact in all of long-term and post-acute care where their families are so far behind the skilled facilities, if somebody falls, we still call. Very little transparency, so I think that is one. And then I would say that remote monitoring, that's been a very difficult technology to deploy. We've had two epic failures in our own home health agency, and for not lack of effort. And I think, though, that we... there's going to have to be some wearable or something that requires no effort on the part of a person who's got four or six comorbidities and doesn't want to be monitored because they've made bad choices all their life. And so, that would be [inaudible 01:01:33].

Maria Nadelstumph:

Okay. Good point. Ben?

Ben Firestone:

Well, I just hope it's not the novel coronavirus. I think a lot of people are going to be talking about affordability models next year. I think that's something we're seeing more and more hit the front headlines in our space as the graying of America continues to come our way. How are people going to pay for it? And I think that's a good model that we could explore in Season 2.

Maria Nadelstumph:

Yeah, Season 2 is perfect. And then, the grandmas and iPad segment, we will definitely tie in. So again, thank you for our designers, thank you for our advisor, and thank you for our participants here today. We're all here to continue answering any questions if you want to come up one on one. But thank you for attending today's session. Thank you, guys.