From Hospital to Home: Kindred Healthcare Is Redefining Post-Acute Care

By Diana Mahoney

Kindred Healthcare, the nation’s largest post-acute care provider, is approaching the challenges of value-based post-acute care delivery head-on. The Louisville, Ky.-based organization is forging a new path with its innovative care management model for delivering integrated, patient-centered care “from hospital to home.”

In the conventional episodic care environment, post-acute care has largely been regarded as an independent add-on rather than an integrated or coordinated service. As a result, post-acute care services and settings operated as distinct silos. This model is inconsistent with evolving health care payment and delivery reform efforts, which are predicated on the understanding that the patient experience does not end at discharge but extends to events and outcomes across the continuum of care.

At Kindred, leadership have focused heavily on the creation of integrated markets for acute and post-acute care. They have also actively pursued alliances with leading health care systems and accountable care organizations (ACOs) to create a shared-risk environment for enhancing patient outcomes in the post-acute setting to prevent unnecessary readmissions and obtain optimal reimbursement.

Kindred’s long-term goal, according to Chief Medical Officer and Senior Vice President, Dr. Marc Rothman, is to become a population health manager in the post-acute space, coordinating and managing the full range of post-acute services to optimize the safety, quality and experience of care across the continuum, including long-term care hospitals (LTCHs), skilled nursing facilities (SNFs), assisted living facilities (ALFs), inpatient rehabilitation facilities (IRFs), rehabilitation services, home health care and hospice.

Reaching this goal requires breaking down post-acute care silos and implementing integrated systems and processes to meet patients’ needs. Consistent with new payment models and quality mandates, it also means constantly demonstrating that the care being delivered produces value by measuring and reporting safety, quality and experience outcomes.

Dr. Rothman recently spoke with Industry Edge about the unique challenges facing post-acute care providers in today’s health care environment and how Kindred, which provides health care services in 2,692 locations in 46 states, is meeting those challenges.

**Q: Seamless care delivery across settings is one of the major goals of health care reform, and one that presents unique challenges to post-acute care providers. Can you describe some of these challenges?**

**A:** Among the unique challenges that we face in the post-acute care world is the large number of transitions. Transitions of care between settings are difficult for patients physically, mentally and emotionally. We see that as patients are discharged from acute care hospitals. But our post-acute care patients often undergo two or three transitions of care within the continuum itself. For example, we might have a patient go from a long-term acute care hospital or inpatient rehabilitation hospital into either a subacute unit or home health, and from there either go into one of our House Calls practices — which we’re increasingly involved with — or potentially transfer back into one of the facilities or even into hospice.

As we all know, it’s very complex to have a consistent information transfer from one site of service to another. So innovation around electronic health records that speak with each other, care transition programs and coaches, and ways to simplify the instructions for patients to follow at home — these are all examples of the challenges that both patients and providers face in the post-acute care space.
Q: What are some other differences among post-acute care sites and services?

A: Post-acute sites differ in multiple ways: The acuity of the patients, the skill sets of the staff, the various documentation requirements and regulatory oversight all differ, and physician availability and coverage varies widely. One of Kindred’s unique challenges is integrating these multiple levels and varieties of care into a consistent, standardized, evidence-based and patient-centered experience so that we can meet expectations from CMS and participate in the largely value-based but site-neutral way that a lot of health care is going to be delivered in the future. We have to be able to report like outcomes and quality metrics across multiple levels of care, and we need physicians to be engaged at multiple levels of care to a degree at which they may not have been in the past.

We at Kindred are fortunate in that our breadth gives us an understanding of multiple levels of post-acute care and gives us a good perspective on what needs to get done to drive that integration, but that doesn’t make it any less challenging.

Q: In considering the post-acute care experience from the patient perspective, how do you organize and deliver care so that the patient perceives this as a continuum rather than a series of independent episodes?

A: We do that in a number of ways. We do that with our people, by educating them at different sites of service about the rest of the continuum. We also have staff who work in multiple sites of care to gain experience. In several markets we have implemented transition care teams of nurses, care managers and sometimes social workers, who follow patients as they move across the continuum. We’ve done that with great success in places like Boston, Indianapolis and Las Vegas, and the patients have great outcomes. They have a very low incidence of missed meals and missed medications, length of stay is shortened and rehospitalization is reduced. Those patients feel like Kindred is one entity through which they are navigating.

On the clinical side, we are working to standardize workflow and process across the levels of care. Obviously, some things will be different. If you’re tending to the patient in the home, it will not feel or look exactly the same as what you’re doing in a long-term care hospital, but some of the basic care protocols should be the same.

Q: How can you manage this coordinated “story” for patients in the home setting, where there is much less oversight?

A: We’ve done several things to continue the care in the home as part of our “Continue The Care” strategy. One example is our House Calls program, where teams of primary care physicians and nurse practitioners make regular visits and post-acute care follow-up visits in the home or in assisted living. Another way is through the transitional care programs I mentioned. The nurse transitional care manager goes to the home within 24 to 48 hours of discharge to examine the medication, to see if the situation is safe and to help find anything that might have fallen between the cracks — any gaps in care that can be addressed. And we now have a Kindred Call Center (1-866-KINDRED) where teams of nurses make calls to patients after discharge to search for gaps in care that can be corrected after a transition takes place.

Q: Is there a shared sense of this mission among the Kindred clinicians and staff?

A: We have an incredibly dedicated workforce. Let’s face it: Post-acute care and long-term care have never been considered the most glamorous places to practice if you’re a doctor, a nurse, a social worker or a rehab therapist. I believe that practitioners, clinicians and nonclinicians who come to practice in our space really do it because they have a deep-seated passion for doing the right thing for patients, especially the frail elderly and other vulnerable populations.

That’s important, but it’s not the whole story. Being accountable for standardized quality measures and processes, and transforming the patient experience, takes real effort and dedication. Even with well-meaning staff, we know we won’t get there by accident. I think our teams know that as health care evolves, we all have to be committed to higher standards of care and be more transparent about our outcomes. We’ve watched those changes take root in acute care, and everyone knows it’s our turn now.

Q: In terms of readiness, the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 mandates reporting of standardized patient assessment data and quality and resource use measures. How is Kindred preparing for those changes?

A: The IMPACT Act will mandate that, by 2018, a large number of functional clinical and resource use measures and outcomes are standardized across the post-acute care continuum. We welcome that and have been playing an active role in helping to advise CMS and its contractors on feasibility and which parts are most important for improving patient care. There is a sense that post-acute care cannot be what it was in the past. The days of acting as independent silos are over. We understand that. What we have to do as an organization is deliver the tools and resources to help our sites achieve these standards. As the measures and outcomes become more defined and standardized, it will help us focus on the targets for consistently delivering the quality of care our patients deserve.
Q: With respect to patient experience data that Kindred is collecting across the sites of service, how will that information be used to inform strategies and decisions?

A: In my opinion, quality is a hard thing for patients to interpret. Often the patient experience itself is the proxy for quality. We need to understand what patients are thinking and feeling as they go on the journey with us in post-acute care. We want to get to the heart of how patients feel they are being interacted with, how they perceive their treatment at the hands of health care providers, and whether they feel connected to or detached from systems that are continuously trying to deliver good care.

As a physician, I think about it this way: It’s easy to elicit a smile from a patient in the moment, but it’s hard to know whether that patient feels truly safe, whether they feel secure or whether they can appreciate that their care is being delivered consistently. That’s very different from a momentary interaction and a quick smile as we go about our work.

Even though CAHPS surveys are not mandated for all of our settings, Kindred is implementing standardized surveys that align with the CAHPS surveys across all our divisions. We are trying to be innovative and push further than the CMS statutes require, and 2016 is the year for implementation of those processes. Once the data begins to roll in and we start to see where our patients are and what is driving their experience, we will start the process of developing a united approach to the patient experience for 2017.

Q: Are Kindred caregivers engaged in the effort?

A: They are, and they seem excited about this new focus on patient experience. The senior leadership of the company is engaged also, which is critical. Folks have been waiting for this to happen for a few years, and we finally got the momentum and the resources to make it happen. And we are reaching out to learn from the bright spots in the industry — other organizations that have used this kind of standardized data to drive their patient experience programs. It’s a very exciting time for Kindred, in my opinion.