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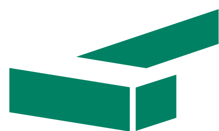

Senior Living BUSINESS

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FINANCIAL NEWS, GROWTH STRATEGIES, AND BEST PRACTICES FOR PROVIDERS AND SUPPLIERS

IN THIS ISSUE

Fundraising Strategies For Today's Economy
Establishing a "culture of philanthropy" starts with the board and transcends throughout the organization. Fundraisers may have to work a little harder in today's economy; but by building that culture and maintaining strong relationships with donors, organizations can continue to have successful campaigns.

See page 1

▪▪▪

Electronic Health Records: Make The Move
The incentives granted by the federal government to implement EHR systems do not apply to long-term care providers. Nevertheless, that's no reason not to get with the program. In coming years, those who don't comply with EHR standards will be left to survive on their own.

See page 1

▪▪▪

Best Practices Q&A Brian Lee
The founder and president of Custom Learning Services shares his thoughts on how to improve employee satisfaction, motivate staff, and ultimately become an employer of choice.

See page 2

▪▪▪

Recent Financings

See page 4

▪▪▪

The Acquisition Market

See page 15

ELECTRONIC HEALTH RECORDS: MAKE THE MOVE

Using EHRs Improves Efficiency, Quality Care, and Competitiveness

Back in July 2010, the federal government, through the **Department of Health and Human Services** (HHS), instituted the Medicare and Medicaid Electronic Health Record (EHR) Incentive Program, which grants incentive payments to health-care providers for satisfying "the meaningful use of certified EHR technology." Payments began in May of this year: Eligible hospitals receive an initial payment of $2 million, with additional payments based on a discharge formula. Eligible professionals (e.g., physicians, medical directors) receive a maximum grant of $44,000. Medicare-eligible hospitals and professionals that do not successfully demonstrate "meaningful use" by 2015 will be penalized by having their reimbursements adjusted.

Unfortunately, long-term and post-acute care (LTPAC) providers—skilled nursing, assisted living, home health, independent rehab, hospice, PACE, behavioral, adult day care—are ineligible for the incentive grants. Efforts to try to expand eligibility to these types of organizations have been unsuccessful…so far. And given the laggard economy and the reining in of federal funding, that's unlikely to change in the near term.

The government's ultimate goal, however, is for health-care providers to have access to a dynamic, integrated, longitudinal, person-centric EHR system by 2015. The only good thing about not being included in the incentive program is that LTPACs—unlike the hospitals and professionals—won't be penalized in 2015 if they haven't satisfied the "meaningful use of certified EHR technology."

Nevertheless, getting on the EHR bandwagon now is a smart idea for all LTPACs. Implementing an EHR system is just as relevant in a continuing care or skilled nursing setting as in any other venue, because the system will increase the organization's efficiency and effectiveness and improve the quality of care, patient safety, and continuity of care. Once a patient is registered in the EHR system, information regarding services provided at any level resides in one place.

"That creates enormous efficiencies and, obviously, higher quality care," said Walter Tanenbaum, Director of the Health Information Technology Group at **RSM McGladrey, Inc.**, in New York City. "Knowing what drugs a patient received in an acute-care hospital setting when continuing forward to a home-health environment, for example, is extremely valuable."

And as the health-care industry inches along toward accountable care organizations (ACOs), bundled payments, and shared savings scenarios, "Those that cannot run with the fastest, so to speak, are clearly going to be left behind," he added.

...continued on page 2

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EHR, *continued from page 1...*

Definitions: EMR, EHR

EMRs (electronic medical records) and EHRs (electronic health records) are often confused and the terms are sometimes used interchangeably, although their meanings are actually quite different. It's important, therefore, to understand the difference.

An *EMR* is a collection of health-related information on an individual—an electronic version of the (old) paper charts in a clinician's office. The EMR is created, gathered, managed, and consulted by authorized clinicians and staff *within one health-care organization.* EMRs allow those clinicians to track data over time, easily identify when the patient is due for preventive screenings or checkups, check patient progress within certain parameters (e.g., blood pressure readings, vaccinations), help prevent patient rehospitalization, and monitor and improve overall quality of care within the practice.

An *EHR* does everything that an EMR can do but focuses more broadly on the total health of the patient, allowing for more coordinated, patient-centered care. An EHR reaches beyond the health organization that originally collected and compiled the patient information. An EHR can be shared among authorized clinicians and staff across *all the health-care organizations involved in the patient's care*. An EHR can also be integrated with other components (e.g., lab, radiology, pharmacy, surgery, other specialists). The data in an EHR moves with the patient to specialists, the hospital, the nursing home, the next state, even across the country, allowing all members responsible for the patient's health care to access the latest information and enabling a smoother transition from one care setting to another. The patient may access the information, as well.

Integrating with other systems

Integrating technology is a big hurdle in the traditional acute-care environment, which generally includes multiple hospitals in a geographic area, networks of community-based health centers, critical-access hospitals, etc. Integrating technology is even more difficult for continuing-care providers, mainly because the resources needed to implement a plan—including the skilled technology workers—are not readily available. Because of the requirements of the EHR initiative, the health-care industry is said to be short about 500,000 skilled technology workers, according to Tanenbaum.

In any event, the ACO model, slated to begin on January 1, 2012, makes it imperative for LTPACs to organize themselves to participate in and integrate within the new scenario—which will likely include a global payment system, as well. The entity taking the leadership position in the ACO and pulling all the moving parts together will likely be a major hospital, which will also have a head start on the technology, the most resources, and the biggest budget. The technology that the hospital already has in place—or is planning to implement—will influence the choice of technology that ACO partners must implement, both to be compatible and to accomplish the end objective (better quality of care at less overall cost).

Any EHR system, therefore, will have to be robust enough to meet the needs of the hospital and other acute-care providers, yet scalable and affordable enough to meet the needs of a small LTPAC partner. "Most of the software companies already have multiple product lines or are merging with others to provide a solution for the hospitals, as well as for the ambulatory care environment," Tanenbaum explained. "It's a business objective to accomplish that, but the integration is very complex. So far, the systems cannot communicate well with each other—which is a huge issue."

Implementing a system

A process—a professional process—needs to be applied by an LTPAC facility that is looking to implement an EHR system in order to partner with other facilities, whether or not it's an ACO construct. And it's not a good idea to skip any of the steps in that process, according to Tanenbaum. "You don't want to learn, after the fact, that you've implemented the wrong system," he cautioned.

1. *Define your requirements*. Integration is important, but you must first satisfy the needs of your organization. The technology that you acquire has to be usable in your organization and accomplish your own objectives of efficiency and effectiveness.
2. *Vendor evaluation/selection.* Send a request for proposal (RFP) to a selected pool of potential vendors, including the vendor that serves the hospital in the ACO leadership role—which, of course, is one of the criteria for selection—with requirements that can be measured, monitored, and made quantitative. That way, you can compare vendors on an objective basis. And when you've narrowed the field to the two, three, or four viable—or potentially viable—vendors, provide scripts to each of those vendors to use in a demonstration. That way, you can compare apples to apples and make a final determination. The RFP process allows you to eliminate vendors who are least able to satisfy your requirements; the demonstrations actually show you how they will do it—and if they really can do it.

3. *Negotiate.*

4. *Implementation.* Once you've acquired the technology, you have to implement it. And you have to have skilled people available to make it work for you—and keep it working for you. Most vendors will provide on-site training at a cost of about $1,000 per day plus expenses; they will also provide online training.

> *"An integrated, dynamic, longitudinal, person-centric electronic health record empowers personal health accountability, wellness, and proactive care through transitions of care interoperability based on standards."*
> *—John Derr*

The biggest determinant of whether a technology acquisition and implementation project is successful is how well the current state to future state transformation occurs, according to Tanenbaum. That requires defining, at a very granular level, the workflow and work distribution of each workstation of the current operation and then, based on its features and functions, using the new system's tools to design the future state.

"Health-care organizations usually rely on vendors to implement for them," he said, "and a vendor has different objectives. They're concerned with installation—load the system and submit the bill. The organization's objective, on the other hand, is to use technology to gain efficiency and effectiveness."

It's nearly impossible to predict the future, but Tanenbaum suggests organizations adhere to the following:

- Don't lock yourself out of future innovation. Make decisions with an eye toward being able to utilize, capitalize, or leverage that technology into the future.
- It's not the technology itself but the application of that technology and how it's implemented that's important. The technology must follow the needs of the users.

Resources required: manpower and money
We tend to think about the required manpower resources in terms of the skilled technical people that implement the systems, but the resources needed to support the technology once it's implemented are really the most important ongoing consideration.

Education on these systems is a huge need, according to John Derr, President and CEO of **JD & Associates Enterprises** in Anacortes, Washington, and a commissioner on the HHS Certification Commission Health Information Technology (CCHIT) Standards Committee. Even the people who work with technology in a health-care facility may not have a clue about EHR systems.

Many small LTPAC facilities still utilize basic accounting programs and are working on paper, while some have graduated to software programs handwritten by an accounting firm. "That just won't work anymore," Derr said. "They've got to form interface portals. And some very good vendors have worked very hard to create suitable programs to help these small organizations with their interconnectivity and interoperability."

The cost of implementing an EHR system varies, depending on where a particular organization stands in terms of its current technology. Implementation can also be quite complicated, depending on the capabilities required and the number of people using the system. If the organization has no digital technology at all, it must first complete a whole level of preparatory work.

"When we help our clients define their technology requirements," Tanenbaum said, "we have them do a complete, detailed gap analysis. By identifying gaps between the current situation and the future vision for utilizing technology, they can visualize what is required to ameliorate those gaps, the level of investment they need to make, and the likely return on that investment."

So while it's difficult to pin even a ballpark cost on implementation of an EHR system, pricing for on-premises software suitable for a small- to mid-size nursing home might be in the vicinity of $25,000; hosted software-as-a-service products range from about $2,500 to $5,000 for installation plus $350 to $3,500 per month.

Now here's an idea…
Even though the cost of implementing EHR technology is not prohibitive, small, not-for-profit assisted living and nursing facilities may not be able to afford the expense—yet they will need a compatible system if they expect to partner with an ACO. Derr has an idea.

Eligible hospitals will receive federal incentives of at least $2 million (and perhaps as much as $5 million) to implement EHR systems. That hospital could, in turn, give a small portion of that grant to one or more local home-care agencies or nursing homes to assist those facilities in creating a compatible interface.

A hospital must spend its incentive money to satisfy "meaningful use of certified EHR technology"—and also needs to cut down its rehospitalization rate. If the hospital can help its partners build their interfaces, those partners can help satisfy that required "meaningful use" and also help meet the rehospitalization challenge. "That doesn't seem to be an unreasonable request," Derr said, "so don't be afraid to ask." □