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Turn-Key CEO: Why Palliative Care Must Soon Come to Skilled Nursing

By **Maggie Flynn** | April 2, 2019

Given their emphasis on rehabilitation and recovery, skilled nursing facilities aren't typically places where patients receive palliative care.

That's despite the fact that only a small portion of nursing home residents who would benefit from such care usually receive it, according to one study published in 2017 by the Journal of the American Medical Association. And even when palliative or hospice care is offered in the SNF setting, the results aren't always ideal. In fact, the perceived quality of hospice care in nursing homes compared poorly with other settings like assisted living and home health, according to findings from the Indiana University Center for Aging Research and the Regenstrief Institute.

In general, the state of hospice in SNFs is such that the Department of Health and Human Services' (HHS) Office of the Inspector General (OIG) singled out SNFs as areas for improvement in hospice care.

Turn-Key Health, which is part of the Philadelphia-based Enclara Healthcare, works to expand access to palliative care through partnerships with health plans and other risk-

bearing entities such as accountable care organizations (ACOs). And even though it has a very limited presence in the SNF sector today, CEO Greer Myers believes that it will have to enter that space soon, as new payment models increasingly request palliative coverage for their covered beneficiaries in SNFs.

Skilled Nursing News sat down with Myers to talk about Turn-Key's work in palliative care, how it partners with Medicare Advantage plans, and why SNFs will be a new frontier for palliative care.

Can you tell me about the services Turn-Key Health provides?

I would say the three legs to our stool are: Being able to identify members who are likely going to be over-medicalized or have an inappropriate death. If you think about those members … they're individuals who don't elect the hospice Medicare benefit or elect it very late. They have a very bad experience, high expenditures during the last 12 months of life, and when their loved one passes away, the caregiver is left wondering: "What just happened?"

So our predictive analytics identifies those members for health plans.

The second part of what we do is we create networks and stand up networks of palliative care professionals; we work with hospice and palliative care companies to do that. We'll go out and engage a hospice and palliative care company to create a separate team to provide supportive care, completely unrelated to hospice. It's purely related to supportive care and having the conversations that are really difficult — that most physicians don't want to have, [so] they don't have them.

The third thing we do is we standardize the care and the delivery process using our own platform. That's how we began. We tested the thesis that nurses and social workers could provide palliative care in a non-medical environment and achieve the exact same results, many of the results that have been published in control studies in the U.S. around medically based palliative care.

What it results in is significant decrease in expense, but more importantly, we focus on quality interactions. If that's all we focus on, then everything else follows.

When you say a decrease in expense, who sees those savings?

First of all, there's obviously a decrease in expense to the patient and the caregiver for all the treatment and/or non-beneficial treatment they're getting. Having them age at home,

and be able to stay at home without going to the hospital constantly, is a significant economic burden for patients.

Second, the Medicare Advantage plan. Obviously, when you look at the last six to 12 months of life, and we often refer to a Health Affairs publication that shows — I think it's around 48.7% of individuals during the last 12 months of life are very high expense, persistent. So everybody benefits. The patient benefits, and the caregiver benefits from both an economic and a quality perspective. The Medicare Advantage plan benefits hugely from having that intervention early, because that is obviously an expense to them that's negative. They're losing money every single month that that member stays on the plan and accesses health care in the way in which they've traditionally accessed health care.

Our base medical loss ratio savings for that population is around 20%, and there's another 15% just from an earlier election of the hospice benefit. So it's not insignificant in terms of the savings for the plan or for the patient.

Can you talk about your geographic footprint and reach?

We're part of a larger company called Enclara Healthcare. On that side, we serve every single state except for North Dakota. We have 90,000 terminally ill patients that we care for every single day, and we do that predominantly on the medication side, so we ship medications out and have medications delivered to patients, and do medication therapy management to those 90,000 patients, and we contract with hospice and palliative care companies to do that.

We have about 20 years of history on that side; we have around 500 different hospice and palliative care clients, and over 700 employees, so it's a pretty big enterprise. It started [with] the pharmacy side serving hospices, and Turn-Key grew out of that. You had this real torquing down on home health, and then you had this simultaneously the torquing down on the hospice benefit, and it created this massive gap where people are free-floating out in the community, and they don't know how to have conversations, they don't have advance care plans, they don't have goals of care established, and they have multiple physicians.

The problem that we are solving for is: How do you take that big of a population, and think outside the box? Because everybody thinks, "Okay, we've got to bill Medicare for something." And we don't bill Medicare for anything. All of our work is health plan-based, ACO-based, generally focused on Medicare Advantage but also applicable to commercial Medicaid and dual (eligible)s. But it's rethinking who has the skill set to best affect the

quality of this huge group of patients that are sitting out there. And that skill set resides generally within hospice and palliative care organizations.

Can you talk about your presence in SNFs?

SNFs are very limited, because of the regulations inside of SNFs, we tend to look for short stay, and then move out. Right now we're not focused on long-stay SNF patients; we've been asked to, but we haven't done it yet.

Is there a reason why not?

There hasn't been a big demand for it, I guess is one. And then two, from a regulatory standpoint, the way in which there's oversight of those patients, there's governance around that for Medicare patients in terms of documentation.

So if somebody's in a SNF and they elect hospice, there are very clear guidelines about what has to be done. But if you have separate oversight of the patient in the skilled nursing facility, we don't have great visibility in how to work in that environment. Now we have been approached by several large Medicaid providers where that is a substantial issue, and also a Next-Gen ACO, where I think we're going to have to start doing that.

It just hadn't been forefront for us. Our big push is in the home or where they live, whether that's home-based, assisted living, where they reside, as opposed to something that might be temporal, where if they drop into a SNF and pop back out, they're where they were before … we're there after. Long-term SNF stays, we have not really explored that yet.

Can you explain a bit more, how you come into the picture after a SNF stay?

If it's a short-term rehab stay — let's say a member that we have on program and they end up going into short-term rehab — we would already have established goals of care, advanced care plans, be monitoring. We would have done medication reconciliation, all of our motivational interviewing would be done, that individual would go into the SNF. We would not go into the SNF, but we would wait for them to come back out.

Right now we're not getting into them, but like I said, we've been asked several times to actually do that. So I think I think we're going to have to get into the SNF environment, particularly for duals, and we do handle duals now. So it's something we're going to have to do; it's just not our specialty.

How would you go about starting that process?

The first thing I think we would do would be really look at it from a regulatory perspective, to better understand the credentialing process, and how to work with SNF concentrations. Because some of our partners do have preferred SNFs, and have expressed serious interest in having this type of service in that SNF population.

We need to better understand the documentation and credentialing because what we would be going in and doing is a consultative service; it's a little bit different than a hospice. You're not providing medications, you're not providing direct care, you're looking at the patient and making sure that everything is good, that their goals of care are being met, that things are going according to plan both from a psychosocial as well as from a medical care [perspective].

I don't think it would be a heavy lift; it's just that right now we've paused and said, "If it's long-term, then there's a completely separate team managing that individual and that patient, the physician is engaged on a regular basis." And have shied away from it. But we'll end up getting drawn in.

Why this is such an issue for managed Medicaid companies and dual-eligibles?

[In SNFs], it either goes private pay or it goes Medicaid. Long-term SNF benefit isn't a Medicare benefit, but duals and Medicaid, it's big. So when you think about people like Centene or Molina, then it becomes pretty material in terms of what they're trying to tackle and they're having, I think they're having a tough time handling the population, because it's almost hands-off. They get in their own environments, and they can't really control it that well, what's happening and the individual patient wishes. It depends on the quality of that SNF, right?

How do you see palliative care and the work that Turn-Key does evolving in say, five or ten years?

There are two factors that I think are driving what palliative care is doing. One is there is significant awareness around palliative care now, and I think people are starting to understand the difference between that and hospice. As baby boomers are aging into palliative care, and their parents are aging into it, I think there's a consumerism that's driving an understanding that there's a better way to do a lot of this, and so that's something that didn't exist before.

Then you have the health care ecosystem, whether it's a Medicare Advantage plan, Medicaid, or even commercial. Then you have CMMI [the Center for Medicare & Medicaid

Innovation] pushing toward risk-bearing ACOs. They're done with kind of the free-handout ACO environment; they want skin in the game. You have all of that happening, and when you look down and kind of peel the layers off, the first layer that people have been peeling off is [readmissions]. And you see great work being done in the data that we look at. In health plans that are progressive, the rehospitalization rate is really good, because they're focusing on it, right?

The next layer when you go down below that, you say, "Okay, well, don't look at the disease, don't look at CHF, COPD, cancer — end-of-life is almost its own type of disease state." And you look at the expense associated with it, I think more attention and care will be paid to it. So I think in five years, you're going to see integration across the framework of health care and that's going to be in SNFs. I think the inflection point we're getting to is: How do you leverage all these assets that are out in the community that have specialized skills to do this and have these conversations?

In terms of expanding on palliative care, I think you'll see growth on the predictions side, where people will be identified earlier, because the referral-based model doesn't work. It results in a 20 day median length of stay in hospice.

I think you're going to see more community-based resources that are trying to tackle this problem from a humanistic perspective, versus what's being done now. So in five years, I would hope that it's very mainstream and that palliative care is supportive care. That doesn't mean you're forgoing treatment, it means that somebody is watching out for you and taking care of you and people have a better end-of-life experience. In 10 years, it's even better because it's integrated. CMMI's doing some really fascinating work around advanced payment models in advanced illness, in serious illness, to try to figure it out.

This interview has been condensed and edited.