Seagrove

REHAB PARTNERS

CONSIDERING IN-HOUSE THERAPY?

Top 7 Things You Should Know

How confident are you in the effectiveness and financial benefits of your therapy program? If anxieties about liabilities or profit losses nag you, or you just want to learn more about in-house therapy, read this guide so you can stop worrying and start improving.

As we transitioned to PDPM back in the 4th quarter of 2019, many providers were nervous regarding how to successfully make the change. Many leaned heavily on trade organizations, their contract therapy provider, and/or consultants, in order to learn as much as possible about PDPM, how payment would be generated, and what therapy's new role might look like in this non-therapy-minute-driven payment world. (My original and then later updated PDPM whitepaper can be found here: The Ultimate Guide to PDPM.)

Fast forward 18+ months and the world is looking a bit different, and the therapy portion of the SNF industry continues to evolve. When PDPM was first announced, there was a lot of discussion about facilities potentially converting to an in-house therapy model now that the therapy department was not THE revenue driver in the building and was potentially looking a bit more like a cost center (at least as it relates to Part A patients). You may have taken that leap while others remain in the previous model wondering if dipping your toe into the in-house therapy pool may be right for you. Well, today, we are discussing just that...

Before we get into the meat of the topic, let me first say that facilities who have provided in-house therapy on their own (without some external support or internal corporate structure) have historically done so less efficiently and/or effectively and at greater expense. Granted, your team may be delivering excellent patient care, but the operations and processes of these programs are usually not up to current standards and the regulatory assumptions that they are operating under are often out-of-date. It is not uncommon for those facilities to be under-serving their long-term care population (in SNFs) and not meeting the needs of the AL/IL on CCRC campuses. This under delivery of therapy can impact residents' ability to successfully "age in place" and the underdelivery is also often an increased revenue opportunity. Let me give you an example: We worked with a SNF client who had been in-house for over a decade when we were asked to review their programming. Among other issues, we found that the therapists were using documentation requirements from the early 2000s, productivity was in the 50s (versus 80+), and pay rates had not modulated with the local market after a new COTA school had opened in the area. I mention this example to demonstrate that therapy is a complicated beast and taming that beast takes people who are focusing solely on therapy regulations, trends, operations, compliance, and outcomes for you. There just aren't enough hours in the day for your therapy manager to run the day-to-day operations while also keeping up with all of these things... it takes a village. This fact, combined with historical staffing shortages in the therapy space, are why contract therapy providers rose in popularity under the RUGs system. Now that

those staffing issues have been waning thanks to PDPM and PDGM, it is likely time to take a second look at your options. Which leads to a core question:

Why should you consider converting from contract to an in-house therapy model?

1. Cost Savings and Increased Revenue

I think the most obvious answer is cost savings. Contractors usually work to make somewhere between 18% - 30% margins at the facility level; meaning, if you are paying them 100k per month on their invoice, they are working hard to take $18-$30k back to the home office to cover overhead and generate their profit. For some, that is a margin that could end up back in your facility with a well-managed in-house program. For others, such cost savings may not always be possible depending on your situation, for example, some facilities are so small and therapy is so limited that you couldn't hire the fractions of therapists needed to meet the facility's small therapy needs without overpaying for their services. In those cases, continuing to outsource makes a lot of sense. However, there are many facilities who are paying a premium for therapy services and much of that premium could be reinvested back in your facility in the form of programming, hiring more staff, capital improvements, or putting it in the rainy-day fund to benefit your residents or overall operation. We find that stand-alone larger SNFs (more than 100 beds or so) and especially CCRC settings (even those with very small SNF size alongside a larger AL/IL setting - total 200-250+ residents), are oftentimes paying tens of thousands and some are paying *hundreds of thousands* of dollars more for therapy services than they would if they were in-house with the right support.

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2. Control of Your Team

We have clients who have been in-house for decades for one reason or another. When I have asked them, "Why are you in-house?" Their top answer usually surrounds being "in control". That includes being in control of staff schedules, being in control of who comes and goes from their facility (depending on where else that individual may have been), and being in control of who and when to hire. Essentially, they see the therapy department just like any other department – an extension of the rest of their staff that they have control over. There's no additional layer of management that they have to contact in order to deal with a disciplinary issue or problem. There is one set of HR policies that all staff have to follow instead

of most of the staff following the facility HR policies, while therapy staff follow another companies' policies from another city or state where the contract therapy company is headquartered. Essentially, it comes down to controlling their own destiny, so to speak.

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3. We Are All One Team

From a staffing standpoint, there has traditionally been an "us vs. them" mentality in many facilities between the therapy and nursing departments. It is true that these two departments do very different things, however, we are all here for the same reason – to provide great quality care for the patient/resident. Using a therapy contractor can often exacerbate this mentality as the staff literally works for two different companies. And as the therapists and nurses talk, it may be apparent that the therapists may have a better benefits package, have different "holidays", and may be recognized differently by their different employers. These things further exacerbate the "us vs. them" mentality and can create issues among a team that should be working closely together on a daily basis.

From a therapist standpoint, it is my experience that most therapists want to work for the facility instead of a contractor. Of course, there are exceptions. But therapists who work for a regional or national therapy provider can often feel disconnected from their employer or like a cog in a wheel of this large (on the magnitude of hundreds of millions of dollars annually and thousands of therapists for the large providers) national machine. Therapists often perceive that such large corporate contract companies will make them work "harder" than an in-house facility and put more pressure on them to do things that may or may not be in the patient's best interest. That perception may be flawed depending on the situation, but that is usually the perception, nonetheless. (Which has some historical precedent given whistleblower cases linked to large corporations driving numbers and productivity outside of patient need.) Therapists also feel like they may have more autonomy as clinicians when in-house, which again may or may not be true depending on the contract company (there are good, ethical ones out there who value clinical judgement). For these reasons and others, it has been our experience that finding staff to work in in-house facilities becomes much easier than when hiring for a position in a contracted facility. Once word makes it out into the therapy community that a facility is in-house, I have literally had

therapists show up at a facility and fill out applications for jobs that didn't even exist yet, just because they wanted to work for an in-house facility. There is great value to them in being part of one unified team, all working together toward a shared goal.

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4. Liability Protections vs. Reality

I have had clients ask me before, "If I contract out, don't I get some liability protection?" Let me take a minute here to say that I am not a lawyer (and this is not a legal opinion). Historically it seems like the (somewhat faulty) assumption to this question within the long-term care industry at large was yes. Because people assumed that if the facility was sued for the therapist's actions (think unnecessary therapy that inflated the RUG category and, thus payment), then wouldn't the contractor be on the hook? However, what we now see in practice is actually quite different...

If you review many of the DOJ settlements from the past decade or two, many of those settlements are with the facilities themselves and the therapy contractor is not mentioned or included in the settlement. If, in fact, the contractor is at fault, then the facility has to turn around and then file suit against the contractor. (Several links to McKnight's articles covering SNF settlements related to rehab claims are in this previous blog post, including one that quotes U.S. Attorney Carmen M. Ortiz for the District of Massachusetts, "Settlements like this one show that, when a facility contracts with an outside rehabilitation therapy provider, the facility has a continuing responsibility to ensure that the provider is not engaged in conduct that causes the submission of false claims to Medicare.") All that to say, while it seems that some liability protection would exist here, it doesn't always appear so in practice. This is ultimately because the facility is in charge of the services being provided on its behalf, or at least to the courts it should be. No matter if that is dining services, housekeeping, or therapy services, whether it is your staff or someone else's staff providing those services, the facility is ultimately held responsible. So if your perception of liability protection is what has kept you from going in-house, then I encourage you to consult a lawyer and case precedent to discover what the reality is. Certainly having a therapy specialist as part of your team often helps to decrease liability as it increases compliance and ethical operation,

but the reality is there are ways you can experience that level of expertise and oversight without a contract therapy provider.

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5. Understanding Indemnification by the Contractor

The other issue that some clients ask about is indemnification. They believe if I have a contractor, then they will indemnify me for any denied claims. This is absolutely true, however, it is important to understand exactly *what* they are indemnifying you for as you weigh indemnification into your thinking about whether or not to go in-house. If you are getting reimbursed $500/day for a patient and the contractor is getting $100/day of those dollars for therapy services and this claim is ultimately denied, then the contractor will indemnify you for the $100/day that you paid them, but not the $500/day that Medicare paid you and you ultimately lost. I have reviewed contracts for SNFs and made this clear to the administrator or CEO, and it was clear that this was not their original understanding. They were expecting to be indemnified for the entire amount of revenue that was recouped instead of just what they paid the contractor.

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6. Buyer Beware - Prioritize What Is In Your Best Interest

If you are currently contract and are looking to explore an in-house option, this is not something that you will want to telegraph to your therapists or your contractor before it is time to make the conversion, and then you will want to be prepared with a detailed plan. There are certain clauses in contracts such as termination, non-solicitation, and non-competes that may dictate what you can and can't do. Many facilities will look at a contract and see the non-compete clause prohibits them from keeping their current staff and then assume they cannot move forward because they like their staff. However, this is not always the case and often you can keep your staff, but you will likely have to pay something to do that. As a mentor once told me, "All contract issues can be resolved with a check." In addition, depending on your State, non-compete clauses for staff members may not be legally enforceable. Your individual facility's options should be taken into account when analyzing a potential in-house conversion. (In addition, to keep your options open for the future and not run into unknown staff buyout expenses, you may want to consider updating/renegotiating your current contract therapy contract to include exact staff buy-out terms, and/or set up the non-compete clause to sunset/expire after you have done business together for a set amount of time. Even

if you are not interested in an in-house program right now, those types of contract changes at least keep your options open.)

If you make up your mind to make an in-house conversion, when you give notice to your contract therapy provider, don't be surprised if your contractor now offers you an in-house management model. While your contractor wants to keep you on as a client to continue to get their 18-30% margin at the facility level per month, if you are leaving, then they will often suggest this, which seems a last ditch effort to keep you paying them in some other way. In this model, you will pay the contractor a "management fee" to manage the therapy department. Based on reports to date, this fee usually ranges from 6-12k per month depending on the size of the facility and the amount of work this will be for the contractor. Here's where I feel that this option from your therapy contractor is a bit disingenuous... Essentially, your contractor will offer this model simply to keep you as a client. This was likely not an option they offered you when you hired them initially. And if this was in your best interest and they are promising to deliver the same expertise for you, then why was it never offered to you before? This is not their primary or preferred business model since they can make more revenue/profit in the traditional contract model, but they will often do it if their hand is forced instead of losing your business entirely. I think a contractor offering this model simply to keep you as a client doesn't ultimately make a lot of sense for the facility. If you think about it, most of their business is all in the traditional contract model, however, the few facilities who wanted to go in-house will now be in an in-house management model, which isn't their specialty and doesn't fit their corporate structure...

These two models (contract vs. in-house) have operationally opposite strategies for generating revenue for the contractor. In the traditional contract model, getting higher productivity out of the therapists typically means more margin for the contractor. Likewise, treating more patients does as well. However, if they offer an in-house management model as you are walking out of the door, you are likely paying them a flat rate, so ensuring that the staff are fully meeting the needs of the facility no longer garners the contractor more revenue. As margins get tighter across the industry, and a contractor has to choose where to put more of their efforts, I imagine that those efforts will be directed to their facilities where their efforts will be rewarded with greater revenue, instead of within in-house facilities where more work does not mean more revenue for them.

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7. Don't Go It Alone, Find a Partner You Can Trust

I think we can all agree that the therapy department and therapy programming is complicated. Keeping #6 in mind (knowing that in-house management offered by a contract therapy company is often not in a facility's best interest), the fact remains that oversight for an in-house program *is* in your best interest. So what are you to do?

By now you may suspect that you're missing out on profits from your therapy program, but making a shift in a space so nuanced feels risky. I hear that. But, it's too important not to tell you: You may be losing a lot more than you think.

This isn't just true for those facilities outsourcing their programs, it's true for even the best in-house operations. Here's why:

- If you contract your services out, beyond losing control of a team that's not yours, as mentioned before, you're sending an extra 18-30% to someone else's home office that could be invested back in your facility.
- If you manage your program in-house, you lack the major benefit of having a contracted program: professional oversight. Facilities who try to do this entirely on their own often do not do it well; they have compliance, regulatory, productivity, and operational challenges that are difficult to overcome. This means that your leadership is not only managing the day-to-day, but also navigating changing national regulations and protocol. There simply isn't bandwidth left to fully optimize efficiency, profitability, compliance issues, and patient/resident outcomes.

You shouldn't be forced to choose between two less-than-ideal options.

After decades in the trenches of broken therapy models, I knew that better was possible. (When we talk, ask me about what I call my "planes, trains, and automobiles" experience within a contract therapy company, which led to this aha moment.) I had an experience that prompted the thinking that you ought to be able to provide consistently exceptional therapy for your residents while keeping more of your profits for your facility, not losing them to an ivory tower corporation. I left the contract space in 2013 and instead launched Seagrove Rehab Partners in order to focus on in-house therapy, and I created an innovative approach - one that is a much better fit for locally-owned facilities, smaller chains, CCRCs, and nonprofits who could greatly benefit from an in-house therapy program with the right partner. Our In-House Therapy Alliance™ service was designed to give you the most tempting benefits of a contracted program, while in-house.

The **In-House Therapy Alliance™** is a hybrid model, where the therapists work for you, but you contract out the management support you need. We come in and work closely with your therapy manager and staff to provide the management support and oversight (productivity, compliance, regulatory, operational, clinical, and more) that is missing in many in-house programs. It is a "turn-key" option to convert your contract model to an in-house one in which we provide services your contractor offers at a fraction of the price (therapy software, staff CEUs, management oversight, denial support, staff recruiting, documentation audits, and more). We want to help you maximize your profits, not take them away. Which is why our service is a monthly flat-fee only - that means, no surprises, no gimmicks, and no hidden agendas.

If you are considering an in-house conversion or just want to explore if in-house may be a good fit for you, give me a call (850-532-1334), send an email (mark@seagroverehab.com), or schedule a Zoom meeting. We would be more than happy to do a complimentary assessment of your situation so that you know you are getting the best therapy services in the most cost-effective way possible. The assessment is no cost to you, and we'll say no if we are not best suited to help - and if that is the case, we can help point you toward contract companies whom we trust if that is a better fit for your situation.

So, let's connect to discuss your options. We believe you ought to know your true risks, your facility's true potential, and have the key to take control of them both.

Best regards to you, the residents in your care, and your teams,

Mark McDavid, OTR, RAC-CT, CHC

About Mark

Mark is president of Seagrove Rehab Partners and is an experienced leader with a proven track record of dynamically growing rehab operations for long-term care providers. In 2013, he acted on an aha moment after realizing most administrators feel like they have to choose between the headaches of an in-house therapy program or the loss of profits if they contract out. So he created the In-House Therapy Alliance™ for single skilled-nursing facilities and small chains, an innovative third approach to therapy that gives you the most tempting benefits of a contracted program, while keeping your profits in-house. Mark's knowledge and its application to business strategies has earned national recognition, including appointment to AANAC's Expert Advisory Panel and two terms as board member-at-large for the National Association of Rehabilitation Providers and Agencies, where he currently leads the SNF special interest group.