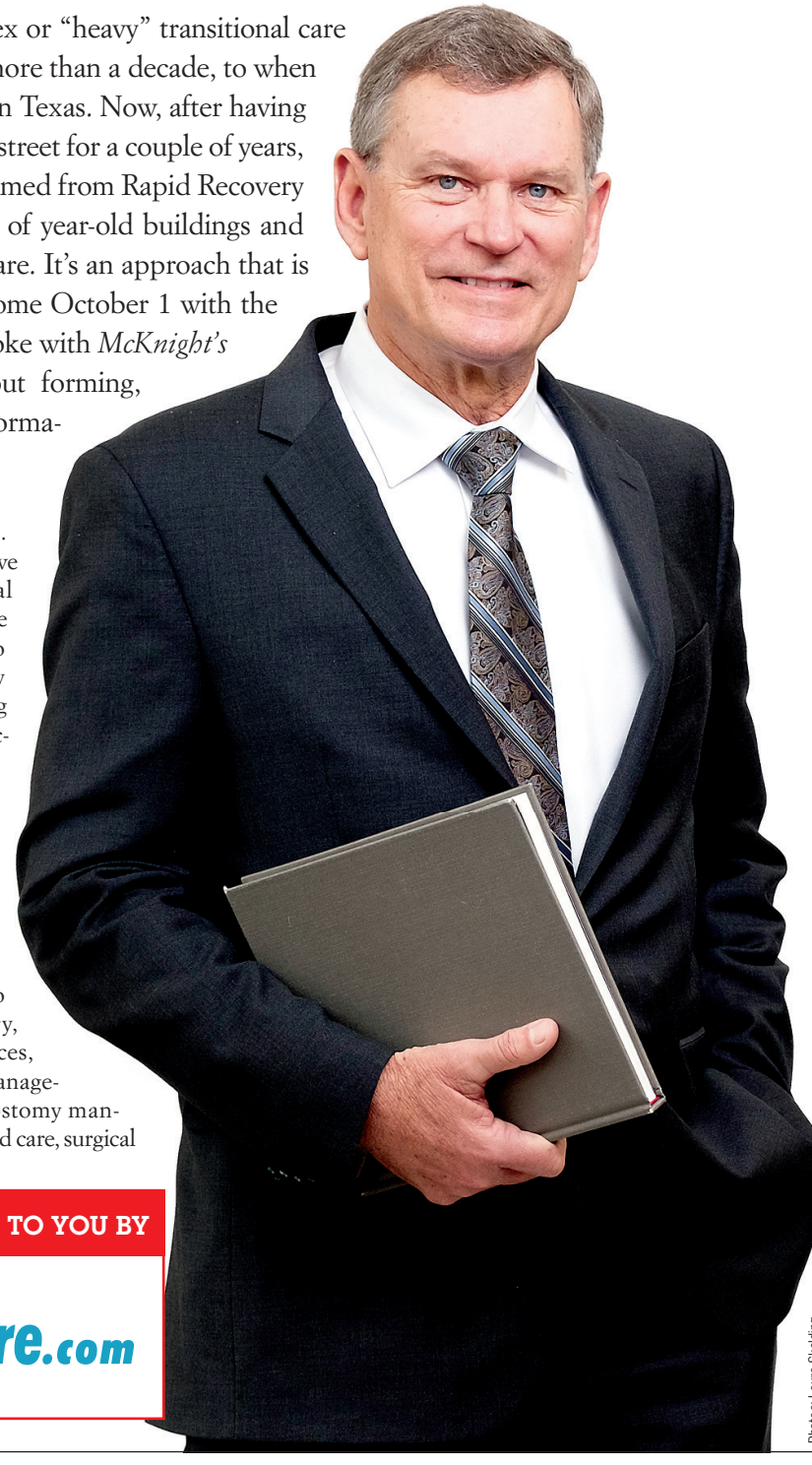
In PDPM's sweet spot

Mark Fritz's plans to provide complex or "heavy" transitional care for post-acute patients date back more than a decade, to when he founded Remington Medical Resorts in Texas. Now, after having helped out the struggling developer Mainstreet for a couple of years, his Bridgemoor Transitional Care — renamed from Rapid Recovery Centers — has emerged with a handful of year-old buildings and renewed vigor to provide higher-acuity care. It's an approach that is expected to capitalize on changes that come October 1 with the Patient-Driven Payment Model. Fritz spoke with *McKnight's* Editor James M. Berklan recently about forming, staffing and operating a medically transformative brand of care.



Photos: Laura Skelding

Q: What are Bridgemoor's parameters?

A: There are four facilities: three 70-bed facilities and one 105-bed facility. They're pretty much all in the San Antonio-to-Fort Worth area, and one's in the Houston market, all about three hours away from one another.

We're now taking much more medically complex patients. We have hospital-grade oxygen piped in and suction so we can take ventilator patients, heavy cardio care, and pulmonary groups.

We built and then retooled our care processes to support PDPM in October. We're already working with hospital systems and physicians to set up protocols to care for specialty, high-acuity patients.

It's not that we had any crystal ball. If you've listened to MedPAC, they were pointing us in this direction.

Q: What is your patient profile?

A: We focus on patients who need telemetry, infusion services, central line management, tracheostomy management, wound care, surgical

drain management, and physical, occupational and speech therapies, to name a few.

Q: How is staffing affected?

A: We have a highly engaged provider staff that includes our own embedded nurse practitioners who work on the floor directly with our nurses, physicians and their extenders.

We have an in-house pharmacy, which supports rapid medication changes and 24/7 access to a pharmacist. In mid-March, we began in-house labs, too, so instead of waiting hours or days for results, we're able to run our labs in two to 12 minutes. These systems help staff make real-time decisions for our patients.

Q: What's the toughest part about staffing this?

A: Our biggest challenge is getting nurses, because it's such a hybrid position. We get nurses typically with some LTAC and rehab experience. They're a really good fit for us. They understand our patient needs but it can be hard finding them.

All other aspects— like telemetry, in-house labs — are mechanical things and are pretty easy to do the math on.

Q: Where does tech come into play?

A: It is playing such a big role in what we do today, I can't stress it enough.

We have one hospital system on Epic, and we use Netsmart and completely integrate our EMRs. The discharging physician can see if everything's good or not; we can communicate back with the physicians and hospitals.

They don't have to depend on nurses giving them information. They see it on their Epic screen, we see it on our screen and we all see the same language. These

"All our staff want the ball. They want to run, and it's exciting."

are some exciting things in our industry, and it gets me out of bed every morning.

Data is a tool that helps us determine where our weaknesses are so we can better treat our patients. Data drives everything.

For outsiders — hospitals and physicians — data is what they use to determine who they send patients to. Data is for public consumption and star ratings and length of stay and return rates. Those are the things that drive great relationships.

Q: How do you tout quality?

A: All of our buildings have either already achieved or are in the Joint Commission accreditation process, which is a much higher standard than the federal regulations require. Our staff are very proud of reaching that.

It draws more and more physicians to us. Our hospital systems are more pleased because we can have our own labs and then they have a higher level of confidence because they can write that order in just a few minutes.

Q: What is the average length of stay?

A: We're running right around two weeks. Our return rate to acute care is 6 percent to 8 percent. I can't stress enough that the on-site physician coverage makes the difference. We have several physicians in the building every day.

A nurse practitioner heads up our rapid-response team, so if a patient wakes up and you're doing vitals and the patient has a 99.7-degree fever, the first step is to get the nurse practitioner involved. We are not waiting until 9 p.m. to find their temperature is up to 101.

Q: What drives referrals?

A: I still believe in healthcare and believe it's local. Personally, I meet with a hospital system from the C-level down. I want to hear from them and what they need from us.

It's easy for case managers to refer to us because aesthetically we're more like a hotel with private suites. And having a chef makes that even easier.

We don't want to wait until October 1 and then start waving a flag to our hospitals and other providers that now we can take those heavier care patients.

The only time I look at census is during ramp-up so we can hire staff ahead of time to be ready. We look at revenue versus cost.

In my previous life in long-term care, we always looked at how many people do we have in house. If you're making 1,000 widgets per day and making only $1 per widget, but you could make 500 widgets and earn $5 per widget, what would you do?

Q: What's behind the company name change?

Rapid Recovery Centers is a trademark of Mainstreet so we had to change it. With Bridgemoor, we look at ourselves as a bridge from hospital to home. It became effective February 1 and we announced it February 11.

Q: What advice do you have for peers interested in doing something similar?

A: If you want to do this, first you have to make a 100 percent commitment. You have to be disciplined with execution and manage costs. All our staff want the ball. They want to run, and it's exciting.

There's room for everyone in this. I think PDPM is a good thing, at least on the surface.

Things got better when hospitals moved from cost-plus DRGs and medical care actually got better. I think that's what's happening.

Right now, we're just one year old, so we're saying let's get operations up and going. We want to see where we're at with PDPM and get some of those questions answered.

Many managed care programs and hospitals are already asking us about the possibility of entering different markets. ■