

Welcome to Bridge the Gap Contributor Wednesday, I'm Meredith Mills. I'm so excited to be here with all of you in the middle of a pandemic, which has brought our industry truly to the forefront of the news media and the healthcare system overall. When I was asked to be a part of this podcast by Josh and Lucas, number one, I was so excited because I've been following Bridge the Gap for quite some time, but I also thought, what can I really bring to this podcast that would be unique and different? Where am I an expert? Because I really view myself as a Jack of all trades and a master of none.

I've spent my career in senior living over the last decade, being a marketer, being an executive director, running a campus, working in partnership creation with other healthcare entities, and now I run strategy and operations as the Chief Operating Officer for my company. So when I think about the area that I can speak best to for all of you, and don't let me lose you yet, but it truly is healthcare policy and innovation. In the US, we have such a different healthcare system from the rest of the world, and I've gotten really into researching it. Not only because in my marketing role, I had to understand how we fit into the continuum of post acute providers and be able to explain that to referral sources, but also because I obtained my master's in healthcare administration from Penn State, we are, and that really allowed me a greater look into our system and the ways that it's changed over time and how it really affects older adults in such a unique way. But before I learned more about how our healthcare system affects older adults. I had a personal experience that really impacted the way that I viewed our residents and how they interact with the acute healthcare systems.

I was stopped at a stop light one day and before I knew it wasn't a complete day because I had been rear ended by a 16 year old who had four other people in his car; that's another story we'll go on and was thrown into the car in front of me. Luckily I was not badly injured, just very, very stunned. And the EMT's thought that I might have a concussion. So I ended up in the emergency room at the local hospital. That happens to be a coronary hospital that takes on a lot of trauma from the region and often has very limited beds. So I ended up in the emergency room in a makeshift area that just sort of had curtains in between the beds. And as I was laying there, making sure that I didn't fall asleep with what was supposed to be a concussion. I heard of voice next to me. And at the time I was serving as a marketing director at one of our campuses and my husband was an executive director who was overseeing our secure memory unit.

And so every night I would help him, has I tried to gather him to go home for the evening. We ended up inevitably helping so many amazing older adults get to bed for the evening and sort of get them settled and reoriented and calm for the night and so I knew those residents really well. I most certainly knew the voice of this wonderful Southern lady I'll call her Annabel for purposes of anonymity, but I knew Annabel quite well. She was a wonderful lady, a true lady from the South and a beautiful musician. She played the piano from memory, but she had great moments of anxiety and concern. As she would remember things or not remember things and not know where she was and the only way to calm her was, and my husband discovered this, to put headphones on her with the iPad and put on the Sound of Music that always worked.

So because of Annabel's unique Southern drawl, I was able to recognize through the curtain that she was in the emergency room bed next to me, she was there with her daughter, apparently had had a fall and they suspected a broken hip. I can't describe to you how painful emotionally it was to listen to Annabel

tell her daughter that she wanted to go get up and use the ladies room and to have the nurse come in and tell her, no, you just need to go in your bed. A lady like Anabel did not want to, as she told her daughter, urinate in this bed. I thought to myself, the dignity issues here are so intense and the confusion, the anxiety, I wish I could've just put those headphones on her at that moment and started the Sound of Music because she needed to be transported somewhere far away from that emergency room bed.

It really hit me at the moment how impacted our residents are by the transitions, through the acute part of the healthcare system. And it made me passionate about understanding how we can make the experience better, especially for older adults. And so for all the folks out there who are not fans of the Affordable Care Act or Obamacare as it's called, I think one of the things that's grossly misunderstood with the affordable care act is the impact positively in fact that it's had on Medicare funding and innovation. So with the Affordable Care Act, there was an entire center set up to test and follow how Medicare could be more innovative with the way that they fund health care for better quality outcomes. So in the past, doctors and hospitals have all been rewarded for the amount, the volume of services they've provided, thus the term fee for service and the Medicare innovation center has really tried to pilot different ways that they can fund quality care and thoughtful care and coordinated care for older adults.

So that rather than performing more surgeries or labs or tests or having more appointments, doctors could be rewarded financially for keeping people out of the hospital, keeping people from having those surgeries and tests and labs. Imagine that. I just find the innovation that is going on with Medicare to be so interesting because it's finally focusing on rewarding practitioners and entities for providing good care for our older adults. It's been really interesting to watch the carrot and stick approach that Medicare has taken over the last 5 to 10 years with rolling out some of these innovations. Many of them you may have heard of, in fact, the readmissions program has very much affected our industry. And I think that you probably have seen that some of your hospitals have not been excited about a resident who may have been discharged back to you a little too quickly, going right back out to the emergency room.

That's because they get penalized financially for that, but other hospitals are still working their way around it. I've personally given presentations to C-suites of hospitals and shown them the millions of dollars they've been losing around the hospital readmissions reduction program. And they've sort of said, well, we're making it up elsewhere. So that doesn't really mean that much to us. And so it just shows that, you know, the dollar can go so far in pushing innovation with our healthcare system, but it takes a lot to get these hospitals and some of the larger entities to really change their approach and to change their style and to think about the experience of our older adults and our seniors in their care. But if we look at what an ideal experience for an older adult, like Annabel could have looked like, and we look at the way that Medicare is trying to restructure to create that, I mean, wouldn't have been amazing if doctors from that hospital were already extended to support our facility, that they could have come and seen her within our walls and a mobile x-ray could have been brought. And there could have been a better education level of the nurses to understand what a dementia resident patient is going through an emergency. And maybe there also could have been a better focus on do not resuscitate orders and advanced directives before a crisis. Practitioners could be more educated and comfortable with having those conversations so that Annabel maybe wouldn't have even gone out for additional care.

Then on top of all that, what kind of funding could have been redirected to prevent her fall that caused the hospitalization, or maybe it could have been redirected to cover more therapy and fitness programs

for older adults. There are so many things that our healthcare system could do, and Medicare is starting to take steps towards that right direction, but we still have so much work before we can get to a truly ideal coordinated care world for our older adults in the United States.

As I shared, in my example, with the hospital readmissions reduction program, it's really difficult to get our hospital providers and their leadership to move in a very drastically different direction to support seniors and older adults to have better coordinated care. So how do we transform the support of our seniors without being able to affect things at that higher level? I love the quote from author Malcolm Gladwell that says that part of me thinks that innovation, real innovation in healthcare delivery needs to happen from the bottom to the top rather than the other way around. And I've found that that is absolutely true. It's so difficult to affect things from the acute level, but what can we do at our level to transform the experience of seniors in our healthcare world? What I found is that partnerships with preferred providers, when you can push larger volumes of patients to a home health or a hospice or a wound doctor, or a primary care physician, you can leverage not only their full time support and dedicated staff, but you can also indoctrinate them into your culture and your expectations.

The more that we use preferred providers and establish those relationships, the better the experience will be for our seniors. I feel also that now more than ever in this pandemic, we have found that having a strong medical director overseeing our entire company has been hugely helpful. Having someone who understands the care of older adults, understands the direction that Medicare is headed in and is on board with that is worth its weight in gold. We are so grateful to have that type of support. But if you can find someone who might even be independent, premier, larger healthcare system can think a little bit more independently and strategically and can help you to coordinate more resources on site. It offers such a better experience to your residents.

And then lastly, having a point person on your team, who's truly responsible for coordinating all the different entities that touch our residents, whether they be therapists, home health, hospice, primary care providers, specialists and of course our acute hospitals and skilled nursing facilities that our residents interact with when they have an acute episode, having one point person who can communicate with the families, as well as the resident and all of your care staff about the care plan is so crucial. And I encourage everyone to make sure that they have that core resource person on their team who coordinates care and communicates with both the resident and their family members.

We all feel passionate about the Annabel's of the world, having a better experience with the healthcare system, but we can't count on the acute hospitals or maybe even Medicare to bring that to them. It's our responsibility to try to create that transformation from the bottom up. And I hope that you'll feel inspired to do so. Thanks for listening to this week's Bridge the Gap contributor Wednesday, please feel free to connect with me [btgvoice.com](https://btgvoice.com) and hashtag Bridge the Gap.