Empowering leaders

Covenant Care recently completed its plan to downsize from a national chain of 57 skilled nursing facilities in seven states to a regional provider with 30 SNFs in California and Nevada. Along with the mainstreaming came restructuring into clusters of facilities. Leaders at the smaller groups consolidate outreach and take cues from one another. The result has been improved relationships with local communities and better patient outcomes. Covenant President Dava Ashley recently shared details of the strategy with *McKnight's* Executive Editor James M. Berklan.

Photos: Orange County Headshots

Q: Why did you essentially shrink the company by half?

A: We wanted to focus on the West Coast. Our expertise in value-based programs and managed care resonated with our clinical partners on the West Coast.

Q: Now you emphasize local relationships?

A: We've always believed healthcare is local. It's always been a part of our culture, and we've always attracted leaders with an entrepreneurial spirit.

We wanted to innovate and work within our communities. We believe the executive director and director of nursing — facility leadership — know the best way to serve their community, whether it has to do with new clinical programs, staffing or collaboration with physicians and health systems.

We took a look at our portfolio and said we naturally have facilities in similar geographic markets that share similar hospital and managed care relationships. We developed clusters of three — one is four.

Those facility leaders work together to leverage their partnerships with the community, making sure they're providing services of the highest quality.

Q: Who is pivotal in all of this?

A: This model expresses our confidence in the executive directors and directors of nursing. We believe they are the key drivers.

We know that consistency in those two positions is everything. When you have consistency in leadership, it helps with consistency in the whole building. People say their relationship is like a marriage, and we believe that. We wanted to tie those leaders together.

Over time, this model will drive excellence in quality outcomes and financial metrics at the local level.

Q: How did this idea come about?

A: We had this model when the company started way back when. We kind of dusted off what we did long ago.

We understand that the field drives our organization. Empowering local leadership to meet the needs of their community and solicit feedback on improvements is vital.

It worked because we developed an incentive compensation plan for leadership that rewarded clinical and operational outcomes for their facility.

Q: How did you reposition workflow?

A: Not only did we align the skilled nursing facilities last July, but we also adjusted our regional staff. We looked at everything. We wanted to make sure, for example, that we were aligned with our home health agencies supporting the clusters.

We looked at realigning our regional staff to be more integrated with the clusters. Each cluster would have an executive director whom we promoted to be a market leader. They're still running their facility but would take a leadership role with their cluster to really take advantage of resources, problem solving and being creative to serve the communities and staff. It's a career path that we thought would be really great.

Before the cluster realignment, we did a pilot in three regions. We learned from that and tweaked things. For example, we learned that this model wasn't for some people and they chose to do something else.

Before the change, we had a typical regional structure with a director of operations over a certain number of buildings. We collapsed one of those positions and created two VP roles that were a little more strategic, helping support the clusters from a strategy and resource utilization perspective.

We did have some decide this model wasn't for them, and that was OK. It opened up opportunities for others to say this is exactly what I want. So we got some new people on board, which is always good for the promotion of new ideas and creativity. The cluster model empowers the group to problem solve, and look for new opportunities and hold each other accountable to high standards.

We had some natural market leaders we knew would be good at it. And we spent two days before even doing the pilot, talking about it, getting feedback, incorporating changes. We wanted to make sure we were creating a system that was in line with our vision to empower them. My COO and I took a lot of road trips, meeting at facilities, trying to build the best programs possible.

You have to put the time in, really spend time with the people — coaching and teaching. I always say if you're not directly taking care of a patient, you should be taking care of someone who is. This model focuses the resources on supporting the local level to deliver the best outcomes to those we serve.

> *"Keep your leaders focused on getting high-quality outcomes."*

Over time, this model will drive high-quality outcomes and operational excellence at the local level.

Q: How successful has the transition been?

A: I would say we're more nimble and able to adapt in a quicker way, based on the environment and what's going on.

We've seen cluster leaders coming up with great ideas for their communities that were just amazing. It's been really good. They share resources with their sister facilities. We've had nothing but really positive feedback.

One cluster's members were working with the same hospital, same health plans and sought to integrate medical groups and physicians to partner with them on clinical operations, such as medical directors. They chose to utilize one medical director for the cluster. It was a natural fit, where before each facility would have a different medical director. Now they share a resource who can look at the same markets and create stronger clinical protocols for them.

Now we have a medical director helping align clinical programs across the continuum, acute, SNF and our own home health agency. It aligns our services to better serve our community.

Q: What comes next?

A: We'll continue to work with our market leaders, supporting them and getting feedback. Over time we'll get outstanding financial and clinical outcomes, even better than we have so far.

We will spend time up front with our leaders so they really understand our culture and our mission.

We want the whole continuum even deeper ingrained with home health, so then we have a really strong clinical continuum for our patients. At the end of the day, that's what really drives us.

We will take our leads from the field and what they're seeing. If they say there's a new facility they'd like to bring into our cluster, we'd be open to that.

Q: Can others do this?

A: They should consider it. We have the opportunity due to the geography, but it's a concept you want, regardless — empowering the local leadership to serve their local communities. Be willing to allow them to do that.

Look at what you have leaders doing now that maybe they don't need to do. Keep your leaders focused on getting high-quality outcomes, and evaluate what back-office tasks can be done elsewhere.

If you don't have geographic clusters, you could leverage the intelligence of your independent leaders to work together, share ideas and problem solve. ■