



# Reducing Staff Turnover

Supporting Frontline Teams Through Value-Based Care



# Objectives for this session

- Understand the challenges facing senior housing
- Learn how technology-enabled, value-based primary care models work
- Explore how these models streamline communication and improve care continuity
- Discuss ways value-based care provides additional clinical support to strengthen workforce resilience
- Review strategies for leveraging these models to enhance staff retention and drive operational success



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# Pressures Facing Senior Housing

# Industry Challenges at a Glance

Senior Housing faces mounting financial, staffing, and occupancy challenges— underscoring the need for an innovative solution



## Rising Acuity

Residents are entering senior living later and sicker—straining staff and leading to higher hospitalization rates



## Regulatory Requirements and Quality Measures

Growing pressure to meet quality standards as patient acuity and complexity rises



## Operational Burden

Staffing shortages and rising care demands are pushing facilities to the limits of their capacities

# Rising Acuity

Later entry into senior housing, higher complexity

87

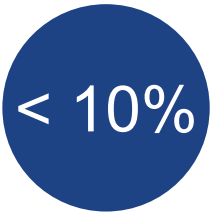
Average age of residents entering senior living

14

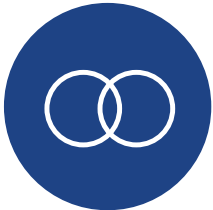
Number of average chronic conditions for AL residents

# Regulatory and Quality Pressures

Stricter requirements for SNFs and higher expectations for Senior Living



National rate of SNFs who achieve deficiency-free quality surveys



Strict CMS requirements for SNFs (minimum staffing ratios, performance metrics, etc.) and quality expectations for SL

# Operational Burden

Labor shortages and administrative inefficiencies are driving staff burnout and turnover

70%

Senior living communities report critical staffing shortages



High rates of employee turnover due to burnout and labor shortages

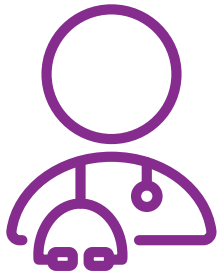


# Why Traditional Care Models Struggle



# Traditional Care Models: Entirely Fee-for-Service

Prioritizing volume over value results in worse outcomes, inefficiencies, and unnecessary spending

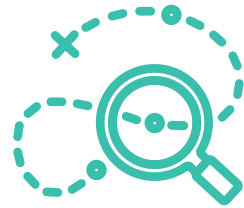


- Pay for service quantity
  - Driven by patient volume
- Focus on acute conditions
  - Reactive care model
  - Siloed treatment

# Shortcomings to Fee-for-Service frameworks



**Volume over Value**  
Incentivizing visits over outcomes creates inefficiencies without improving resident health



**Fragmented Care**  
Siloed providers lead to poor communication and care continuity. Staff waste time on administrative reconciliation



**Reactive vs Proactive**  
Focus on treating illness after it occurs rather than prevention. This leads to increased burden when conditions escalate



**Financial Pressures**  
Operators face rising costs without measurable improvements in staff support or resident outcomes. Burnout worsens as staff juggle high caseloads and paperwork.

# Ideal State of Care

Driving staff satisfaction and retention, while improving resident outcomes



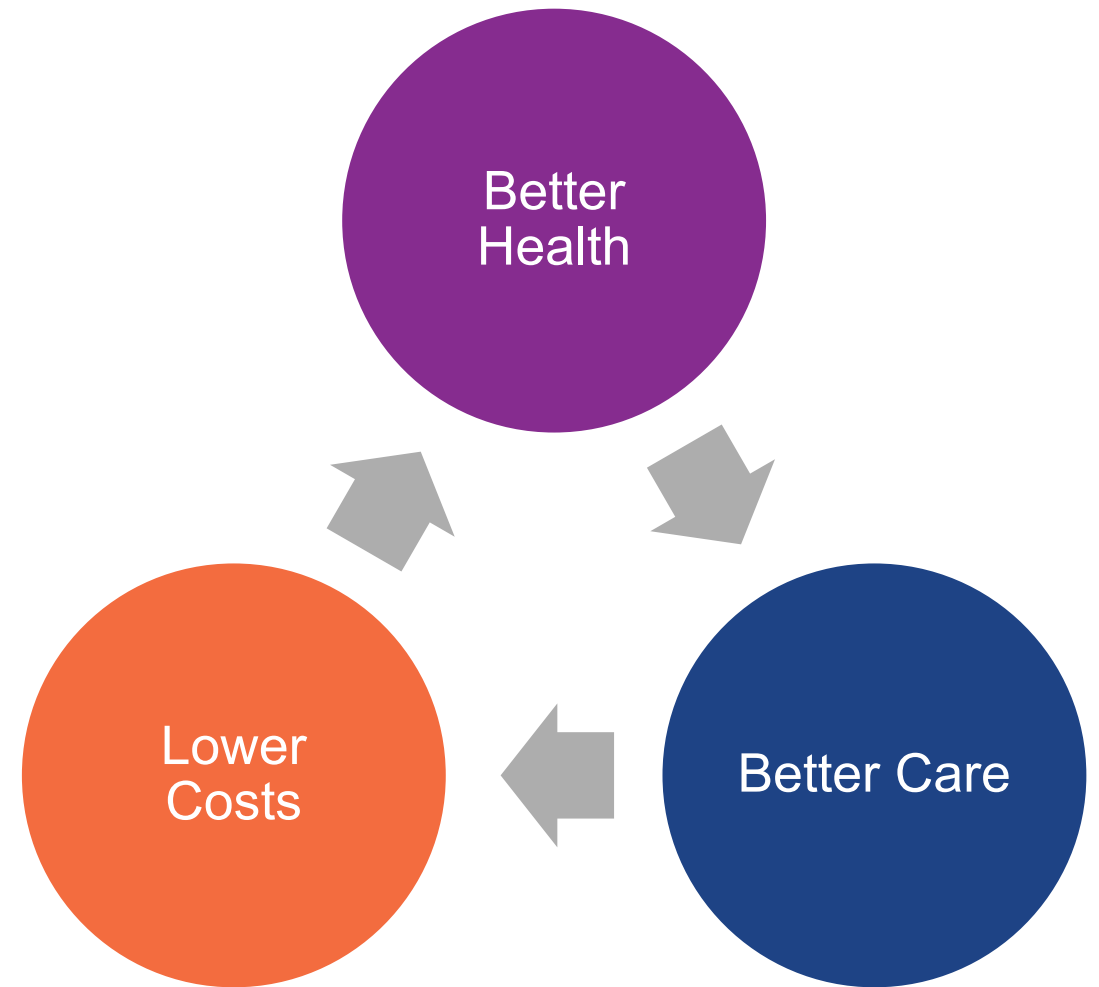


# Value-Based Care Models

# What is Value-Based Care

The concept that healthcare providers should get paid for keeping people healthy rather than the volume of services they deliver.

The goal is to help seniors maintain the highest possible level of wellness, rather than waiting until they get sick to provide care – which is often more complex and expensive.



# Key differences from Fee-for-Service

## Fee-for-Service Model



Reactive Care  
Focus on Acute Conditions  
Pay for Service Quantity  
Siloed Care



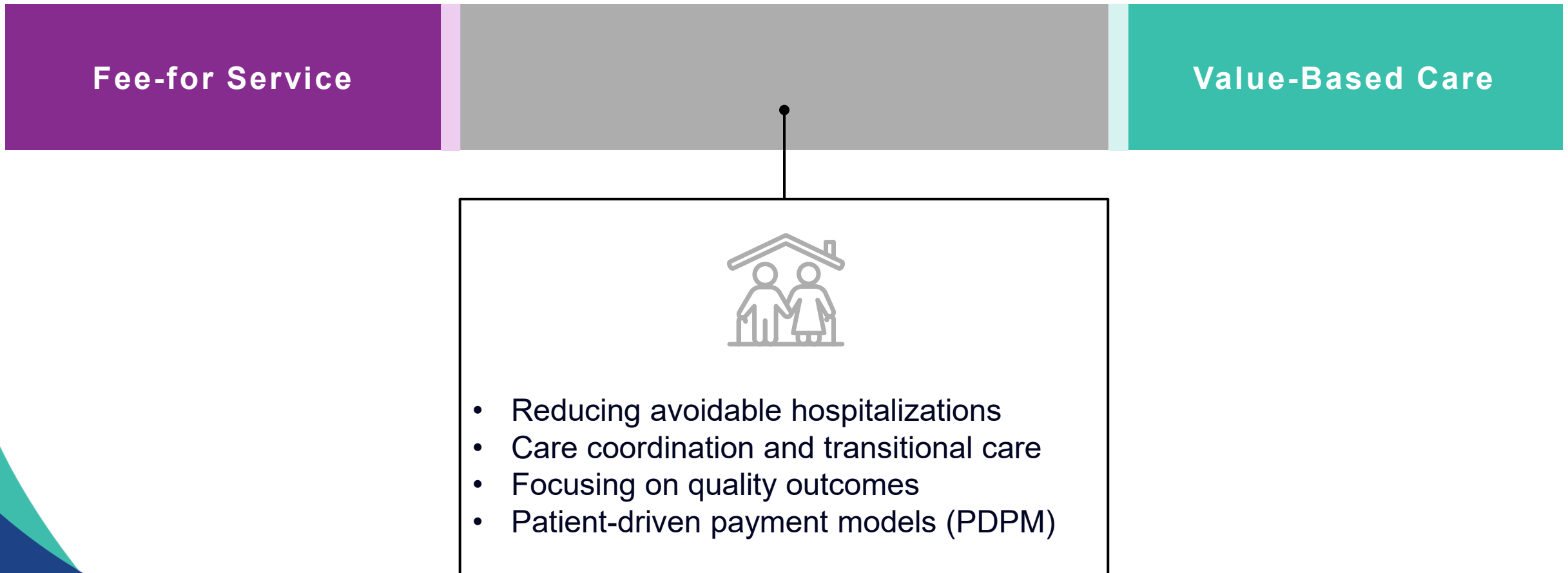
## Value-Based Care Model



Proactive Care  
Focus on Chronic Conditions  
Pay for Outcomes  
Care Team  
Accountable “Quarterback”

# Most Facilities Inhabit the 'Grey Area' of Care Models

Many communities utilize value-based practices without even realizing it



# Many ways to participate more in Value-Based Care

## PRIMARY CARE QUALITY MEASURES

### **Many communities are already participating in VBC without knowing!**

SNFs and Senior Living communities likely already participate in value-based programs such as PDPM and value-based payments where facilities are compensated for their quality performance

## ACCOUNTABLE CARE ORGANIZATIONS

### **Ensure care continuity and drive shared savings**

Groups of providers work together to coordinate care for patients. By keeping patients healthier and reducing unnecessary costs, they can generate shared savings payouts

## I-SNP PLANS

### **Integrate additional revenue streams with senior-specific benefits**

Specialized MA plans for people in institutional settings, which focus on tailored benefits to improve quality and reduce hospitalizations. Offers additional revenue stream opportunities.

## ... AND MORE

### **Flexible partnerships and affiliations**

Flexible partnerships allow communities to join programs that fit their needs—whether through affiliations, payor partnerships, enablement plans, or innovative care models—all aimed at improving outcomes and lowering costs.



# Value-Based Care Offers Flexible Solutions

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**PDPM/Quality  
Measures**

**Accountable Care  
Organizations**

**I-SNP  
Plans**

**Additional  
Partnerships**

- Configurable to your community's needs and strategic priorities
- Add new revenue streams
- Enhance resident satisfaction and outcomes
- Reduce staff administrative burden so you can focus on delivering high-quality care



# How Value-Based Care Models Support Frontline Teams

# How do value-based care models drive impact?





# Aligned Incentives Prioritize Care Quality

## WHAT IT MEANS

### **Aligning Financial and Clinical Goals**

Establishing clear guidelines where providers are rewarded for driving outcomes, not patient volume

## HOW IT WORKS

### **Quality-Based Incentives**

Incentives focus on keeping residents healthy, preventing unnecessary hospitalizations, and improving quality of life

## IMPACT

### **Engaged, Collaborative Team Culture**

Encourages proactive, involved care, fosters collaboration across teams, drives sustainable revenue through better quality performance



# Integrated Care Teams Promote Continuity

## WHAT IT MEANS

### **Connected Collaboration**

Teams use technology to share data and coordinate care across different settings

## HOW IT WORKS

### **Unified Platforms**

Integrated systems, such as facility and patient portals, discharge tracking, and EHR-integrations, enable real-time communication and continuous care plans

## IMPACT

### **Consistent Quality**

Easier to access information and fewer communication gaps lighten staff workloads, while residents benefit from consistent care



# Workforce Support Reduces Staff Burden

## WHAT IT MEANS

### **Empowered Staff**

Additional clinical staff and tools help manage workloads more effectively

## HOW IT WORKS

### **Smart Support and Automation**

More providers are available to support existing staff in clinical care, while technology such as ambient listening scribes help streamline documentation and charting tasks

## IMPACT

### **Improved Satisfaction**

Staff spend less time on paperwork and more time on meaningful care, enhancing employee morale and resident experience



# Proactive Care Prevents Complications

## WHAT IT MEANS

### Early Intervention

Care teams meet with patients before conditions become severe, lowering clinical complexity

## HOW IT WORKS

### Predictive Insights

Data-driven alerts through remote monitoring and risk stratification guide timely interventions before symptoms escalate

## IMPACT

### Lower Clinical Burden

Staff avoid stressful emergency situations while residents enjoy better health outcomes



# Operational Efficiency Enables Clinicians to Focus on What Matters— Providing Great Care

## WHAT IT MEANS

### **Simplified Processes**

Workflows are optimized through tech and organizational changes to drive speed and simplicity

## HOW IT WORKS

### **Streamlined Systems**

Integrated tools reduce redundancies and delays

## IMPACT

### **More Time for Care**

Staff reclaim time from administrative tasks, improving focus and reducing burnout, while residents receive more high-touch care



# Turning Care Alignment into Impact



## Care Continuity

Dependable, coordinated care reduces fragmentation for staff and residents



## Clinical Outcomes

Aligned goals improve hospitalizations, health metrics, and overall quality



## Staff Support

Additional providers lighten frontline workload and improve staff satisfaction



## Team Collaboration

Shared priorities strengthen communication and streamline cross-team coordination



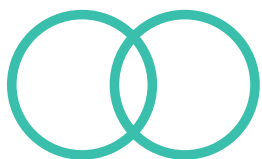
## High Value Care

Resources shift towards interventions that improve resident well-being



# Implementation Strategies

# Value-Based Care Implementation Considerations



## Team Alignment

### **Success starts with shared goals**

Ensure leadership, clinical teams, and technology partners are aligned on the purpose, expectations, and workflows—creating a unified approach to care delivery and decision-making.



## Data Collection

### **Real-time insights drive smarter care**

Establish systems to monitor, interpret, and act on data—enabling early intervention, patient prioritization, and continuous performance evaluation.



## Partnership Over Vendor

### **Collaboration is key**

Strong partnerships foster collaboration and shared accountability. Moving beyond transactional vendor relationships ensures aligned goals, integrated workflows, and support when you face challenges.



## Ongoing Education

### **Building a Resilient Team**

Continuous learning empowers teams to adapt to evolving care models. Regular training and knowledge sharing drive consistent quality, innovation, and improved patient experiences.

# KPI and Quality Measure Tracking

## KPIs immediately after launch



Resident adoption rate with clinical model



Resident satisfaction rate with clinical model



Staff satisfaction rate with clinical model



Adherence to clinical model standards

## KPIs tracked over time



Utilization trends:

- ED visits per thousand
- Admits per thousand
- Risk-adjusted total cost of care



Resident outcomes:

- Length of stay
- Medication adherence
- Annual Advanced Care Planning (ACP)
- CMS quality metrics (eg, blood pressure control, screening completion)



Shared savings achievement

# Key takeaways on value-based care



## Medical Group

- Onsite physician-led care teams
- Integrated primary care, behavioral health, and care coordination



## Value-Based Care Programs

- Choose risk options that match your growth strategy
- Select experienced & realistic partner



## Happier Residents

- Better experience
- Better health outcomes

## Healthier Communities

- New revenue streams
- Improved census
- Reduced burden on staff



# Thank you!

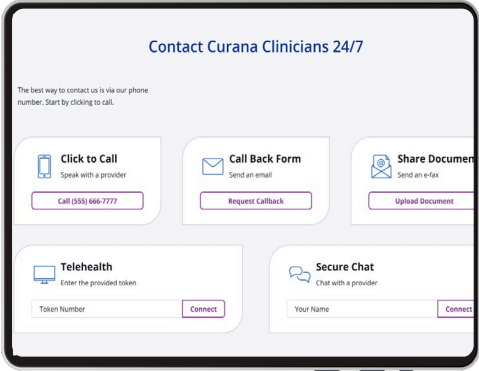
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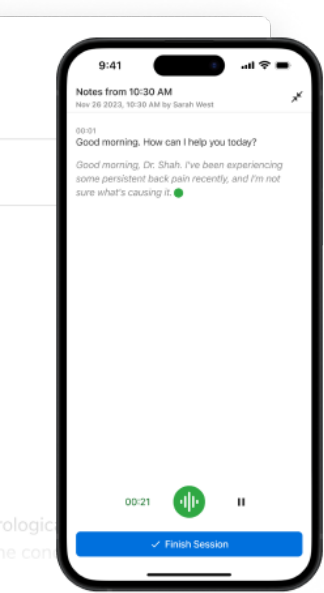
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# Value-Based Care Technology

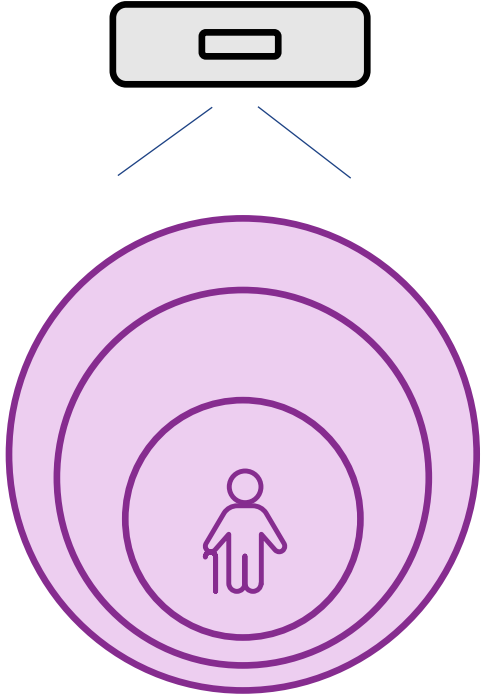
## Patient and Facility Portal



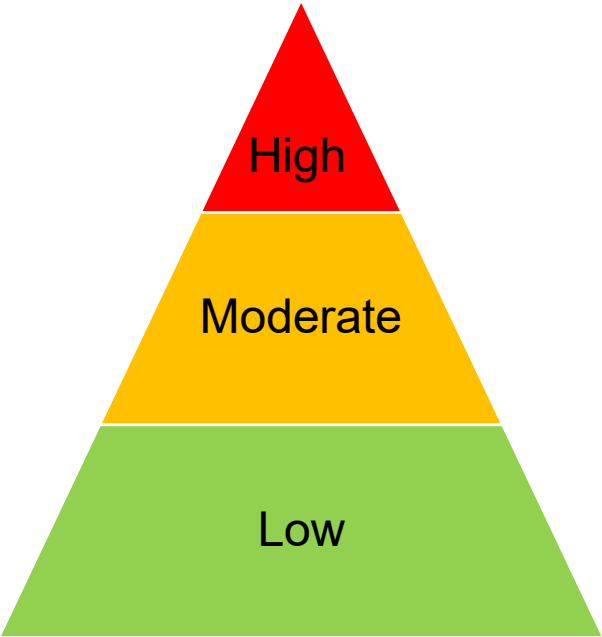
## Ambient Scribe Documentation



## Remote Monitoring



## Risk Stratification



# Curana partner saw widespread impact with VBC

## Clinical

10%

Reduction in  
weekly ER visits

55%

Reduction in  
falls with injury

## Operational

0

Med errors

95%

Average daily occupancy went  
from 89% to 95%

## Satisfaction

25%

Increase in  
resident happiness

100<sup>+</sup>%

Increase in  
employee happiness