

# Long-Term Care Providers Position Themselves for the Future

**I**f one thing is certain in long-term care, it is that the future is not, especially since President Bill Clinton's Health Security Act says very little about such care. To help providers prepare for what is ahead, futurists at the recent annual meeting of the American Association of Homes for the Aging (AAHA) in San Diego put forth their views of what long-term care will look like in the twenty-first century.

Predictions vary. But experts were in unison when they warned long-term care providers to look out for 2010, when the first of the baby boomers turn 65. They will be like no clients before them. Their characteristics, attitudes, and needs will affect long-term care providers' approach to care and the types of services they offer, as well as how facilities are designed. However, a more pressing concern may be, What will be the place of long-term care in a reformed system? And how can providers of such care remain viable?

## A CONTINUUM-OF-CARE MIND-SET

The term "long-term care" may be replaced in the twenty-first century by "continuum of care" or a similar term that evokes the concept of care through all times of life and all phases of illness. Such a shift in terminology can be seen in the president's healthcare reform proposal, which refers to an "extended acute care benefit," noted Dennis L. Kodner, PhD, vice president and executive director, Institute for Applied Gerontology, Metropolitan Jewish Geriatric Center, Brooklyn, NY.

Kodner, who was recently involved in a one-year study on the future of long-term care, said that providers need to know how to meet clients' needs while confronting the challenges and trends ahead. The future is not what it used to be: Healthcare professionals need to challenge the notion of what long-term care is, to visualize the obstacles and opportunities, he stated.

The United States is experiencing a paradigm shift in its notion of long-term care to an "elder-care range of services" that comprises acute care,



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long-term care, and housing, Kodner pointed out. Such a shift challenges care givers to provide elderly clients preventive services to limit disabilities.

The command center of long-term care will be case management care plans, asserted Kodner. He said that a typical long-term care management plan will be similar to the Catholic Health Association's client-focused plan (see **Figure**). Kodner noted that such plans require integrating mechanisms such as centralized planning and management; an organized continuum of services and providers over time, place, and profession; uniform information systems; utilization and quality management; and case-based capitation financing.

To make the shift from the long-term care mind-set to the continuum-of-care mind-set, providers must set the following goals:

- Prevent disabilities. Kodner asserted that Americans need to make the prevention of disabilities a major focus of research.
- Strengthen family care. The family provides 60 percent to 70 percent of a person's personal care throughout his or her lifetime, said Kodner. Home- and community-based care needs to be encouraged. He added that churches and synagogues could help. After elderly persons are hospitalized for the second time in a short period, their families' willingness to care for them in the home is reduced by 50 percent, Kodner noted.
- Improve the management and delivery of services. Long-term care administrators need to help employees sharpen their care-giving skills.
- Promote technology. Kodner said that long-term care professionals need to promote "gerotechnology," to research what technology makes sense for home- and community-based care.

## LONG-TERM CARE REFORM

Although President Clinton's healthcare reform proposal deals little with long-term care, the proposal does include Title 15, which would create a home- and community-based service program, noted Kodner. Although Title 15 covers the young and old, it is restrictive, making eligible for

coverage only those persons who have difficulties with at least three activities of daily living.

Kodner foresees a push for Medicare health maintenance organizations (HMOs) and preferred provider organizations (PPOs), especially since the managed care HMO and PPO boundaries are becoming more open-ended. Because of these changes, Medicare HMOs have high rates of enrollment in some areas of the United States.

The issues driving long-term care reform include the following:

- **Rising demand.** The United States is experiencing an increase in the number of elderly Americans and in the number of young Americans with long-term care needs, such as persons with AIDS and disabilities

- **Fragmented financing and delivery systems.** "Form follows financing," Kodner remarked. He explained that only if Americans change the way they pay for care will the delivery system change.

- **Escalating costs.** The integration of long-term care and acute care is a way to keep costs down.

- **Lack of adequate protection.** Kodner reported that 80 percent of elderly Americans have private supplemental insurance (Medigap) policies for acute care. In contrast, he predicted that only 20 percent of Americans will have private long-term care insurance in 2010.

- **Cutbacks in public funding.** Because of the federal budget deficit and state Medicaid cuts, reimbursement for long-term care will be based on case mix and capitated payments. Kodner noted that some states and the federal government are already experimenting with fixed payments and capitated payments for home care, mimicking what is occurring in acute care.

- **Mediocre quality.** Kodner said that "islands of quality" do exist. Long-term care providers will focus more on quality, "not as an outcome, but as a resource to be managed," he said.

- **Growing consumer awareness and concern.** People used to assume that Medicare covered long-term care; now, Kodner pointed out, they know better.

- **Overemphasis on the medical model.** Kodner noted that in the Netherlands long-term care facilities are more social institutions than medical institutions. There, residents' health is monitored by visiting nurses, indicating that long-term care facilities need not have a nurse on the premises at all times.

- **Bias toward nursing homes.** Reimbursement for nursing home care is easier to secure than home- or community-based care.

Many people wonder whether private long-term care insurance will be a saving grace for the elderly. Kodner foresees public-private long-term care insurance similar to Medicare and the Medigap insurance we have today. He noted that President



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Clinton proposes covering home- and community-based services, but not nursing home care. Private long-term care will be different from what we have today, said Kodner, noting that it will be *standardized* "private long-term gap insurance."

### LONG-TERM CARE PLAYERS IN 2010

In trying to secure their piece of the healthcare pie, some providers are moving into uncharted territory. For example, Kodner noted that multilevel hospitals will reduce acute care beds and move into ambulatory care and long-term care. He advised long-term care providers to extend into acute care, especially subacute services (see **Box**, p. 28).

Home- and community-based care is the foundation for long-term care in the Clinton proposal. Kodner acknowledged that the better the care in the home or community, the sicker people will be when they are admitted to nursing homes. Such facilities must be ready to accommodate persons who are seriously ill and in need of acute care services.

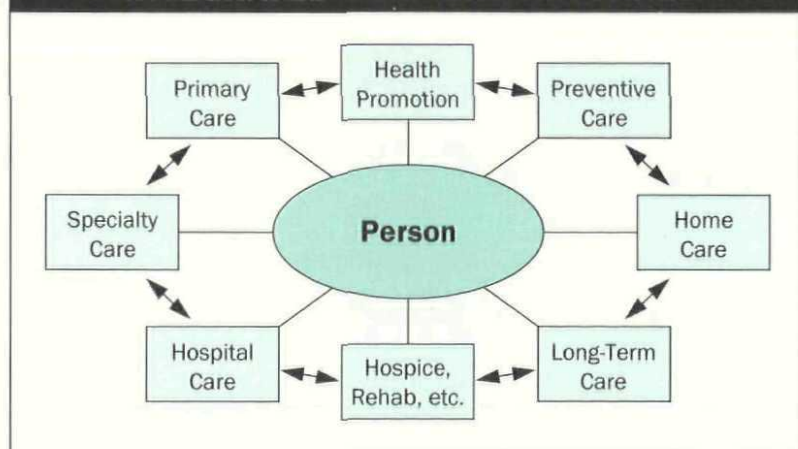
Technology will change the face of long-term care by promoting home care, noted Gregory Scott, a partner at the Lancaster, PA-based architectural firm of Reese, Lower, Patrick & Scott. He questioned, however, whether persons receiving home care will get the social support they need.

### THE ME GENERATION

An age wave is driving what the long-term care system will look like in the year 2010, noted Kodner. There will be 40 million Americans 65 years of age and older. They will be better educated and have higher incomes than any group before them.

With them will come a change in the notion of longevity because they will live healthier lifestyles, benefiting from biomedical breakthroughs

## INTEGRATED DELIVERY NETWORK



and illness prevention, asserted Kodner. There will be a shift from formal home care to a greater use of assistive devices like walkers and canes. Persons between 65 and 85 will be less disabled and less chronically ill than persons in that age range today, predicted Kodner.

Elderly Americans will have more political clout in 2010 than they have ever had, noted Kodner. Long-term care clients will be more knowledgeable about long-term care, demanding amenities, rights, and more services for the money, Kodner predicted. Clients will have more say in what institutions they will live in, whereas today families often decide where elderly loved ones will reside, he acknowledged.

Residents are now referred to as customers, pointed out Stephen E. Proctor, executive vice president, Presbyterian Homes, Inc., Camp Hill, PA. He believes this is an appropriate term, and it is one that employees understand.

Scott, Proctor, and Martin Valins, director of research, retirement and health care at Reese,

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Kodner said.**

Lower, Patrick & Scott, asked those attending their session to describe the long-term care customer of the future. Participants emphasized that long-term care providers will have to be flexible in order to cater to a diverse customer base.

Scott, Proctor, and Valins later asked participants to discuss the changes they are experiencing in their facilities. Participants brought up the following:

- Average age of residents has increased to 88 years.
- Residents' and families' expectations are increasing; they are demanding more.
- Government regulations are becoming more restrictive.
- More family members are together in facilities (e.g., mothers and daughters, sisters and brothers).
- Prices are increasing for private-pay patients. (One participant said that in 1957 her facility charged \$8 a day.)
- Staff members are more culturally diverse.

## SUBACUTE SERVICES: SEIZE THE OPPORTUNITY

To be a player in the future continuum of care, healthcare consultants at the recent AAHA meeting advised long-term care providers to add subacute care to their services. The window of opportunity for get-



Kelly

ting into subacute services is about one to two years, depending on the region, warned Marshall W. Kelly, president, Rehab Partners, Inc., New York City. He noted that in the competitive Northeast the window may be less than two years.

### THE SERVICES AND THE CLIENTS

What types of services are considered subacute? David M. Roberts, president, Focus Advisors, Inc., Oakland, CA, said they include services for patients who have experienced stroke, amputation, traumatic brain injury, spinal cord injury, sleep disorders, or orthopedic problems. In addition, subacute care serves persons in need of respiratory or infusion therapies, wound care, presurgical and postsurgical care, pulmonary care, plastic surgery care, or pediatric care.

Kelly said that subacute patients are medically stable and have high acuity, requiring no more than 30 days of institutionalization.

### ISSUES TO CONSIDER

Long-term care providers face the following issues when they provide subacute services:

- Different mind-set. Long-term care providers, who are accustomed to knowing their census, will not know it in the subacute area of the facility, said Kelly.
- Marketing. Subacute services require sophisticated marketing strategies such as reporting outcomes.
- New revenue streams. Negotiating with insurers is not easy.
- Salary scales. Long-term care providers will have to hire nurses with recent hospital intensive care unit experience, which will be costly.
- Culture clash. Kelly noted that the long-term care portion of the staff will have differences with the subacute care staff, which will command more resources.
- Local delivery systems. Long-term care providers will have to negotiate for their part of the pie. Subacute services

will be most affected by reform because they are more cost-effective than acute care services.

### POSITIVES OF SUBACUTE SERVICES

Subacute care is profitable because there is a readily available supply of patients, said Kelly. However, the key to attracting them is to establish appropriate marketing and pricing strategies. Long-term care facilities are appropriate sites for subacute services because they can accommodate a 30-day stay at a better rate than that of a hospital, added Kelly.

Vendor assistance should be available, asserted Kelly. For example, if staff members are having difficulty with ventilators, most vendors are willing to send a representative to train staff in their use.

Offering subacute care services is a way long-term care providers can maintain prestige, noted Kelly. Also, because they provide cost-effective care, long-term care providers now have access to capital to gear up for subacute services.

Patients will receive more appropriate care in more appropriate settings through subacute services, asserted Roberts. In addition, offering subacute services provides a new revenue source

One participant said that among his 300 employees, there were 21 languages and 9 alphabets.

• Staff members are not service oriented, remarked one participant, who pointed out that facilities are on a collision course between what residents want and what employees are willing to provide.

### LONG-TERM CARE FACILITY DESIGN

Today's nursing home models are built around the concept of the Nightingale Ward, which advocated cleanliness and discipline. Valins noted that this medical model does not take patients' life-styles into account.

The future of long-term care in the United States may already exist in Europe, where buildings such as priories are reused for long-term care facilities, said Valins. Such "recycling" has only recently begun occurring in the United States.

Atrium spaces, which are common in Europe, allow daylight to stream into corridors, giving residents the feeling of walking down the street. Some

*Valins suggested using facilities as community resources, providing intergenerational care.*

facilities keep corridors cool so that residents are not totally isolated from the elements. In addition, long-term care providers can motivate elderly to walk outdoors. Valins described a facility in England that has pavilions on its grounds. The pavilions include telephones (so residents can call for help if needed) and restrooms. He said that many residents would like to walk outdoors but are concerned about getting to restrooms when necessary. Some European facilities use stairs as therapy, observed Valins. He said it motivates residents by presenting them with a challenge.

Scott described a facility that recently was allowed to waive state regulations and placed Murphy beds in the rooms of Alzheimer's patients. He said it helps keep such patients aware of their daily routine: They know that when the bed is down, they sleep; when the bed is closed up, it is time to be awake.

Valins admitted that there is a challenge in taking the medical model building type into the next cen-

*Continued on page 30*

for long-term care providers, including higher revenue for existing beds.

### NEGATIVES OF SUBACUTE SERVICES

Roberts admitted that although subacute services are a great opportunity for long-term care providers, they do pose some challenges. He explained that long-term care providers need to develop staff and programs to provide the services. In addition, long-term care providers need to document programs' effectiveness through outcomes studies. He also pointed out that long-term care providers will need to develop links to local delivery systems for financial information and referrals.

Although long-term care providers who offer subacute services can benefit, Roberts said that hospitals and hospital-based skilled nursing facilities or transitional care units can also provide subacute services, warning that most hospitals are planning to introduce transitional care units within the year. Therefore, a long-term care facility may have to act quickly to become the subacute care provider in its area.

Other negatives include cash flow issues, capital improvement costs, cul-

ture clash (between long-term care staff and subacute staff), and financial risk, admitted Kelly.

### SUCCESS INDICATORS IN SUBACUTE SERVICES

Offering subacute services is not for all long-term care providers, acknowledged Kelly. Successful ones will have the following:

- Strong managers
- Access to technical knowledge
- Exceptional Medicaid reimbursement rates
- A high managed care penetration
- Few subacute providers in the area
- Physical plants that have enough space and rooms
- A sufficient population base, most likely an urban area
- High census in area hospitals
- Access to capital
- Sufficient professional staff

### MARKETING ISSUES IN SUBACUTE SERVICES

Today, families are involved in choosing subacute care for their loved ones. So, a



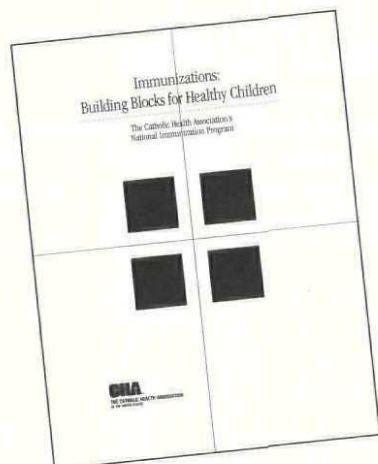
Roberts

facility needs to be acceptable to the patient and the family, noted Kelly. The physical plant must have a separate entrance for subacute services, an inviting reception area, and adequate therapy space.

Printed material that markets the facility and its services should not be developed until the facility's mission and services are well defined, advised Kelly. He noted that both families and insurance companies will be looking at brochures, newsletters, and fact sheets that promote the facility's competencies. In addition, Kelly suggested that long-term care providers send letters to all insurers, telling them about the subacute services available at their facilities and the price.

To market subacute services appropriately, a long-term care facility must hire a sophisticated marketing professional, asserted Kelly. He added that facilities should not hesitate to show financial justification to insurance companies as to why their facility is best. For example, a facility's success at weaning patients off ventilators should be promoted. "Let insurance companies know you can save them money," advised Kelly.

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**ANALYSIS**

*Continued from page 29*

ture. He warned that doing nothing would be reckless. A facility could be converted to an assisted living facility, but that does not contribute to a community feel, he offered. Valins suggested using facilities as community resources, providing intergenerational care. Another option he recommended was implementing programs for subacute services.

**STRATEGIES TO REMAIN VIABLE**

With the inevitable changes ahead, how can healthcare providers remain viable in the twenty-first century, especially those who provide long-term care? Kodner recommended that such providers practice the following strategies to remain viable:

- Be flexible and open to change.
- Practice strategic management and planning.
- Diversify. Kodner suggested looking at the range of services in the area. Do they meet the continuum's needs? Are there gaps that could be filled?
  - Form networks.
  - Build operational systems. Kodner recommended investing more financial resources in quality management and information systems.
  - Practice outcomes management.
  - Focus on client satisfaction. Kodner warned that baby boomers will demand services never before requested.
    - Invest in staff. Kodner advised providing additional training for staff. Proctor added the following:
      - Be out in front, not out of touch. Stay in touch with who your customers are today.
        - Take prudent risks.
        - Educate boards of trustees and be educated by them.
        - Listen to your newest customers. Find out why they chose your facility.
          - Place customers first.
          - Incorporate forward thinking into everyday activities. Look outside long-term care—to other types of healthcare providers and to business—for answers to how customers behave.

—Michelle Hey