

LONG-TERM CARE AND HOSPITAL COLLABORATION

To Survive in a Reformed Healthcare System, Long-Term Care Facilities Can Initiate Hospital-based SNFs

Despite the push toward integrated delivery of health-care, many experts are predicting that initial legislation to reform the delivery system will focus on hospitals and physicians—largely neglecting long-term care providers. But this does not mean that those who serve the elderly can maintain the status quo. The same environmental pressures that are leading to systemic reform make it imperative that skilled nursing facilities (SNFs) and others who care for seniors adapt to changing concepts of how care should be delivered.

One concrete action long-term care facilities can take is to initiate collaborative efforts to develop hospital-based SNFs. At the American Society on Aging's annual conference in March,



**INTEGRATED
DELIVERY
NETWORKS**

Anne Burns Johnson, vice president of senior services at Bridge Housing, Oakland, CA, noted that hospital-based SNFs are an area of current and projected growth, with good reimbursement.

"If you can get in the door and work with a hospital on its SNF, it positions you in the hospital's inner circle," Johnson pointed out. "This is a critical part of how hospitals manage patients these days." By, in effect, solving a hospital's problem for them, long-term care providers

can establish relationships that may be crucial as reform progresses and eventually encompasses the full continuum of care.

THE IMPERATIVE FOR ACTION

The future for freestanding SNFs is bleak, Johnson predicted—with "survival of the fittest"

Summary Establishing relationships with hospitals may be critical for long-term care facilities facing financial pressures and uncertain futures. One option is to initiate collaborative efforts to develop hospital-based skilled nursing facilities (SNFs). Hospitals, under pressure to move patients to less intensive settings and to diversify, are naturally drawn to long-term care as a related business where they can make limited personnel and financial commitments and extend their continuum of care.

Before approaching hospitals to initiate collaborative efforts, long-term care providers should understand how they think and what their strengths and weaknesses are.

Long-term and acute care providers have many options for collaboration, including management

contracts and joint ventures. In a traditional management contract, the long-term care provider furnishes the administrator and a few key staff in exchange for direct reimbursement for those staff plus a management fee. Another option is for the long-term care facility to provide all the staff for a fee or percentage of revenue.

Joint venture options are to form a subsidiary corporation to renovate a floor of the hospital or to have the hospital buy a large percentage of the long-term care facility and share the profits.

All these options have potential pitfalls, including differing financial expectations and the threat of unionization at the SNF. Nevertheless, for long-term care facilities struggling under reimbursement cutbacks and other pressures, the benefits may outweigh the risks.

being the rule. Reimbursement cutbacks, rising benefit costs, reduced access to capital, and increasing competition are affecting their viability. At the same time, hospitals are being forced to increase their efficiency and move patients into less intensive settings. Thus current economic pressures on both hospitals and long-term care facilities are driving changes in their relationship, Johnson said.

"It is not all gloom and doom," she stressed, and long-term care

providers can take steps to improve their chances of survival during these uncertain times. Typical responses to current environmental forces include developing a specialized market niche, such as high-tech care, the high or low end of the market, or quality differentiation; selling out or merging; expanding the product (e.g., adding assisted living or Alzheimer's units); and maximizing opportunities to develop synergistic relationships and joint ventures with hospitals.

This latter strategy may meet the needs of acute care providers as well. As hospitals under stress look for ways to diversify, "long-term care is a natural," Johnson said. "Although hospitals are willing to spend money, they look for ventures where they don't have to spend a lot of money and/or the rate of return is very high"—perhaps as much as 15 percent. Other factors also make long-term care attractive:

- Unsuccessful experiences in the 1980s (with ventures as far-fetched as selling yogurt) have taught hospitals to try related enterprises.

- They also need ventures that are not threatening to physicians, who tend to dislike authority, Johnson said.

- In dealing with insurance companies, hospitals like to cross-market and build a continuum of care to save ambulance fees and other costs of transfer—in addition to improving the quality of patient care.

- Hospitals "like activities they think they know how to do," where they can make a limited personnel commitment and remain in control.

The upshot is a growing movement toward hospital-based SNFs. In the East San Francisco Bay area, for example, studies show that the

Economic pressures on hospitals and long-term care facilities are driving changes in their relationship.

number of acute care hospitals is steadily declining, while hospital-based SNFs and home health agencies are increasing, Johnson said.

Although the opportunity for collaboration is growing, before approaching acute care providers, long-term care administrators must "know how they think and also what their strengths and weaknesses are," Johnson advised.

PROVIDERS' STRENGTHS AND WEAKNESSES

"The traditional relationship between hospitals and long-term care providers is like a teeter-totter, where the hospital has all the weight and all the control and the long-term care provider is often left up in the air," Johnson said. She warned that this unequal relationship will continue, so long-term care providers that want to collaborate with hospitals must understand their relative position.

Differentiating Factors Several factors differentiate acute care hospitals and long-term care providers:

- Time frame. Hospitals deal in short-term, episodic cases. And this time frame is being shortened, as hospitals focus their admission activities and discharge planning on the 73d hour—when they can transfer patients to hospital-based SNFs and get a second type of reimbursement. Obviously, long-term care providers think about length of stay and relationships in terms of much longer time frames.

- Budgeting perspective. Despite their financial troubles, "hospitals still have lots of money and are used to making major purchases," Johnson said. The point at which the organizations start worrying about cost differences varies greatly. Hospital managers consider it significant when the discrepancy between two options is more than \$50,000. At retirement homes, the cutoff is \$10,000; for assisted living facilities, \$1,000; and for SNFs, \$2,500.

- Regulations and licensing. Hospitals must deal with well-defined federal and state regulations, but SNFs face regulations far more rigid and specific. Hospitals set their own policies and procedures and only get into trouble when they fail to follow them, Johnson said. Long-term care facilities, on the other hand, can get into trouble

by not following what is dictated by the state or a particular inspector.

- **Training and credentials.** Hospital administrators require no licensing and credentials, yet traditionally view long-term care administrators, who are licensed by the state, as less qualified and capable. For example, in California long-term care administrators have to be licensed *unless* the program is hospital based.

- **Governance and decision making.** Hospitals are bureaucratic and complex. They use process-oriented decision making, with input from boards, medical staff, and other groups. Long-term care facilities tend to be individually owned and more entrepreneurial. "Because of these differences," Johnson said, "long-term care facilities entering into a relationship with a hospital will find it very arduous, difficult, and almost impossible to keep track of who's in charge."

Strengths and Weaknesses Hospital strengths are substantial, Johnson said. They include access to start-up funds and capital, willingness to take risks, control of referrals to long-term care providers through discharge planners and utilization management staff, and community presence and reputation. "I have never heard of a commu-

nity rallying around a skilled nursing facility in trouble, but they do rally around hospitals," she added.

But in long-term care ventures, "hospitals' weaknesses are not insignificant," she said. She advised long-term care administrators to "build on them, put them into your marketing message."

Acute care providers' primary weakness is "they don't know long-term care. They think differently, they approach problems differently." Johnson said that hospitals are poorly informed about what is involved in long-term care. "They think that it's simple, and it's not."

In addition, hospitals do not know how to manage the skill mix needed in long-term care, such as nurses aides, and they are not as accustomed to dealing with unskilled workers, including recent immigrants. Hospitals also tend to overpay their long-term care staff because they do not know any better.

Another weakness in long-term care ventures is that hospitals are more used to interacting with physicians and insurance companies than with families and consumers. For example, the hospital staff is not accustomed to dealing sensitively with

WHERE TO START

For long-term care providers wanting to initiate collaborative ventures, Anne Burns Johnson provided some concrete recommendations at the American Society on Aging's annual conference in March.

PLANNING

- Know your community and your competitors—visit them regularly and anticipate their moves.
- Know your own business, including specific referral sources, such as discharge planners and physicians.
- Know your own strengths and weaknesses—what you can do and what you cannot.
- Know your own goals: growth, maintenance, or survival.
- Know the hospital decision makers—their motivations and processes. Get on a planning committee, advisory group, or foundation.
- Find a hospital that matches your facility in terms of expertise, reputation, and administrator personality.

PITCHING THE PROPOSAL

Some nursing home administrators may feel uncomfortable approaching the hospital chief executive officer with a proposal for collaboration, Johnson said. If so, she suggested several alternatives:

- Approach the medical director or director of nursing—the person who has responsibility for getting the patients out
- Get to know hospital council representatives, who can be a good entree and source of data such as occupancy statistics
- Hire a marketing or planning person to develop a more structured plan for presenting the proposal

PROPOSING CONCRETE OPTIONS

When approaching hospital administrators, long-term care professionals should propose concrete options, Johnson advised. These can include relatively simple ways of beginning to work together. For example:

- Have the hospital respiratory department offer services in your SNF.
- Use the hospital education department for training the long-term care staff.
- Offer therapy space to the hospital, and set up a clinic.
- Provide discounted home care for patients discharged from the hospital.
- Use financial incentives to encourage a relationship, such as discounts for sending all their patients to your facility.
- Provide home care to hospital-owned or hospital-run assisted or independent living sites.
- Offer discharge planning support and staff for no cost to the hospital. The SNF's Medicare liaison can spend 95 percent of his or her time at the hospital; the SNF still gets reimbursed for it and is ensured a good flow of referrals.
- Propose an in-house SNF to hospitals, and emphasize how much money they can save and the advantages of working with a local company rather than a national chain.



families in crisis, Johnson said.

She also claimed that hospitals have weak project management, with overruns on items such as construction costs "that wouldn't be tolerated by a chain of SNFs." In addition, hospitals "can easily lose control of their referrals," Johnson said. Most discharge planners have a fair amount of autonomy, which can be a problem, she noted. "In

one hospital that has had a home health agency for six years, the discharge planner still sends people to another home health agency."

Long-term care providers' strengths are fundamental and play off hospitals' weaknesses, Johnson said. They include their operating experience, marketing orientation (which is more in tune with the needs of families, residents, and the community), fund-raising abilities, and knowledge of the system and how to make it work.

COLLABORATION

Although "the typical hospital response to the current environmental stresses is to diversify," not all hospitals think alike, Johnson said. Some are more willing to take risks than others, but "the days of the wild cowboy CEO are gone. More and more you're finding the kind of analytical approach to how projects are evaluated."

Hospitals' Options Hospitals have several options when looking at diversification into a SNF (or another senior service, such as a home health agency, hospice, assisted living, or geropsychiatric unit):

- Establish a "favored nation status." Hospitals can pick a SNF, ensure it will be available for admissions seven days a week (among other factors), and transfer all patients there.

- Develop a new SNF and lease it out for someone else to run. Hospitals can convert an empty floor, but this will be easier if the hospital is new and meets handicap requirements.

- Enter a joint venture with an outside SNF provider.

- Develop a SNF and operate it with a contract for the management (where the hospital contributes the resources and staff).

- Open a new SNF entirely on their own. But fewer hospitals will be choosing this option, Johnson said, because of the economic crunch

Hospitals do not know how to manage the skill mix needed in long-term care.

and environmental pressures.

Long-Term Care Providers' Options In collaborating with a hospital, long-term care facilities need to gauge their capabilities and resources and assess the future of the prospective hospital (since 2,000 of them will close their doors in the near future, Johnson predicted). The three options available are signing a management contract, entering a

joint venture with a new or existing hospital-based SNF, and building and managing a SNF with a hospital lease.

She added that the latter option may work "if you have lots of money or are in an area that is underserved." But unless the facility is already under construction or is part of a retirement complex, "it's probably a poor choice because of poor timing—healthcare reform is moving too fast."

MANAGEMENT CONTRACTS

Long-term care providers have two options regarding management contracts, Johnson said:

- Traditional. The long-term care provider furnishes the administrator and director of nursing and maybe a few key staff (e.g., social worker, activities director) in exchange for direct reimbursement for those staff plus a management fee (Medicare reimburses 3 percent to 7 percent of base revenue for management fees).

- Leasing. The long-term care facility provides all staff for a fee or a percentage of revenue. This provides more flexibility regarding the pay scale and the option of using nonunionized staff even if the hospital is unionized (although the threat of unionization may remain). Plus it allows the long-term care provider more autonomy in management.

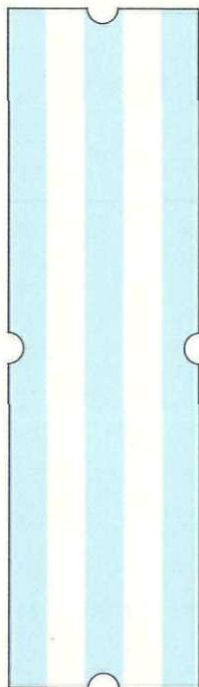
Despite the advantages to providers, management contracts do contain several pitfalls. First, referral patterns take time to develop. Hospital staff will question the hospital-based SNF's nursing competency and whether it can be "as good as what's being done on the floor or across the parking lot or even across town," Johnson said. She added that administrators must educate physicians on the clinical benefits to them and to the patients of using a hospital-based SNF. And

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discharge planners require a lot of coaching to ensure they understand the concept.

In addition, the facility will be subject to both Joint Commission on Accreditation of Healthcare Organizations and Omnibus Budget Reconciliation Act reviews—"a double whammy." It takes a lot of time and a lot of effort to deal with both, Johnson pointed out.

Moreover, the participants' financial perspectives are often not aligned. Hospitals may be interested only in maximizing the DRG reimbursement by getting the patient out of acute care fast, while the long-term care provider is trying to maximize its benefits and keep the costs low.

JOINT VENTURES

Long-term care facilities and hospitals entering joint ventures have two options, Johnson said:

- A new facility: forming a subsidiary corporation between the acute care and long-term care providers to renovate a floor of the hospital

- A leveraged buyout, where the hospital buys a large percentage of the long-term care facility and the two share profits

No matter how they are constructed, the pitfalls of joint ventures are much the same, Johnson said. First, the two parties must agree on policy control—who is in charge and what latitude the managing partners have in making decisions. And the potential exists for differing financial expectations. The hospital mainly wants to discharge early, while the long-term care provider wants to manage long-term profits. The hospital may not see the income as significant in terms of its overall budget.

The lower wages in SNFs compared

with hospitals are another potential problem. "If you insist on paying the same, it's down-the-road disaster," Johnson said. To help avoid conflicts, the partners can form a subsidiary corporation to employ the SNF workers, and the SNF can pay slightly more than competitors (though probably still well below the hospital) and offer more fringe benefits. Such arrangements may also help the SNF avoid unionization threats, although the potential still exists.

Johnson also warned that good legal scrutiny is required for structuring a leveraged buyout of an existing facility, particularly if it is a not-for-profit and for-profit partnership. And she reminded meeting participants of one final pitfall: The reputations of the partners are linked, for good or bad. If one of them gets into trouble, the other's fortunes could also be affected.

COLLABORATION FOR SURVIVAL

Despite the potential problems associated with collaborative efforts, for long-term care providers facing uncertain futures they may still be a good idea. Long-term care facilities may benefit greatly down the road by forming closer ties with strong acute care providers, whose power may increase as the leaders of integrated delivery networks after healthcare reform. And collaborative involvement in a hospital-based SNF will position the SNF manager in a powerful role as a gatekeeper to community convalescent and skilled nursing facilities for those needing care after discharge from the hospital. Thus, trying to understand the hospital's position—how it thinks, its strengths, and its weaknesses—may be necessary for long-term care facilities to continue their mission of serving the elderly in their communities. —Susan K. Hume