Long Term/Post Acute Care: Why Are We in This Business?

HealthCare Roundtable
April 19, 2001

Cecily Lohmar, Principal
New Heights Group
Cecily@reach-newheights.com
704.895.3410

www.reach-newheights.com
Agenda

• **Strategic context**
  – Post acute care
  – Long term care

• **Market Trends**

• **Evaluating your strategic agenda**

• **Making it work today and tomorrow**

• **Case studies**
Roundtable Questions

• Trends in LTC and implications on future service need

• Assisted living trends and potential opportunities

• Integration of LTC with acute care

• How to make post acute and/or long term care more successful

• Specialty LTC programs
“You must either find a way or make one.”

- Hannibal
Post Acute and Long Term Care

Post Acute Care

Long Term Care
Post Acute – What is It?

• The multiple settings along the continuum that follow the acute medical/surgical episode:
  – Fills the treatment gap between inpatient acute care and residential care
  – Patients do not need acute care but still require medical care
  – Typically less costly than acute
  – Is transitional

• PLUS, unique expertise and knowledge absent from med/surg
  – Restorative focus
  – Adaptive equipment
  – Patient safety
  – Caregiver training, education

*Post Acute is NOT Acute Care Light*
Post Acute IS NOT a Stand Alone Service

- Acute care and post-acute settings are *interdependent* – you can’t close one without affecting the other

- **Trickle down effect**
  - Increased acute LOS
  - Placement difficulties
  - Increased overhead across remaining units
  - Increased cost per unit in acute
  - Decline in outcomes
# Distribution of Hospital Discharges to Post Acute Settings

<table>
<thead>
<tr>
<th>Type of Provider</th>
<th>Total 2,476,412</th>
<th>25.3</th>
<th>100</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skilled Nursing</td>
<td>1,320,701</td>
<td>13.5</td>
<td>53.3</td>
</tr>
<tr>
<td>Home Health</td>
<td>799,893</td>
<td>8.2</td>
<td>32.3</td>
</tr>
<tr>
<td>Rehabilitation</td>
<td>278,073</td>
<td>2.9</td>
<td>11.2</td>
</tr>
<tr>
<td>Psychiatric</td>
<td>43,794</td>
<td>0.4</td>
<td>1.8</td>
</tr>
<tr>
<td>Long-Term Care</td>
<td>33,951</td>
<td>0.3</td>
<td>1.4</td>
</tr>
</tbody>
</table>

*Psychiatric facilities/units are included, since they are often part of a postacute care episode.*

*Source: MedPAC December 14, 2000 Meeting. Information based on 1997 data*
Growth of Post Acute

Source: HCFA 2001

Medicare Use Rate (per 1,000)


Skilled Nursing Facilities
Home Health Agencies

Source: HCFA 2001

Rehabilitation

Source: HCFA 2001

www.reach-newheights.com
Long Term Care – What is It?

• **Settings beyond the acute and post acute episode**
  – Shift from transitional care to residential
  – Focus on maintenance vs. restoration
  – Caretakers vs. health care providers

• **Unique expertise**
  – Adaptive equipment and environment
  – Safe, supervised environment for resident
  – Real estate and hospitality vs. health care
Long Term Care CAN BE Stand Alone

- Unlike post acute, long term care has limited interdependence with acute care
  - Different business
    - Real estate
    - Hospitality

- Stand alone nature creates greater challenge for healthcare providers entering market
  - Strategic justification
  - Mission vs. margin
  - Operational differences
Long Term Care Growth

• Nursing home beds per 1,000 elderly have remained relatively stable (45-55/1000)
  – Slow but gradual shift from NH to ALF for high functioning residents
  – Leaves nursing homes with higher care/higher cost patients
• Assisted living has experienced most market growth in LTC
  – Focus on affluent markets
  – Just beginning to see growth in lower – moderate income segments
• Retirement communities
  – Rise and fall, and rise again
  – Scaled down CCRCs
Market Realities
An Aging Population

Projected Growth 1999-2004

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Growth Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>4.2%</td>
</tr>
<tr>
<td>Over 65</td>
<td>6.5%</td>
</tr>
<tr>
<td>65-74</td>
<td>2.7%</td>
</tr>
<tr>
<td>75-84</td>
<td>8.7%</td>
</tr>
<tr>
<td>85+</td>
<td>16.5%</td>
</tr>
</tbody>
</table>
With Age Comes Infirmitry


www.reach-newheights.com
And an Increasing Need for Assistance

Payment Constraints: The BBA

Skilled Nursing

- Pre-BBA
  - Cost Based
  - No Cap on Ancillary
  - 1996 Average Cost Per Day is $414

- Post-BBA
  - Per Diem PPS
  - Average 2000 Payment $312

Inpatient Rehabilitation

- Pre-BBA
  - Cost Based
  - 1996 Average Cost Per Discharge is $12,391

- Post-BBA
  - Per Discharge PPS
  - Prelim Projections - $10,900

www.reach-newheights.com
The Future Outlook

• Post acute:
  – Increasing demand for and acuity level within all settings
  – Providers will adjust to PPS through shifts in patient mix and services provided
  – Specialty programs will increase in near term; long term likely to be integrated into general programs
  – LTAC popularity decline post PPS

• Long term care:
  – Demand will continue to increase
  – Shift from traditional nursing home to ALF
  – Medicaid and HUD support will drive shift of ALF development to lower income markets
  – Traditional nursing homes will shift to skilled settings
The Big Question

• Should we be in this business?
  – Why?
  – What?
  – How?
“In the middle of every difficulty lies opportunity”

Albert Einstein
Evaluating Your Agenda

Redefine your objective
- Is objective clear throughout system?
- Has the objective changed under BBA?

Clarify your strategy
- Growth
- Capacity
- Distribution

Establish appropriate measures of success
- Unit/service profitability alone no longer valid and may not address objective

Implement service “redesign” to fit financial realities
Why PAC or LTC?
Post Acute Objectives

• To improve care management
  – Continuum use
  – Outcomes
  – Enhance risk based payment
  – Indirectly improves profitability

• Support core business
  – Improve services to existing patients
  – Increase market share
  – Increase acute care cycle time
  – Improve patient satisfaction
  – Enhance image in community

Post acute objective best tied to acute services given interdependence of the two

www.reach-newheights.com
Is Post Acute For You?

1. Acute care utilization management difficulties
2. Large elderly/chronic population
3. Centers of Excellence in chronic disease areas
4. Limited access to post acute outside of system – placement difficulties
5. Unused beds in existing facility
6. High re-admission rates for elderly
7. Interest in expanding geographic market
8. Greater than 15% of acute discharges referred outside of system

<table>
<thead>
<tr>
<th>Measure</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALOS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>65+%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strategic Plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outliers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Occupancy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CQI</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strategic Plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discharge Disposition</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Is Post Acute For You? (cont.)

If you answer “yes” to 4 or more of these questions, post acute is an appropriate strategy for your system.

If you answer “yes” to 2-4 questions, more thorough assessment warranted.

If you answer “yes” to less than 2 questions, consider other means of addressing the unmet need.
Why PAC or LTC?
Long Term Care Objectives

- To diversify business
  - Revenue distribution
  - Overhead allocation

- To generate profits
  - Affluent populations
  - Non-gov’t dependent businesses

- To fill unmet need
  - Mission driven
  - Often lower income markets

Long term care objectives more related to new business and financial performance; less effect on core business
Strategies for PAC and LTC

• One strategy does not fit all

• Core strategies
  – Growth
  – Distribution management

• One indirect strategy – subtle but valuable
  – Community support
## PAC / LTC Strategies

<table>
<thead>
<tr>
<th>Distribution</th>
<th>Acute LOS</th>
<th>PAC</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Readmit rate</td>
<td>- Rehab</td>
</tr>
<tr>
<td></td>
<td>Discharge to home</td>
<td>- Skilled</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Home Health</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- LTAC</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Growth</th>
<th>Market share key programs</th>
<th>PAC</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total revenues / profit for key groups</td>
<td>- Rehab</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Skilled</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Distribution</th>
<th>Acute LOS</th>
<th>PAC</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Discharge disposition</td>
<td>- Rehab</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Skilled</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Home Health</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Growth</th>
<th>Revenue distribution</th>
<th>LTC</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Overhead allocation</td>
<td>- Nursing Home</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- ALF</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Housing</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Growth</th>
<th>Profits</th>
<th>LTC</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>- ALF</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Housing</td>
</tr>
</tbody>
</table>
Community Support – An Indirect Strategy

- **Philanthropic response**
  - Genuine commitment to community need
  - Support not for profit status

- **Connect with community**
  - High touch settings of PAC balance high tech care
  - Ability to generate strong community support for service, setting, and organization
  - Can help manage negative publicity
  - Development campaigns enhanced
  - Overall stronger market position leads to increased market share throughout

- **Difficult to measure value, but don’t underestimate**
Making it Work - Redesign

Successful Post Acute/Long Term Care

Organization

Operations

Resources

www.reach-newheights.com
Operational Redesign

• Redefine use of techs/aides to leverage prof. staff

• Adjust wages and benefits
  – Consider separate compensation packages

• Develop horizontal clinical ladders
  – Professional development should enhance ability to leverage
  – More clinical skill does not man less clinical time

• Use cooperative care model when appropriate
  – Functional assistance/ADLs
  – Monitoring functions
  – Exercise routines

www.reach-newheights.com
Operational Redesign (cont’d)

• Evaluate administrative functions
  – Documentation
  – Meetings/conferences

• Evaluate “outsourcing” functions
  – Pricing
  – Delivery
  – Contribution to the system—at what price?
Organizational Redesign

• Consolidate post acute management/admin functions

• Consolidate admission, discharge, other patient management functions

• “Dehospitalize” service
  – Overhead
  – Philosophy of care and management

• Evaluate cost:benefit of ownership structure
  – Hospital-based
  – Freestanding
  – Joint venture
Resource Utilization

• Integrate into continuum
  – Refine admission and discharge criteria
  – Extend care paths to include post acute and long term care

• Evaluate coding function

• Educate, educate, educate
  – Care managers
  – Physicians, clinicians
  – Patients, families

• Re-evaluate market to ensure correct service size
If It Still Isn’t Working…

• Are you reading your market correctly?
  – Home health or assisted living?
  – Rehab or skilled?
  – Skilled or LTAC?

• Outsource service/contract management
  – Minimizes risk
  – Clarify objectives up front

• Partner with local provider
  – Guarantee payment for outliers
  – Integrate into your continuum so both win
  – Provide training, technical support to new program

www.reach-newheights.com
Case Study - 1

• Situation
  – Three hospital system in urban area
  – 50-bed skilled unit; mix medical-rehab
  – 24-bed rehab unit

• Issues
  – Overused skilled unit
  – Underused rehab unit
  – Patients not crossing facilities
  – Inconsistent, inappropriate referral patterns
  – Distinct operating units
  – Inconsistent support of core businesses
Case Study - 1

• Plan
  – Consolidate post acute – org and ops
  – Downsize both units
    • 16 rehab beds
    • 36 skilled beds
  – Consolidate medical direction
  – Integrate/consolidate care paths
  – Develop stronger ties to nursing homes through clinician involvement
Case Study - 2

• Situation
  – Two hospital system in affluent, urban area
  – 32-bed rehab unit
  – 40+ bed sub-acute unit in 180 bed LTC facility on hospital campus
  – New retirement community in JV with for profit company
    • Independent living
    • ALF
    • SNF

• Issues
  – Historical competition among settings
  – Multiple reporting relationships
  – Residents of CCRC don’t support growth of ALF/SNF; utilization well under projections
  – Not supporting core business or generating new profits
Case Study - 2

**Plan**

- Downsize rehab to 15 beds, relocate
- Shift on campus LTC beds to sub acute, focus on transitional vs. residential
- Shift retirement center SNF beds to sub acute, focus on referrals from other facilities
- Integrate admission, care coordinator functions for all PAC settings
- Develop matrix organizational structure
  - PAC
  - LTC
Case Study - 3

• Situation
  – Tertiary hospital serving large rural population
  – Operates skilled unit and acute rehab unit
  – Planning underway for ALF

• Issues
  – Units losing money, even before BBA
  – Competition between units
Case Study - 3

• Plan
  – Focus on operational improvements on both units
  – Consolidated management, admissions, pathways, etc.
  – Anticipated harvest strategy for rehab
  – Stopped ALF plans
    • Not familiar with business
    • Profitable market saturated in area
Case Study - 4

• Situation
  – Tertiary hospital system (tertiary hospital, two community hospitals)
  – Service area largely rural
  – Heavily invested in PAC/LTC, not by design
    • Four nursing homes
    • Hospital based SNF
    • One specialty unit in swing beds
    • Small ALF
Case Study - 4

• Issues
  – All settings losing money
  – Medical staff not invested in PAC/LTC
    • Limited utilization
    • Difficult to get physician support/coverage
  – Facility locations and markets served not key markets for system
  – High demand for ALF but lower income population can’t afford; Medicaid does not support
Case Study - 4

- Plan
  - Maintain all facilities
  - Focus on operational improvements to enhance profitability
  - No significant system change
  - Try to recruit physicians to support services
  - Enhance geriatric services through geriatric assessment clinic
Case Study - 4

• Why this won’t work
  – Role of LTC in system remains unclear; management and physicians do not see benefit
  – Operational improvements in facilities alone will not turn around finances
    • System overhead
    • Support functions duplicated
  – Inability to gain system attention will result in the continued position of LTC as a “loss leader”
    • System won’t see potential if it isn’t looking for it
Contact

Cecily Lohmar, Principal
New Heights Group, LLC
704.895.3410
Cecily@reach-newheights.com
www.reach-newheights.com