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The Nelson A. Rockefeller Institute of Government

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DIVERSIFICATION INTO LONG TERM CARE:
A NEW OPPORTUNITY FOR HOSPITALS?

Michael J. Bierley
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Michelle is a 76 year old widow, has an annual government employee retirement income of $20,000 to $25,000 (including pension, Social Security, and savings), owns a home in Rochester, New York valued at $60,000 to $80,000 and is now having problems in coping with living alone and maintenance on her large home. Security is her primary concern, coupled with a subtle desire to have someone take care of her after all these years of being the caregiver of her family.

Until recently, her only option was the selling of her home and moving into an apartment. With passage of the proposed continuing care retirement communities legislation in New York, her options would be expanded. Michelle could now consider a high quality apartment with amenities including meals, housekeeping and provisions for health care.

Other available resources would be located nearby, she would have an opportunity to form new social relationships and remain near her family. She would meet people of similar age, background and interests. Michelle might find a new male companion in her more secure environment. Such continuing care retirement communities have been developed in other parts of the country (300-600) and do offer a range of options to senior citizens. The definition of continuing care residential communities developed by the New York Association of Homes and Services for the Aging is used in this paper. The definition states:

A continuing care retirement community is an organization established to provide a comprehensive, cohesive living arrangement for the elderly, philosophically oriented to the enhancement of the quality of life and physically focusing on a core of services in a residential setting. In addition to independent living, the CCRC may offer congregate living, domiciliary care and health care, including health related and/or skilled nursing care, but not general hospital inpatient care. Available services may include security, meals, social activities, recreation and transportation.

Purpose

The purpose of this paper is to explore one of the two models commonly associated with continuing care residential communities. The two are a capitation model and an acute care model. The acute care model relies on a hospital to provide leadership in developing new ways to finance long term care.

Hospitals are already vertically integrating their institutions with a variety of long term care services and facilities. They are becoming Health Care Centers and expanding their community role. Health Care centers can be logically linked to continuing care retirement communities. Hospitals already provide acute care, a range of community services, referral sources, longer term rehabilitation, and skilled nursing facilities. Continuing care residential communities in turn can provide necessary cash flow to hospitals after financial stabilization, enhance the health care aspects of the residential community, allow the hospital to spread overhead costs over a broader base, develop community volunteer programs, encourage future bequests and use the continuing care residential community as a profit center to offset other expenses such as Medicaid which would provide a savings to the State of New York. More
detailed information will be found in the body of this paper on the role of the hospital in a
continuing care residential community. However, at this juncture, it is appropriate to
introduce a few caveats regarding this model. Not all hospitals are equipped to do this.
There is considerable risk involved. Continuing care residential communities cost an
average of 15 million dollars, must be managed properly; the selection of a target population is critical
and appropriate advertising must be created and used extensively. Some hospitals are familiar
with managing elderly services and because they come from a highly regulated environment,
may have difficulty in adapting to a less regulated housing program. With this brief overview,
let us move to the more detailed sections of this paper which will cover demographics, trends,
hospital restructuring and diversification into elderly services. A case study in continuing care
retirement community development using the acute care model, and a rationale for the
passage of Article 46 of the Public Health Law of New York State.

This paper is about Jeff Goldsmith and Charles Darwin. It is about Jeff Goldsmith
because it deals with the part of the answer to his question, “Can Hospitals Survive?” and
because it deals with vertical integration as a response hospitals are making to changes in their
environment. This is particularly true of hospital who are responding to the increasing
numbers of elderly in our country. The paper also deals with Charles Darwin in that it deals
with the survival of the fittest in the healthcare environment. Our hypothesis is that hospitals
which adapt well to their changing environment and diversify will survive, and that those
institutions who do not will become extinct, never to be heard from again.

This paper examines how hospitals are responding to an ever increasing number of
elderly patients through examination of a multi-hospital system and one local healthcare
organization that has diversified into long term care and developed a vertically linked structure
to respond to the needs of the elderly.

The first section of the paper will deal with the hospital as an acute care institution,
demographic characteristics of the elderly patients, the economics of healthcare and the
elderly and the quality of care they receive. The American Hospital Association conducted a
survey of 417 hospital in 1981 to determine what types of services they are providing to the
elderly. This survey will serve as a basis for our discussion of how we see the hospital
responding to the needs of the elderly in the future.

Since the provision of care to the expanding elderly population, which will comprise
13% of our population by 1990, is an issue which effects the entire healthcare system, we will
be discussing various trends in the healthcare systems over the next 17 years and their impact
on the elderly. The main portion of this paper will deal with the reasons why hospitals are
restructuring and diversifying, as they respond to the increasing numbers of elderly patients.

The graying of America is one of the most significant trends affecting our society today.
Since the beginning of the century, there has been an eight-fold increase in the number of
older people. In 1900, three million or approximately four percent of all Americans were age
65 or older. In 1980, the older population represented 11.3% of the population and continues
to grow. By the year 2030, 21% or 64 million Americans will be 65 or older.

The significance of this growth, however, is how the growth is distributed among those
over 65. The oldest segment, those 75-84 and, especially, those over 85, are the fastest
growing segment. They are also among the greatest users of healthcare and hospital services.
For example, by the year 2000, 50% of the older population will be 75 and older and 15% will be 85 and older. It is this later group which will continue to place the greatest demand on the healthcare system.

Two technologies support this statement. They are “Curve Squaring” and “Life-Spanning” Technologies.

Curve squaring technologies are primarily disease controlling; i.e., the prevention, diagnosis and cure of cardiovascular and cerebrovascular disease and cancer. Curve squaring technologies will have an impact on population age distribution and size in the future, as seen in graph one.

In America considerable biomedical research is directed toward death causing diseases; especially cardiovascular disease, stroke and cancer. Since all three take their greatest toll later in life, increasing progress would benefit the aging population. This graph illustrates what would happen to the traditional population curve with continued medical advances in these three areas. The curve would begin to become “squared,” hence the term “squaring of the population curve.” What occurs is that the major killers of middle age become under better control which results in many more aging persons living longer. The more technological advances made, the longer the life span. This squaring will have a major impact on the healthcare system; especially hospitals and nursing homes.

As we see, the effect of these curve squaring technologies, relative to current life expectancy projections, is to increase further the number of older people in the population; which will have an impact on the hospital.

Another squaring can be seen in the second graph which demonstrates what could occur with increased control over the aging process itself through life span extending technologies. With continued research underway on how we age, we may expect breakthroughs in the future which affect how long we live, sustaining implications that the underlying, non-disease related biological aging process may be brought under scientific control.

Examples of life span extending technologies which are likely to occur by the year 2000 include: (Herbert, 1977)

- Breakthrough into cellular aging process;
- Tissue regeneration;
- Altering of aging of organ systems;
- Control of diet;
- Immunological control of aging.

As Hayflick comments: “If potential success in either of these endeavors can be measured by the current attitudes and priorities of the biomedical research establishment it is clear that the search for cardiovascular disease, stroke, and cancer cures is much more likely to effect human longevity than is gerontological research. By curing these diseases, a maximum of 18 years of additional life expectancy could be attained; but if efforts to increase the life span itself were to be successful, there could be no fixed end point. Furthermore, the resolution of the leading killers will in no way reverse or halt the decline in physiological decrements characteristic of age changes; whereas efforts to increase the life span could lead to such a reversal.” (Hayflick, 1976)
EFFECT OF SQUARING TECHNOLOGIES

GRAPH I

EFFECT OF LIFE SPAN-EXTENDING TECHNOLOGIES

GRAPH II
The effects of life span extending technologies will probably not be felt until the next century and they will not have as great an impact on the population curve as the curve squaring technologies will.

Hospitals are very much involved in caring for this population. One in five persons over 65 is admitted to a hospital each year. (Brody, 1980) Persons over 65 also make 2.5 million visits each year to hospital emergency departments. Although they currently comprise a little over 11% of the population, persons over 65 use 33% of hospital inpatient days and the admission rate for older persons was 400/1000 days per 1,000 population compared to 136 days per 1,000 for those under 65. Similarly, the average length of stay for persons over 65 was 10.4 days in 1980 compared to 5.9 days for adults under 65. (Spetz, 1982) In New York State, the length of stay for persons over 65 was 14.7 days or 41.3% higher than the national average. (NYSHAC, 1984) Also, the elderly consume 43% of the total hospital days in New York State; again higher than the national average of 38%.

In terms of our earlier demographic projections, they assumed no effect from either curve squaring or life span extending technologies. However, based on current biomedical, gerontological and other research data, it might be wiser to assume that the population transformation, in fact, may be greater than we can now accurately measure. The consequences for the existing healthcare system and the system of the future needs to be considered because more older persons, especially those over 85, could redirect our healthcare resources. Therefore, public expenditures for healthcare of the elderly is significant.

For example, the elderly pay a significant amount of money for healthcare. In 1981, 31% of all hospital expenditures came from the elderly. Per capita expenditures for healthcare for persons over 65 is four times greater than for those under 65. Hospital expenditures for the over 65 group is three times greater than for those under 65. Medicare and Medicaid pay for approximately 65% of the elderly's healthcare and out of pocket expenses make up another 30%.

Hospitals are designed to take care of the acutely ill. Older patients warrant different orientations. The old suffer from multiple chronic conditions which affect their functional independence. Most hospitals do not recognize the difference between acute care and chronic care. It is not unusual, for example, for an older patient to be admitted to the hospital for a fractured hip and also have two chronic conditions like diabetes and heart disease. In addition to their health status, there are usually emotional, social and economic variables influencing the older patient which are quite different than those factors affecting younger patients. Finally, the goal in treatment is usually different for the older patient. Instead of curing, the goal is often to achieve the maximum level of functioning despite chronic disease and disability. Because of changes associated with aging, older patients are diagnosed differently, respond differently to treatment, require longer to recover and are more vulnerable to conditions inadvertently induced by medical treatment; these conditions are known as iatrogenesis.

Because older adults have chronic conditions that progress over time and affect their ability to function independently, a comprehensive mode of care is needed. Our model consists of two parts—a continuum of care and coordination of care. We will be discussing the continuum of care concept and coordination of care later in our discussion. In this section
we have discussed the demographics of aging and its impact on the hospital. It is now time to begin a discussion of how hospitals actually take care of their older patients and what services they typically provide.

The American Hospital Association conducted a survey of 416 hospitals to describe the range and frequency of services offered specifically for older adults and to identify characteristics of hospitals associated with particular services. We will attempt to summarize their survey here. (Evashwich, 1985)

The data was collected in a national survey of hospitals who were asked the question, “Does your hospital offer special services for the elderly?” Six hundred eighty nine hospitals responded positively and 416 of those were chosen for the sample. The survey listed 37 different services that were specifically designed to meet the needs of older persons. Hospitals of every size, service orientation and region were included.

The average number of services provided was seven, the range was one to 29. Discharge planning (75%) and information referral (48%) were the most common services provided. Patient/family education (43%), skilled nursing facility (38%), psychosocial counselling (31%), intermediate care facility (ICF) (25%), and medical/surgical inpatient unit (22%) were mentioned most frequently.

The survey grouped the 37 services into five major groups: acute inpatient services, extended inpatient services, assessment/linking/referral, ambulatory and health/maintenance and support. Acute inpatient services included medical-surgical units, rehabilitation units and psychiatric units. Urban hospitals were more likely to provide these programs. In total, 175 hospitals indicated that they provided acute inpatient services. Extended inpatient services included skilled nursing facility, ICF, swing beds and nursing home follow-up. Two hundred twenty two hospitals provided one of these programs. These services were typically found in either very large (500+ beds) hospitals or very small rural hospitals. Assessment/ linking/referral services showed a direct and positive relationship to bed size and city size. These services included assessment units, outreach, information/referral, discharge planning, and transportation. Three hundred fifty-five hospital indicated that they provided one or more of these programs. Ambulatory services included geriatric outpatient clinics, rehabilitation units, day care and home health care. Two hundred ninety-five, or 71% of the responding hospitals, especially the larger hospitals, provided these services. Health maintenance and support services were most likely to be found in very large hospitals, and least likely to be found in very small facilities. This group included wellness programs, family education, meals-on-wheels, apartments and lifecare communities. Two hundred ninety-six hospitals were involved in providing these services.

The results of this survey demonstrate that hospitals provide a large variety of programs to older persons. Bed size appeared to be a factor encouraging the development of geriatric services as well as an urban location. Rural areas tended to concentrate on skilled nursing facility operation. No pattern emerged in terms of regional variation, except that regions with a large proportion of elderly residents seemed to provide more services. Religious and public hospitals did not predominate in providing services to the elderly. Membership in a multi-hospital system was also not a factor associated with a large involvement in providing geriatric services. Finally, the service orientation of the hospital appeared to be related to the amount
of services provided. Chronic disease hospitals consistently provided more services. The results of the survey would seem to indicate that a hospital in any context can find some way of developing services to the older population. However, before we proceed with how the hospital might further address the needs of the elderly, we need to discuss some predictions of the future healthcare environment to the year 2000.

We spoke of the survival of the fittest in the beginning and the process of natural selection. In the next 15 years what will the healthcare system be like? What type of selection process will take place and who will survive? Predictions concerning these questions abound in the healthcare literature. One such prognostication was presented at the annual meeting of the American Association of Homes for the Aging in November of last year. (Peat, Marwick & Mitchell, 1985)

According to the report, the healthcare industry is in transition from a cost reimbursement system to one based on prospective pricing; from a passive industry to coalitions, from free standing hospitals, to multi-unit systems; from traditional independent practitioners to alternative delivery systems, and from physician dominance to hospital/physician alliances. Given these transitions, hospitals can respond, do nothing, overreact, or control these changes. I feel that hospitals should anticipate certain changes and attempt to control their impact on the hospital. The Peat, Marwick, Mitchell 1985 report goes on to say that there will be a diminished distinction between not-for-profit and for-profit; there will be a focus on clinical strengths; hospitals will abandon losers, there will be increased alliances with neighboring organizations, doctors and others in regional networks; and the demise or rural hospitals, large teaching centers and reactive riveted urban facilities is predicted. Some specific predictions include:

- A 17.3% decrease in hospitals by the year 2000;
- Approximately 1,000 out of 5,800 hospitals will close;
- This will result in a 17% decrease in beds;
- Admissions/patient days will decline by over 15%;
- 75% of all hospitals will be members of multi-unit systems;
- A 31% increase in persons age 65+.

The winners and losers in the next 15 years are summarized in Attachment 3.

With an increase in the elderly and a shrinkage of the acute system, what will follow? The authors predict growth in what they refer to as the elderly care business. Among their main findings are:

- Nursing home bed need is enormous;
- Assisted living arrangements will expand;
- Retirement centers with managed healthcare exposure will expand;
- After the hospital shakeout, elderly care providers will see an increasing market acceptance;
- Elderly care insurance will grow.

Their conclusions are that the status quo will not do and that there will be a shakeout which is unavoidable and overdue. Emphasis will be on home care, ambulatory care, geriatric
care, streamlined operations and regional systems linked by common ownership and service tradeoffs. Up to this point, our information would strongly indicate that the days of the one dimensional acute care institution are over and that if the hospital is to survive, it must diversify its services; especially those dealing with the elderly.

A dynamic tension now exists between the modern hospital which is designed to provide medical services to persons who need acute care for a relatively short period of time and an increasing number of hospital patients who have chronic illnesses and disabilities in addition to their acute condition. This interface between acute care and chronic care is an uneasy one. It is most uneasy in five areas. The first area concerns the appropriateness of admissions. Apart from health and medical considerations, the decision to hospitalized an older patient is sometimes related to factors related to the way healthcare services are organized and financed. Some admissions and lengths of stay are inappropriate. Factors influencing hospital admissions of the elderly include:

- Supply of physicians;
- Regional patterns and practices of hospital use;
- Hospitalization facilitates access to institutional long term care;
- Insurance coverage;
- Lack of alternative settings, particularly in a crisis.
(Hospital Diversification, 1984)

In the area of quality of care, since the special problems of the old are not given sufficient consideration, the older patient does not always receive the quality of care that his younger counterparts receive. Introgentic conditions prevail. Many elderly spend too long in the hospital awaiting discharge to another setting. Approximately 7% of the acute beds in New York State are occupied by persons awaiting placement, primarily in nursing homes, and in Rochester, over 15% of the medical/surgical beds are occupied by such patients. Alternative care placement is a serious concern in our local community. There is also a lack of emphasis on rehabilitation once the older patient is admitted and when the patient is ready for discharge, many hospitals do not follow the patient. Assuming that many hospitals know about these five factors, diversification into long term care might be an attractive option.

Current hospital literature indicates a strong interest in diversification into new non-acute service areas based on the following perceptions: hospitals are a "maturing" or "no growth" industry; long term care will be the biggest growth area in healthcare; hospitals are facing financial pressures; hospitals see increased market competition; and hospitals find it more difficult to gain access to capital. (Divers, 1984) To remain economically viable, organizations must either expand their share of the existing market or develop new ones. Speltz, and others, propose that diversification into providing services for the elderly may be one answer to sustaining or expanding market share. (Speltz, 1982)

Enhancement of the hospitals revenue picture is a main reason why diversification is considered. Prospective Payment has made an impact because under DRGS, the method of paying hospitals has changed. A hospital is paid on a price per case basis which is related to how long the patient stays in the hospital. Briefly, if the patient stays longer than the recommended length of stay (LOS), the hospital loses revenue and if the stay is shorter, the revenue saved accrues to the hospital. The hospital is at risk under this system. However, a
hospital can improve its revenue by developing services that ensure a predictable referral base for its acute services and, more importantly, it develops programs which assist the hospital in discharging its patients in a timely manner. By diversifying into long-term care, a hospital can also best use its fixed costs and spread overhead.

As we discussed earlier, hospitals recognize that the elderly is the fastest growing potential market for hospitals and their services. Hospitals are currently diversifying by unbundling their services. Unbundling occurs when the services usually within the domain of the hospital are removed from the hospital and offered under alternate sponsorship and at other locations. Examples of unbundling include emergency centers, ambulatory surgery centers, services provided by independent practice associations (IPA's) and HMO's. It is beyond the scope of this paper to examine these examples. They are mentioned to illustrate that hospitals are currently diversifying and perhaps to suggest that diversification into long term care might be easier, given experience in these other areas.

There are basically three models of diversification for us to consider. There are probably many other variations, but we will limit our discussion to three. The simplest diversification strategy for a hospital to follow is to develop a new product line. A hospital would simply add a new product, such as the addition of an outpatient geriatric clinic. We assume that the hospital would conduct a market analysis, financial analysis and examine the new service in terms of its corporate mission.

A second option is corporate reorganization. Corporate reorganization is the process of repositioning facilities, programs, services and assets to achieve maximum flexibility for diversification and growth to meet the challenges of the future. (Peat, Marwick, Mitchell p. 3) The ultimate objective of corporate reorganization is to enable healthcare institutions to provide better comprehensive care and fulfill community healthcare needs. This option typically occurs when the hospital faces the complexity of its new services and realizes that a new structure is required. Usually sub-units are set up for the new products under an umbrella management structure that oversees the resource requirements and product of the individual sub-units. Operating units have considerable autonomy within the larger organizational structure and sometimes they sell their products and services to other members of the conglomerate. Another advantage is that assets and liabilities can be assigned and segregated among the components of the system which maximizes earnings.

Various environmental forces limit an institution's ability to respond to the public's healthcare needs, manage diverse activities and retain management flexibility. The rapid increase of restrictive federal and state regulations and control over Medicare/Medicaid reimbursements, HSA's PSRO's and state rate review have been the impetus for developing alternative organizational structures. Other factors influencing hospitals to respond to a changing environment include:

- Inflation;
- Decreased availability of capital;
- Increased competition;
- Reductions in patient referrals;
- Pressures to contain healthcare costs.
Corporate reorganization enhances management flexibility and provides a framework to respond to opportunities which might present themselves. Corporate reorganization can also improve management operations. For example, through corporate reorganization a nursing home or an alcohol treatment program can be separated from the hospital. As a result, each unit has its own mission, resources and management structure and the subsidiaries can focus their efforts on accomplishing their own goals with support of the hospital. Corporate reorganization can also improve the hospital's market position. From what we have learned previously, by expanding into the elderly care business, the hospital can improve its market position. Corporate reorganization forms a close link with long range strategic planning by providing the vehicle to realize the future planning goals of the organization. Other advantages include increasing revenues, protecting assets, expanding planning options and increasing borrowing alternatives.

There are risks to corporate reorganization. The main risk is the potential loss of the non-profit status of the hospital. It is also difficult to coordinate the planning and the corporate reorganization at the same time. There may be additional financial and managerial costs along with lessened control over assets. Since corporate reorganization involves the trustees, it may require very close monitoring with multiple Boards of Directors.

My opinion is that the potential risks of corporate restructuring are outweighed by the advantages. There are several models of corporate reorganization available for the hospital to consider. Figure 1 demonstrates a more traditional arrangement for a hospital. This model is not very complex and is easy to manage. Institutions which choose to go the next step look something like Figure 2 where a parent corporation directs the services of all of the entities. Many institutions take it a step further in the process and establish a diversified corporate conglomerate similar to Figure 3. The corporate model in Attachment 4, which shows the Park Ridge organizational structure is a combination model, and by the end of 1986, it will more closely resemble Figure 3.
Park Ridge organizational structure is a combination model, and by the end of 1986, it will more closely resemble Figure 3.

**Figure 1**

**Initial Hospital Corporate Plan**

- Delivery System/Provider Organizations
  - Parent Holding Company
    - Individual Hospital
    - Fund-Raising Foundation
  - Asset Sheltering and Capital Formation Organizations

**Figure 2**

**Prototype for a Corporately Reorganized Hospital System**

- Delivery System/Provider Organizations
  - Parent Holding Company
    - Hospital
    - Nursing Home
    - Ambulatory Care Center
    - Health Care Foundation
  - Asset Sheltering and Capital Formation Organizations

Entities Subject to Third-Party Reimbursement Regulations
Vertical integration is a third option. Vertical integration involves the common control of at least two enterprises; one of which uses as its input the output of the other. An example would be a vertically-linked long term care system operated by a hospital which would include home health care, housing, an adult home, HRF and a skilled nursing facility; in addition to hospital inpatient care. The supportive housing and outpatient programs serve as “feeders” to refer customers/patients to the acute hospital. Ideally, the hospital would feed the non-acute levels of care so that patients would move in both directions. The easiest way to visualize this vertical integration is to conceptualize a pyramid or continuum of care such as the one in Attachment 5. Jeff Goldsmith characterizes vertical integration as acquiring and developing new forms of delivery of healthcare to capture and control more of the inputs which lend to inpatient hospitalization. The inputs of the healthcare system are patients and the health professionals who serve them. Thus, vertical integration in a healthcare enterprise involves linking together different levels of care and assembling the human resources needed to render that care. (Goldsmith, 1982)

After reviewing the three options for diversification, it appears to me that before a hospital diversifies, it must answer several key questions affirmatively. First, will diversification meet the specific objectives of the hospital? Second, does public policy support diversification? Finally, is the hospital’s provision of long term care consistent with the community’s service needs? After answering these questions, the hospital has to make a choice regarding its level of involvement. Should the hospital develop its own long term care services or direct its efforts toward assisting other providers in the development process? There are four levels of involvement hospitals may choose: (Diversification, 1984)

- Sole Sponsor – Develop and provide services itself.
Figure 3
Diversified Health Care Conglomerate Model

Delivery System/Provider Organizations

Health Care Provider Holding Company (or a Single Hospital)

Hospital

Chemical Dependency Unit

Nursing Home

System-Wide Fund-Raising Foundation

For-Profit Holding Company

Support Services Holding Company

Asset Sharing and Capital Foundation Organizations

Entities Subject to Third-Party Reimbursement Regulations

(Each Potential Service, Function, or Asset Transfer Evaluated for Organizational Options)
• Joint Sponsor – Sponsor services in cooperation with other hospitals or community based providers.
• Catalyst – Provide leadership and incentives to encourage other community sponsors to develop services.
• Discussant – Participate in planning and development with other community sponsors.

The first two roles entail diversification into long term care, whereas the roles of catalyst and discussant allow a hospital to be involved in long term care service development. Finally, when considering its appropriate role, the hospital should consider its resources and financial capacity, the nature and extent of existing long term care resources, and, the nature and extent of the community's need. Our final section deals with the diversification activities of a multi-hospital system and a local healthcare provider who diversified into long term care as a sole sponsor, joint sponsor and discussant.

The Health Central System, a multi-hospital system based in Minneapolis, went through an environment assessment in 1983 and determined five new markets for its system in the future. One of the major new markets identified was the elderly. A quote from their report indicates that “services to the elderly are becoming attractive and necessary for hospitals to pursue. Diversification of hospital programs and collaboration with other organizations are methods being used to provide for the needs of the elderly.” (Health Central Plan, 1983)

Attachment 8 presents a diagram of the process Health Central went through. It indicates major trends in the health care environment affecting the hospital which creates five new markets for health; non-institutional services, partnerships with physicians, the elderly, employers and international opportunities. Most of their plan is very consistent with the predictions made earlier in this paper and with the reasons given for hospital diversification. However, I found their report went one step further in that it specifically identified strategic resource requirements necessary for their system to enter these new markets. These resource requirements included: capital, new organizational arrangements, sophisticated management systems, technology and human resources management. All of these are presented in detail in the report.

The Health Care plan identified critical success factors for hospitals considering entry into the elderly market. These factors were:

• Develop an in-depth understanding of the elderly population and its diverse market segments.
• Have a strong level of commitment for the Board, Medical Staff and Chief Executive Officer to develop aging services.
• Intend to integrate services into a continuum of care.
• Have access to market based strategic planning.
• Be willing to experiment an overcome the hospital’s traditional illness image.
• Explore creative financial opportunities to secure financing.
• Attract and retain specialized human resource capacity in aging services.
• Commit resources to the training and retaining of personnel in a variety of disciplines.
• Educate the community about the new role of hospitals in providing noninstitutional services to the elderly.
• Be able to create and maintain credibility as an interested and trustworthy provider within elderly circles.

Their plan was simply outstanding and could serve as a valuable resource to any hospital considering diversification. Since we have an idea of how a multi-hospital system diversifies into long term care, we now turn our attention to Park Ridge.

Park Ridge, as Attachment III illustrates, has envolved into a very complex organization. Its diversification into long term care began 14 years ago with the opening of the 120 bed Park Ridge Nursing Home. Actually, Park Ridge was a skilled nursing facility which diversified into acute hospital care; since the hospital did not open until 1985. The hospital simply took much longer to finance and construct. However, the founding fathers had the foresight to determine that there was a need for skilled nursing beds in Northwestern Monroe County.

The actual process of diversification into long term care did not begin until 1979 with the formation of a Long Term Care Task Force which was established “to assess the needs of the elderly in our community and to recommend what Park Ridge Nursing Home’s role should be in responding to these needs during the next 10 years.” (Long Term Care Task Force Report) Park Ridge served as a discussant in the process which included community leadership representing many providers and planners. Several Park Ridge Board members were also involved in the task force. The process took 18 months to complete its work and included two subcommittees; one dealing with health and one dealing with housing. Many meetings were held in addition to several site visits to multi-level long term care providers.

The Long Term Care Task Force recommended that Park Ridge offer a continuum of long term care services—institutional and noninstitutional, and develop a Multi Level Geriatric Community on the Park Ridge campus. This multi level geriatric community would contain the following elements:

• Skilled Nursing Facility for psychogeriatric patients;
• Health Related Facility;
• Independent and Semi Independent Housing;
• Adult Day Care;
• Geriatric Screening;
• Home Health Care;
• Gerontological Education and Training.

This plan provided the framework for our future development.

The highlights of Park Ridge’s diversification into long term care since the final report of the task force included the following:

• In 1980 Park Ridge initiated two education and training programs. The first one called “Aging In The Family” was cosponsored with SUNY at Brockport to provide information to families caring for elderly relatives in the community.
- A program for nursing assistants and nursing professionals began and has been offered on an annual basis.
- In 1981, Park Ridge applied to the Department of Housing and Urban Development for subsidized housing for low income elderly. In 1984 Park Ridge was selected for funding after two previous attempts and the project opened its 50 apartments in 1986. A separate corporation, Park Ridge Housing Development Fund Company, Inc. was formed.
- In 1983 Park Ridge was appointed receiver for the Flower City Nursing Home, a 120 bed skilled nursing home, which was bankrupt. Park Ridge operated the home and was named the permanent operator in 1985 when the home was renamed Park Ridge Nursing Home and another Park Ridge corporation was formed.
- In July, 1984 a separate Board was created to oversee all long term care development at Park Ridge. Previous to this date, the boards of Park Ridge Hospital and Park Ridge Nursing Home were identical and met at the same time. This move provided a separate focus for long term care. In addition, Park Ridge Nursing Home, Park Ridge Housing, Park Ridge Housing Development Fund Company and Park Hope Nursing Home became members of the Park Ridge Health Service Corporation, a holding corporation governing all the non-acute services at Park Ridge. (see Attachment 4)
- In 1984 a series of activities began to investigate the need for market rate housing for middle income persons and the concept of a continuing care retirement community was born. This program and the process Park Ridge went through will be the subject of the final section of this paper. Before I begin, however, I would like to mention that several of the needs of the elderly which were identified in our initial plan have been met or addressed. However, since the environment has changed in the past six years, a reexamination of the original document is in order.
- In January, 1985 Park Ridge initiated a personal emergency response program called HealthCall, for elderly persons at risk who are living alone. This program began after a year of needs assessment and discussions with various providers. The program is designed to keep people who are “at risk” of institutionalization at home.
- In 1985 Park Ridge submitted an application for an Adult Day Care program. In April of 1986 final HSA approval was received. Construction is anticipated for later this year. This program will provide a day health and social program for 30 elderly persons per day. These persons will come to Park Ridge during the day for services and return home in the evening.

A continuing care retirement community (CCRC) is different from the older and better known options available to the elderly. It is not an old age home, a nursing home, a boarding home, low income housing or a retirement village, although it has some similar attributes to each of these facilities. A CCRC consists of three basis components:

- An apartment complex designed to permit the elderly to live independently.
- Dining facilities and activity center which might include an auditorium, arts and crafts area, library, beauty and barber shops, country store, banking facilities and other amenities.
- Nursing care available on site. It might also include a clinic where physicians are available for routine health needs.

Typically, CCRC's involve payment of an entry fee and a monthly fee in exchange for a monthly fee in exchange for life care of the resident; including all healthcare. However, a contract for healthcare for life is not possible in New York State. What Park Ridge is envisioning is a hybrid which includes housing and services for a monthly rent and the provision of health services on a fee for service basis.
The formation of a separate Board of Directors for long term care was significant because it provided a separate focus for long term care. One of the first activities of the new board was to examine the concept of developing a CCRC at Park Ridge. Once the educational process was complete, board and staff visited several retirement communities both in and out of New York State. Their conclusion was that we should continue to test the feasibility of developing a CCRC at Park Ridge. The next step was to hire a consultant to conduct a market study and preliminary financial feasibility study.

The board interviewed three top firms and selected a consultant who would conduct a market study and if the market study was positive, they would conduct a financial analysis. The market study included:

- Review of the Park Ridge site and the concept itself;
- Review and analyze economic and demographic data for the market area to determine demand;
- Review present and projected elderly housing and health needs in the market area with planning agencies;
- Review status of existing retirement communities and planned facilities;
- Based on age and income criteria, determine the size of the eligible population within the market area;
- Determine the market penetration rate necessary to achieve a successful retirement center;
- Conduct focus groups of various retirement age persons form different segments of the community.

Since the results of the market study were positive, the financial feasibility projections were prepared. This study developed financial and statistical data and prepared cash flow projections, statements of revenue and expenses and calculated per diem costs and projected rate structure. Debt service coverage were reviewed, and, finally, the feasibility of the project was examined from both an entry fee and straight rental basis. For example, the consultant determined how much the entry fee and monthly fees would be to develop a 200 unit CCRC. They also determined the fees necessary to develop the project on a straight rental basis.

The major findings of the study were that there was a market for a CCRC in Northwest Monroe County of 150-200 units and that Park Ridge should proceed with development. The project would include utilities, housekeeping, maintenance, security, recreational programs, one to three meals per day, emergency call system, on-call nurse/physician, transportation, parking and storage. The project should be oriented toward middle income persons, $25,000 per year, and the average monthly cost should not be greater than $1,500. They also preferred a straight rental over an entry fee arrangement. The CCRC should be on the campus but with a separate entrance. Finally, a professional marketing firm should be engaged. This report was presented to both the hospital and long term care Board for approval.

At this point in the process, we asked ourselves how could we afford a $15 million CCRC? We discussed this internally and came to the conclusion that we couldn’t do it alone; that a joint venture would be needed. But what did we have to offer a partner? First of all, we had land to build the CCRC, a solid reputation in the community and management experience in caring for the elderly. In order to build the CCRC, we needed capital and certain assurances of success.
Basically, we would be willing to lease our land to a developer, manage the project, use our name to market it, receive fees for managing the project, and receive a return on the profits. Finally, we wanted to own it at some point in time and assume no risk if the project didn’t sell. It began to sound impossible. The key question was, how could we reduce the risk to Park Ridge and still not give up total control of the project?

As you might expect another process began; a process of looking for a developer with experience in the retirement field who would assume the risk for the project. We developed a Request For Proposal which was mailed to ten potential developers and we received responses from six. The top three firms were interviewed by our board and staff and the final firm was agreed upon. This firm is currently reevaluating our preliminary market/feasibility study by doing their own analysis. If the results are positive, they are willing to put their capital at risk. We would then have to negotiate a contract which spells out both parties’ obligations, etc. in detail. Assuming the results are positive and a deal can be structured, construction could begin in the spring of 1987. Some of the specific details of this CCRC are confidential and I hesitate to comment on it here in writing, but I would be happy to discuss them in detail later.

In order to conclude this paper, I need to return to the beginning. The hospital of the future will have to diversify in order to survive. It will truly be a hostile environment in the future and, as Darwin described, it will be the survival of the fittest. At Park Ridge we hope to continue to “stay in shape” so that we continue to survive.

Can Hospitals Survive?, as Jeff Goldsmith asks? Yes, if they adapt to their environment and do not rely solely on their inpatient services. (Goldsmith, 1982)

According to our previous data, with the development of HMO’s and the prospective payment system, there will be decline in the demand for inpatient hospital care over the next twenty years. Goldsmith feels that this decline is due to three broad competitive forces which affect the demand for inpatient hospital care and which will influence hospital use patterns in the future: They are: the growth and diversification of ambulatory care, the growth of alternative delivery systems, including HMO’s, and the growth of aftercare for the chronically ill and elderly. (Goldsmith, p. 16) It is the growth in these alternative modes of rendering healthcare which will reduce the demand for inpatient services in the future. These areas can be seen on the figure on the following page.

Since our focus is on diversification into long term care by hospitals we will briefly discuss aftercare. Aftercare represents a competitive threat to hospital utilization. This term encompasses residential care in skilled nursing homes as well as outpatient care and in-home services for the elderly. This is the most rapidly growing part of the healthcare system. Goldsmith feels that until reimbursement for aftercare is resolved, diversification into aftercare is a risky proposition. He goes on to say that aftercare does represent an opportunity for creative extension of the hospital’s service mission to a population of elderly that will wield increasing economic and political power and whose needs are being inadequately met by the existing fragmented system. He feels that adult day hospitals (adult day care) is one of the most attractive areas for hospitals to consider.

Goldsmith’s conclusions are very similar to ours, namely, for hospitals to survive in the competitive market, hospitals will have to change the definitions of their business, as well as their structure and management philosophy. Those hospitals which cling to the concept of
providing inpatient hospital care and traditional hospital-based outpatient care in a single corporation, free standing organizational framework, will probably not survive in highly competitive markets. (Goldsmith, p. 203) Hospitals will be compelled to diversify their offerings of service, softening the mix of services as well as working through cooperative relationships with their medical staffs and other institutions to reach new markets.

Park Ridge, through its corporate restructuring, has evolved into a vertically integrated provider of long term care services which should enable it to respond to the needs of the elderly in the future, and we feel that as a health care provider, we are on the right course.

**Conclusion**

This paper has demonstrated how an acute care model could, through vertical integration, successfully develop a continuing care residential community. The paper supports the passage of Article 46 of the Public Health Law for the following reasons.

First, the legislation would encourage alternatives to institutionalization by allowing provision of services to residents in their apartments. This provision meets a major goal of the New York State Health Department—the reduction of institutionalization.

Secondly, the act could reduce part of the cost of Medicaid beds in New York State by having the CCRC support some of their own beds. Medicaid access would be improved. This meets two important goals of the New York State Department of Health, access and cost containment.

Thirdly, people at risk (i.e., Michelle, age 76) living alone, now have an option to have those risks managed for them in a CCRC. She will have less costly services available to her and these may keep her from becoming institutionalized sooner than necessary.
Forth, as our aging populations, 75-85+, now continue to live longer, policy makers must recognize a need to coordinate housing, healthcare and services. In other words, a total package of long term care services needs to be available. A new comprehensive study prepared for the Wharton School at the University of Pennsylvania concludes that the majority of elderly citizens have the financial means to pay for long term care, according to the Alpha Centerpiece, January 1984. Here in New York for example, state employees, librarians, teachers could fit into that category which would find CCRC's attractive. The state could even develop these as a component of a cafeteria benefit package. Here in Rochester, New York, 25% of retirees could afford CCRC's, as 80% of people over 65 own their own homes. Home equity and assets pay the entry fee while pension, social security and savings take care of the monthly expenses.

Fifth, cultural trends no longer provide that home caregiver. As more women enter the work force, we see an immediate reduction in the 80% who used to provide such care. The "sandwich generation," those caring for aging parents and supporting children in college are in need of help and a CCRC may fill the gap. Those families who must move in order to seek employment would benefit from a CCRC. No one wants to leave an elderly parent along in a big old house.

Sixth, regulation is appropriate and necessary. There is much which can be learned from other states regarding this aspect, especially Pennsylvania and New Jersey.

Seventh, mention has already been made to the value of vertical integration to hospitals, but joint ventures has not yet been addressed. There are all sorts of possibilities in this area. In addition, private developers may find land and facility purchase desirable form a profit and tax benefit point of view. Nineteen percent of all hospitals now own nursing home beds. Two point three percent own senior apartment. They already have experience in managing their own beds. Indicators suggest that 4.2 apartments equal one nursing bed.

Eighth, financing must be provided in order to stimulate growth and development in this area. New York State has a number of financing mechanisms currently in place which could be used for this purpose. If 20 CCRC's were built in the next five years, let's say 10 in New York City and 10 upstate, what an opportunity to try variations and then to evaluate based on compatible and comparable financial reports, plus standardized evaluation criteria. For-profit models, not-for-profit models, hospital based or capitation models. Mixtures such as acute care models with capitation options would be possible.

The possibility of linking long term care insurance with retirement communities is exciting as is HMO retirement communities and other variations of managed risk for this population. Nationally, the supply of nursing home beds is growing at 1% while the demand is 3% according to Contemporary Long Term Care, November 1985, page 43. Continuing care residential communities offer an alternative New York State should not ignore. Article 46 is strongly supported with a provision for financing and evaluation which would allow future expansion as new concepts test out.
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The Next 17 Years  
The Alternatives

<table>
<thead>
<tr>
<th>Winners</th>
<th>Losers</th>
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| - Home Care  
- Outpatient  
- Ambulatory surgery  
- Care of the aging  
- Multi-unit, doctor-involved cost-effective systems of care  
- Regional systems linked by common ownership and reflecting service trade-offs | - Tradition-bound “unnecessary” inpatient care  
- Community hospital pediatric units  
- Single provider HMOs, PPOs  
- Independent, free-standing hospital (especially rural)  
- Large “full-range” tertiary care teaching and community hospitals  
- National alliances linked by loose affiliation |
CONTINUUM OF CARE PYRAMID

- Acute Hospital
  Professional Office Building
- Skilled Nursing Home
- Health Related Facility
- Domiciliary Care
- Semi-Independent Housing
- Independent Housing
- Adult Day Care
  Non-institutional Alternatives
  Home Health
- Homemaker
  Respite Care
- Community Services/Multi-Purpose Senior Center
- Legal Services
- Meals-on-Wheels
- Transportation
- Telephone Reassurance

Attachment 3
HEALTH CARE: NEW DYNAMICS, NEW MARKETS

Restructuring Health Care Industry
Recessionary U.S. Economy
Demographic Change
Restrictive Reimbursement
Growth of Alternative Delivery Systems
Increasing Consolidation

Hospital

New Markets for Health

Non-Institutional Services
Partnerships with Physicians
The Elderly
Employers
International Opportunities

Strategic Resource Requirements

Capital
New Organizational Arrangements
Sophisticated Management Systems
Technology
Human Resources Management
Convalescent care, because of the restrictions imposed by DRGs, has become a logistical problem for most hospitals.

On one hand, we have an urgent need, created by the DRGs, to get patients treated and sent home quickly. On the other hand, we are faced with a generation that is living longer than any in history. Older patients come into hospitals requiring treatment for more complex and numerous ailments, necessitating longer stays. Getting these patients properly treated during their convalescence has become a serious administrative problem, but several innovative hospitals boards have found a profitable solution in joint venture development of skilled and custodial care retirement homes.

The reasons for approaching this market are familiar to most hospital administrators, but have only recently been discovered by Corporate America. One out of every nine Americans is 65 or older, with the population of 85-and-older individuals (at 2.5 million) 20 times larger than it was in 1900. The elderly population increases by more than 560,000 a year and an individual turning 65 can expect to live an average of 16.8 more years.

Moreover, households led by an individual 50 or older account for 42 percent of the nation’s consumer demand, hold half of the nation’s discretionary income and maintain an average of $65,000 in financial assets, twice the figure for the rest of the country.

Several major health care facilities across the nation have discovered that they can serve the expanding senior market outside the hospital, in a hospital-owned retirement community, and that this results in some significant financial benefits for the hospital in return.

The James A. Eddy Memorial Geriatric Center, an affiliate of Samaritan Hospital in Troy, N.Y., working with the assistance of a professional marketing and management firm, created its successful Beechwood community despite regulatory complications with the state, which prohibits lifecare developments. The Eddy Center has now become the nursing home facility for a complex that includes intermediate care and active adult rental facilities.

Freedom Square, a lifecare development, was created on the grounds of Blake Memorial Hospital in Bradenton, Florida, which now benefits from successfully shared services.

The Radice Corporation, a New York Stock Exchange-listed development firm, is joint venturing its Horizon Club retirement and convalescent home concepts to hospitals on a national basis. Radice takes all construction and marketing risks on its ventures and then sells the rental retirement communities, once occupied, to the hospital or other third party, usually retaining a long-term management contract.

The ideal of developing any retirement facility makes many hospital boards nervous, until they look at the facts and figures.

A retirement community provides a “captive” audience of an age group that most frequently uses the hospital’s outpatient facilities, the services that are most profitable for a hospital to provide. The medical staff of the retirement community, even if operating only on an emergency basis, is often able to advise the community’s residents of available services they might not otherwise have taken advantage of, resulting in significant continuing referrals to the hospital’s programs.
A retirement home also provides hospitals with the opportunity to spread their expense bases over a wider area, because many of the home’s operating costs are the same as a hospital’s, including food service, accounting, security, and linen service. Food can be purchased in greater volume, with improved quality and selection, and distributed economically. The operating hours of the laundry go up, but shared costs between the two facilities bring them back down again.

New overhead is eliminated as all relevant facilities are brought closer to capacity.

The new facility can provide hospitals with the added advantage of an opportunity to keep doctors excited about their affiliation by giving them an attractive investment opportunity.

There are several important advantages to developing the club on a rental fee basis, rather than as a traditional endowment community.

For one thing, a rental project can be created much more rapidly. Lenders will not require 50 percent presales for financing, which can extend the marketing life and cost of a project. Time is important, too, since hospitals don’t have their usual luxury of years of consideration prior to development, if they are going to take full advantage of the emergent retirement home market. MultiHousing News, a trade journal, reports that retirement housing is one of the fastest growing sectors of the real estate development industry, with many major corporations entering the picture.

Retirement clubs can also have little or no effect on bond rating, where ownership of a lifecare facility under development can jeopardize a hospital’s standing. In recent years, major rating firms such as Standard & Poore’s have declared that the ownership of a lifecare development can be ill-advised and will effect bond rating because in part of Supreme Court decisions that strip away the corporate veil and make the real owners of a lifecare community directly responsible, and financially liable, for any failings. Occasionally a third party will agree to develop and even to market the retirement home, to the point of guaranteeing lease-up before turning it over to the hospital, when the major risk of financial failure is past. It is then significantly easier to go to the bond market or other sources for funding, and the hospital’s bond rating is undisturbed.

Just because an administrative team can run a hospital doesn’t mean that they will immediately be able to handle the intricacies of managing a retirement home.

Pensacola Baptist Hospital failed twice in launching its Azalea Trace community before it brought in a professional marketing and management team to get the project on track. It’s now one of the most profitable hospital-run retirement communities in the country.

A professional management team will guide the hospital through the first critical months of operation, or longer, to assure that the facility runs smoothly and profitably under the hospital’s administration for years to come.

Ideally, a retirement facility also helps to expand physician outpatient bases, by providing doctors with offices and scheduled hours on the retirement home grounds. Such an arrangement is particularly convenient for those specializing in the ailments of advanced age. The retirement community provides a centralized location where patient treatment and
progress can be monitored on a regular basis by professionals, without necessitating a return to the hospital or physician's office.

With the new insurance plans making nursing home convalescence a realistic alternative for patients who could not have considered it as recently as last year, and with developers willing to bear the risk so that at least a break-even situation is assured, then more hospitals will, in the very near future, be jumping on the retirement home bandwagon.
Hospitals And CCRC’S: A Growing Alternative

As hospital censuses continue to decline, hospital operators are turning their attention to retirement centers as alternative sources of revenue.

By DeWayne McMullin, CPA

The June 25, 1985 edition of the Wall Street Journal had the following lead into an article:

“In Michigan, the family of an ailing, 87-year-old woman is told she must be discharged from the hospital because her Medicare payments have run out. In Oklahoma, an elderly man is released from a hospital even though his physician believes he needs more care. And in Maine, a 73-year-old man is sent home despite pleas from his family that he stay in the hospital.”

Cases like these are producing criticism of Medicare’s new method of reimbursement of hospitals — the use of Diagnostic Related Groups (DRGs). Finding a solution for patient care after Medicare benefits are exhausted becomes even more difficult due to a national shortage of nursing home beds. Nationally, the supply of nursing home beds has been growing at the rate of one percent while the demand has been growing at the rate of three percent. Thus hospitals and elderly patients have no place for long-term rehabilitation. As Senator John Heinz (R., Pa.), Chairman of the Senate Special Committee on Aging, puts it, patients “are being sent to a no-care zone” with few alternatives available.

In the above three cases, the 87-year-old lady in Michigan was admitted to the hospital with the diagnosis as congestive heart failure. Medicare will pay for seven days under the DRG system. Unfortunately, complications kept the Michigan woman in the hospital for almost a month with the hospital having to absorb the cost not reimbursed by Medicare.

At the end of the month the woman was transferred after the hospital made 65 telephone calls. She was placed in the nearest nursing home the hospital could find, a facility which was 200 miles away. Shortly after the transfer, she had a stroke and died without any of her family at her bedside.

The Oklahoma man was admitted to the hospital with a urinary-tract infection and other complications. After two weeks in the hospital he was transferred to a nursing home only to be rushed back to the hospital two days later. He died in the emergency room. His transfer to the nursing home was due to his eagerness to leave the hospital and his condition did not meet the state’s criteria for continued care under the Medicare program.

The man from Maine was discharged from the hospital after a three day stay which had resulted from a dehydration condition. Such a stay is covered by Medicare for only three days per the DRG system. He was sent home in an ambulance since he was unable to stand. His wife tried to take care of him unsuccessfully for a week until a daughter took him to her home for care. He died shortly thereafter.

In each case the hospital had a problem of where to place an individual that was satisfactory for rehabilitation. One avenue a number of hospitals are pursuing is a continuing care retirement community (CCRC). A CCRC is a housing community that is primarily designed for the needs and interests of senior adults and offers health care. A survey conducted by the Health Services Division of Kurt Salmon Associates, Inc., of Atlanta indicated that approximately 30 percent of hospitals with 400 beds or more are currently in some phase of pursuing the development of a CCRC. Why would so many hospitals have an interest in CCRCs?

Aside from the growing interest of hospitals in expanding their services to their community, hospitals are becoming more aware of the growing demand for services to the elderly. Currently over 11 percent of our population consists of people over 65 years old. According to the Bureau of the Census, this segment of the U.S. population is projected to be the fastest growing segment until around the year 2030. By then, approximately 20 percent of the population is projected to be 65 years old or older.

Closely related to the increasing percentage of the elderly in our society is the increased consumption and utilization of health care related services by the elderly. Recently, the National
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Closely related to the increasing percentage of the elderly in our society is the increased consumption and utilization of health care related services by the elderly. Recently, the National
Center for Health Statistics published their study of hospital utilization. The study found that 70 percent of all hospital discharges were persons age 65 or older and the number of inpatient hospital days for persons in this age group is at least 3.4 times that of the general population. An American Association of Homes for the Aging study also showed that those over 65 are admitted three times more often, stay longer and use three times more hospital bed space than younger adult groups. Based on these statistics, it is not surprising to find hospitals becoming more interested in marketing their services to the elderly in our society.

Why would a hospital want to develop a CCRC and not just a nursing home or out-reach programs for the elderly? Methodist Hospital, located in Madison, Wisconsin, addressed these questions after developing a CCRC in 1975 with a resounding answer that there are numerous reasons. In total, the benefits far outweigh the detriments. The hospital developed a CCRC with 210 independent living units contained in a 15-story building that also includes a coffee shop, craft center, gift shop, chapel, library, lounges and common areas.

The hospital found the CCRC offered the following advantages:

- It improved its competitive edge within their community by offering a broader range of services than other hospitals within their market area.
- It provided a source of referrals over the long-run, as residents of its CCRC preferred to be in their sponsoring hospital as opposed to other area hospitals. Referrals for out-patient services as well as hospital admissions increased as a direct result of the CCRC.
- It provided a satisfactory location to place elderly patients who required longer-term rehabilitation than the hospital could effectively offer due to economic considerations and occupancy constraints. Skilled nursing care can be offered much more cost efficiently in the CCRC’s skilled nursing facility than in the hospital.
- It provided positive cash flow to the hospital after the CCRC had been open long enough for occupancy to stabilize. After five years of operation, the CCRC was contributing $125,000 a year to the hospital.
- It established a reputation for the hospital as a facility that specialized in serving the elderly. This can be beneficial as long as service to the younger population is not affected.
- It provided the hospital with an opportunity to spread its operating overhead over a broader base. Purchasing, dietary, personnel, accounting, nursing and other costs centers could be shared with the CCRC which allowed the hospital to operate more cost effectively.
- It provided the hospital with a tremendous source of volunteers to serve the hospital and the CCRC. This enabled both facilities to offer services such as reading to hospital patients and trip coordination for CCRC residents that might not have been offered otherwise.
- It established a source of future bequests for the hospital. The hospital’s sponsorship of the CCRC developed a sense of loyalty among its residents that could not be established with an acute care patient who was in the hospital for a seven-to-ten-day stay. Some residents included the hospital as a beneficiary in their wills for the distribution of their assets.

Of course, the hospital exposed itself to a few risks as a result of the sponsorship of the CCRC. Some of these risks included:

- The chance the project could fail. Although most CCRC’s have succeeded — there are between 300 to 400 in the country today serving more than 100,000 residents, a few have failed. With each failure though, the industry has learned how to develop facilities more successfully.
- An adverse effect on the hospital’s credit rating. The addition of the uncertainty related to a hospital becoming the sponsor of an organization that contracts to take care of individuals for the rest of their lives could lower the overall credit rating of a hospital by one or two notches. As the finance world is becoming more familiar with the life care concept, this effect is decreasing.
- Disruption of hospital operations. Addition of a CCRC increases the administrative burden of departments that are shared between the hospital’s and the CCRC’s operations. Competition between employees seeking positions in the hospital versus the CCRC could be good and bad. For example, while the typical hospital environment has the physician as the team quarterback, the skilled nursing center of the CCRC gives the nurse the opportunity to fill the leadership role. As a result, nursing staff could have a preference for working for the CCRC as opposed to the hospital. Furthermore, competition for the hospital’s limited resources (both financial and personnel) could cause problems should one of the operating departments of the hospital feel slighted with the CCRC consuming resources that otherwise would be available for use within the hospital itself.

- Effect on Medicare reimbursement. Although this effect should be minimal, the addition of a profit center to allocate hospital overhead could lower the reimbursement of Medicare to the hospital.

In summary, the addition of a CCRC to a hospital’s operations offers both benefits and detriments. As mentioned above, a number of hospitals across the nation are actively considering the addition of a CCRC. Today’s competitive environment in health care is forcing hospitals to analyze the services they offer and to respond to consumer demands. The health care needs of the elderly are sure to grow in the future. People in general are living longer, are more affluent and are demanding more and better health care. The continuing care retirement community just may be the solution hospitals are looking for.

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Center for Health Statistics published their study of hospital utilization. The study found that 70 percent of all hospital discharges were persons age 65 or older and the number of inpatient hospital days for persons in this age group is at least 3.4 times that of the general population. An American Association of Homes for the Aging study also showed that those over 65 are admitted three times more often, stay longer and use three times more hospital bed space than younger adult groups. Based on these statistics, it is not surprising to find hospitals becoming more interested in marketing their services to the elderly in our society.

Why would a hospital want to develop a CCRC and not just a nursing home or out-reach programs for the elderly? Methodist Hospital, located in Madison, Wisconsin, addressed these questions after developing a CCRC in 1975 with a resounding answer that there are numerous reasons. In total, the benefits far outweigh the detriments. The hospital developed a CCRC with 210 independent living units contained in a 15-story building that also includes a coffee shop, craft center, gift shop, chapel, library, lounges and common areas.

The hospital found the CCRC offered the following advantages:

- It improved its competitive edge within their community by offering a broader range of services than other hospitals. The CCRC offered a sense of loyalty among its residents that could not be established with an acute care patient who was in the hospital for a seven-to ten-day stay. Some residents included the hospital as a beneficiary in their wills for the distribution of their assets.

Of course, the hospital exposed itself to a few risks as a result of the sponsorship of the CCRC. Some of these risks included:

- The chance the project could fail. Although most CCRCs have succeeded there are between 300 to 400 in the country today serving more than 100,000 residents, a few have failed. Without fail, the hospital's operating department, and the physician as the team quarterback, the skilled nursing center of the CCRC gives the nurse the opportunity to fill the leadership role. As a result, nursing staff could have a preference for working for the CCRC as opposed to the hospital. Furthermore, competition for the hospital's limited resources (both financial and personnel) could cause problems should one of the operating departments of the hospital feel slighted with the CCRC consuming resources that otherwise would be available for use within the hospital itself.

- Effect on Medicare reimbursement. Although this effect should be minimal, the addition of a profit center to allocate hospital overhead could lower the reimbursement of Medicare to the hospital.

In summary, the addition of a CCRC to a hospital's operations offers both benefits and detriments. As mentioned above, a number of hospitals across the nation are actively considering the addition of a CCRC. Today's competitive environment in health care is forcing hospitals to analyze the services they offer and to respond to consumer demands. The health care needs of the elderly are sure to grow in the future. People in general are living longer, are more affluent and are demanding more and better health care. The continuing care retirement community just may be the solution hospitals are looking for.
The hospital found the CCRC offered the following advantages:

- It improved its competitive edge within their community by offering a broader range of services than other hospitals within their market area.
- It provided a source of referrals over the long-run, as residents of its CCRC preferred to be in their sponsoring hospital as opposed to other area hospitals. Referrals for out-patient services as well as hospital admissions increased as a direct result of the CCRC.
- It provided a satisfactory location to place elderly patients who required longer-term rehabilitation than the hospital could effectively offer due to economic considerations and occupancy constraints. Skilled nursing care can be offered much more cost efficiently in the CCRC's skilled nursing facility than in the hospital.
- It provided positive cash flow to the hospital after the CCRC had been open long enough for occupancy to stabilize. After five years of operation, the CCRC was contributing $125,000 a year to the hospital.
- It established a reputation for the hospital as a facility that specialized in serving the elderly. This can be benef-

The continuing care retirement community just may be the solution hospitals are looking for.

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