



# **Changing the Face of Senior Health Care**

Health Facilities Association of Maryland  
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## **Introduction**

The aging of America is pressuring state and federal governments to reevaluate the long-term healthcare system. By the year 2050, the number of Americans age 65 and over is expected to more than double, while those aged 85 and older, who are most likely to use long-term care services, will account for 5 percent of the population, triple the size of this demographic in 2000.

In three years, the oldest baby boomers will reach retirement age, ushering in a generation of seniors larger than any previously served by the nation's healthcare system. To meet current and future challenges, the Health Facilities Association of Maryland (HFAM) proposes a new model of long-term care which puts consumers at the center of the system. HFAM believes that long term care, which for decades has been shaped by funding sources and provider preferences, should instead be driven by the needs, choices, and expectations of the elderly and disabled persons we serve, regardless of the setting in which they receive care.

Policymakers have just begun taking steps in this direction. Rising demand for choice, coupled with funding constraints, has led to President's Bush's New Freedom Initiative, a nationwide effort to allocate resources more effectively and at the same time lift barriers to community living for people of all ages with disabilities and long-term illnesses. The initiative has encouraged many states to launch demonstrations and waiver programs which overhaul the delivery of services for Medicaid recipients. Maryland recently submitted to the Centers for Medicaid and Medicare a mandatory managed care waiver under a Section 1115 Health Care Reform Demonstration Proposal.

HFAM's proposed model builds on and complements this emerging public policy shift, by introducing four essential components to the long term care system:

### **Customer focus**

The primary building block of this new model is the belief that consumers should be the drivers of long term care. This includes individual choice of long term care options in the most appropriate setting, and greater flexibility among healthcare providers to change the way they offer services to create a truly customer-focused system.

### **Care coordination**

The model is premised on linking the entire senior care system through a common assessment tool that provides a holistic picture of individuals' needs and preferences, regardless of the setting in which they receive care.

**Data-driven management**

To optimize quality and promote robust data collection and sharing among providers, HFAM calls for creating a database that crosses the long term care continuum and follows individuals from one setting to another.

**Adequate financing**

The new model envisions a payment system which identifies, and adequately covers, the total cost of individuals' long term care needs; maintains high quality; and remains stable despite budgetary pressures.

These goals are vital to achieving meaningful reform and addressing core problems in the current system. HFAM members understand these critical objectives from diverse perspectives and care settings. Each year, HFAM providers serve 25,000 frail, disabled, chronically ill, and vulnerable individuals. Our membership includes proprietary and nonproprietary nursing homes and comprehensive care facilities, subacute care providers, assisted living programs, adult day care centers and continuing care retirement communities. With 18,000 beds of care and a wide range of capabilities, HFAM providers span the continuum of long-term care, and are part of the fabric of their communities.

**What is wrong with the current care system?**

Long-term-care stakeholders--providers, consumers, and government entities--can all identify problems with the current system, even as we debate the best solutions. HFAM providers believe that today's long-term care system is primarily hampered by a structure which has evolved, to a great extent, in response to the needs, demands, and availability of funding sources. As a result, long term care suffers from a structural failure to put consumers first.

Medicaid, for example, makes eligibility and level of care determinations for the vast majority, 60% to 70%, of nursing home patients. Coverage and financing decisions have shaped the organization and availability of long term care services along the continuum, stifling consumer choice and creating silos in which each provider type focuses on its own payer-driven rules and procedures, with no system-wide framework for coordinating vital clinical and quality management processes.

In short, the failure to place customers at the center of decision-making, financing, and care-related processes is the central weakness of the current system, and this weakness has generated a cascade of woes:

### **Lack of consumer choice**

The current care model was built around a Medicaid entitlement program driven by financing concerns. This priority affects the structure of Medicaid eligibility, level of care determinations, and ultimately eligibility for community services. Clearly consumers not only want greater choice than the current system allows, but they want the ability to drive the health care system, including control of healthcare dollars.

HFAM supports customers' right to choice, but recognizes that simply allowing individuals to receive services in the community will not comprehensively address other critical problems in the current system.

### **Fragmentation of care**

As customers move through the long term care continuum, they often experience a disjointed system, which does not promote communication, cooperation, or seamless delivery among providers. In its acclaimed report, "Crossing the Quality Chasm," the Institute of Medicine underscored the health care system's poor organization. "Care delivery processes are often overly complex, requiring steps and handoffs that slow down the care process and decrease rather than improve safety," the report said. "These processes waste resources; leave unaccountable gaps in coverage; result in loss of information; and fail to build on the strengths of all health professionals involved to ensure that care is timely, safe, and appropriate."

Similarly, the fragmented long term care system in place today fails to effectively integrate or target services to vulnerable senior and disabled populations.

### **Limited use of data**

Data collection is limited and data sharing is virtually nonexistent among care delivery systems. This impedes providers' ability to leverage data for the purpose of clinical, disease, and quality management. Databases vary in adequacy from one long term care setting to another, and do not interact or intersect. The minimum data set (MDS) used by nursing homes, for example, is wholly separate from the OASIS database used by home health agencies. This perpetuates the silos that divide the long term care continuum. As a result, when patients move from one part of the continuum to another, data collection continually begins anew.

### **Unstable financing**

The Centers for Medicaid and Medicare (CMS) and the Maryland Department of Health and Mental Hygiene (DHMH) have made it clear that the Medicaid program cannot sustain the growth occurring in long-term-care. However, with no alternative funding mechanism available, most patients continue to rely on Medicaid. Insufficient resources in the current

system, however, create financial instability for providers who care for Maryland seniors. Long term care customers deserve quality care regardless of where services are rendered, and quality care must be adequately financed.

## **A New Model for Long-Term Care**

HFAM proposes a new long term care model which provides solutions to problems with the current system. The four-point model would serve frail, disabled, chronically ill, and indigent populations, the vast majority of whom would be seniors. Disabled from all age groups would also be included.

### **I. Customer Focus**

HFAM believes that long term care customers should be able to choose the care setting most appropriate for their physical and mental needs, and have input into the delivery of that care. Every aspect of long term care decision-making, service delivery and related processes should follow the customer. Currently, however, consumers encounter a system led by financing, as opposed to their unique needs and preferences.

The federal government has signaled a willingness to fund innovative ideas that give consumers greater choice in long term care options, and HFAM's model strongly supports individual choice. To realize that goal, the model also advocates enhanced flexibility for providers, giving them needed leeway to create a truly customer-focused system.

HFAM contends that the current federal and state regulatory process stifles innovations which would place customers at the center of the health care model. For example, the Certificate of Need process strictly enforces how beds and space in nursing homes can be used. A customer who receives nursing home care and is ready for assisted living may have to leave the facility because it is not allowed to flip beds back and forth between assisted living and skilled nursing. As a result, the customer who has developed relationships at the facility and is comfortable in this setting must move. This is not a customer-focused model.

In an effort to identify strategies and reforms needed to become customer-focused, HFAM recommends a forum, in partnership with the state, to review regulations that impact providers' ability to operate in a customer-focused model. The forum would give consumers, providers and regulators an opportunity to develop recommendations together on changes needed to ensure customer-focused care.

### **II. Care Coordination**

It is the premise of this model that the entire senior care system should be linked by a common assessment tool.

In long term care, everything is determined by and follows the assessment—the plan of care, data collection and quality management. Currently, the assessment tool used by home health agencies, nursing homes, assisted living programs and adult day care programs are each very different. As a result, the same customer evaluated in different settings would end up with an assessment that is limited in scope.

A standardized assessment form would produce a holistic view of individuals' needs, regardless of where they received services. This assessment would maintain the same format as it followed the customer and would be updated as the customer moved across provider types and experienced significant changes in status.

By ensuring uniformity across the continuum, the assessment process would become truly customer-focused, producing a care plan unrelated to a particular setting, driven instead by individual needs. The care plan generated by the assessment would also follow individuals through the continuum, updated as required to accommodate shifting needs. The process would be streamlined further by designating a single point of entry to the long term care system, where assessments would be conducted by professionals with the appropriate expertise. This portal, independent from a particular facility or community-based setting, would also serve a case management function, helping consumers through a myriad of healthcare decisions.

This assessment and case management system must be dependable, accessible, and adequately staffed. Currently, the infrastructure does not exist in the community. However, nursing home staff, who have expertise and a congressionally-directed mandate in senior care, would be ideal to perform this function, conduct assessments and provide outreach to the community. Tapping the experience of professionals who would want the opportunity to work both in the community and a nursing center (much like a model pioneered in Denmark) would be an effective strategy for building the necessary workforce. In this way, the customer—not the care setting or provider--would be the focus.

### **III. Data-Driven Management**

In today's health care system, robust data collection and analysis can maximize care planning, oversight, and quality management. Just as a standardized assessment form which follows an individual across the continuum would enhance care coordination, a common database housing clinical, social, and demographic information from various settings would bolster that same objective.

In HFAM's model, data collection would begin when an individual entered the long term care system. Information gathered from the standardized assessment would be collected, entered into the database, and used to create a plan of care.

Subsequently, each provider and care setting would build on that data, entering information into a common database, the contents of which followed and moved with the individual. This would ensure that at every step in a customer's journey through the long term care system, providers had access to the person's complete record, history, care plan, and unique needs and choices.

Information that could be tracked in a single-source health care information system include: eligibility status, covered services, cost sharing information (premiums or co-pays), allergies, immunization records, prescription medication (including quantity and date dispensed), diagnosis, service history, lab history, and provider contact information.

A continually evolving electronic healthcare record has the potential to provide vast amounts of vital information. To maximize the value of this data for the benefit of consumers, however, providers must have the ability to access it, regardless of where an individual receives care.

A common database, drawing together information from home health agencies, nursing homes, assisted living communities, and adult day care programs, would facilitate data sharing, and promote seamless care. Ultimately, this comprehensive view of each customer would optimize quality and outcomes management, strengthen care planning, and support individual choice.

The database would also be used to track the cost of services delivered to each individual, based on their plan of care. This would help all stakeholders understand, from a fiscal perspective, the effectiveness and efficiency of services. It would also make it feasible for national, state, and local governments to plan adequate budgets for meeting long term needs.

Given the strong interest in the promulgation of health information technology, this database might make an ideal proposal for a federally-funded demonstration project.

#### **IV. Financing**

Like all other components of health care, the financing system should follow customers, regardless of where their care is provided. Currently, the reverse is often true: the financing system determines what services will be funded and in what setting they will be covered. Individuals must then, literally, follow the money to receive care.

Under HFAM's model, each individual's plan of care, drawn initially from the standardized assessment, would detail the mix and intensity of services required for that person. Then, the cost of providing that care would be calculated, using the cost information captured over time in the common database. In this way, each person's health care costs could be calculated, predicted and budgeted.

On a state and national level, the aggregate cost of plans of care for individuals using services throughout the continuum would reflect the total funding needed to provide quality health care for the population. And, since those costs would be a function of independently administered assessments, they would be reflective, not of provider preferences, but of actual customer needs.

Whether this funding comes from Medicaid, Medicare, or private sources, payment for health care services must be adequate to maintain quality. A dedicated financing source must be established, sustained and shielded from annual budget battles in which providers must prove why vulnerable seniors and the disabled are more deserving of funds than other health care recipients.

Inconsistent and unpredictable funding creates insecurity for providers and consumers. To bring security and stability to the system, policymakers may have to look beyond Medicaid for additional revenue sources. Options might include the sales tax, lottery, long term care insurance, and policy changes to create tax incentives, and help seniors maximize the value of assets before they turn to public programs.

## **Conclusion**

The viability of the future healthcare system will depend on our ability to initiate change and embrace innovation. Clearly, the traditional nursing home will play a role in long-term care for many years to come, but the future is a customer-focused model in which choice, decision-making, care planning, data-gathering, and funding follows the customer. Long-term care providers are positioned to be a resource for this new model, and HFAM looks forward to working with consumers, advocates, public agencies and elected officials as we advance into the 21<sup>st</sup> century.