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Continuing Care Retirement Communities Opportunities and Provider Joint Ventures

Track: Long-Term Care

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Summary: This session discusses continuing care retirement communities and other provider organizations, such as nursing facilities, assisted living facilities, and residential facilities. A continuing care retirement community involves an insurance element because of the monthly and up-front fees that provide for financing of health-care services. What opportunities exist for traditional insurance carriers to partner with these organizations to more effectively serve their shared customers?

This panel discusses trends in the retirement housing industry and opportunities for joint ventures between insurance organizations and long-term-care providers.

Mr. Gary L. Brace: I am from Milliman & Robertson. We're assuming that everybody here has a least a somewhat elementary understanding of continuing care retirement communities (CCRCs) because we're really not going to talk so much about the delivery mechanism itself, but talk about some applications specifically related to CCRCs. We're just going to jump ahead with the presumption of the knowledge here.

We have three presenters today. Dr. Judith Black is the medical director of Highmark Blue Cross/Blue Shield in Pittsburgh. Jill Krueger is the president and CEO of Health Resources Alliance (HRA) in the metro Chicago area. Denise

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Wassenaar is the executive vice president working with Jill at HRA. Jill, Judy, and Denise are going to be doing a tag team throughout the presentation here.

HRA is located in Oak Brook, Illinois, founded by 11 Chicago-based senior care providers. The existing 29-member organizations consist of 48 facilities and over 6,000 nursing beds, 1,500 assisted living units, and 4,000 independent living units located in both Chicago and St. Louis. Prior to joining HRA, Jill was a partner at KPMG responsible for overseeing the firm's national long-term care (LTC) and retirement housing practice. In that position she worked with LTC providers and major health systems to develop and implement elder care strategies. Jill is a certified public accountant and certified management accountant. She is public commissioner serving the Continuing Care Accreditation Commission (CCAC) and like myself, is a member of the CCAC Financial Advisory Panel. She serves on the American Association of Homes and Services for the Aging House of Delegates (AAHSAHD), Managed Care Committee, and she is a member of the Alexian Brothers Health Systems Strategic Planning Committee. She also serves on the Board of Directors and is chairperson of the Audit Committee for a publicly-traded assisted living company.

Dr. Judith Black as I mentioned is the medical director of Highmark Blue Cross/Blue Shield and has been the leader in geriatric education program development. For eight years she was responsible for the development of the geriatric program in St. Margaret Memorial Hospital and has been involved in numerous community educational activities and professional presentations. She serves as a physician consultant to the Allegheny County Department of Aging and has a clinical faculty appointment at the University of Pittsburgh. In April 1998 she joined Highmark Blue Cross/Blue Shield and is responsible for providing medical leadership and consultative services to assist in enhancing the care of older adults as well as contributing to and participating in geriatric education within the corporation and the community.

Denise Wassenaar is executive vice president of HRA, works along side Jill, and has over 25 years of experience in the health care field, is a nurse practitioner with a clinical specialty in geriatrics, and the designer of the Geriatric Care Management System.

Before I bring up Jill, let me go through the learning objectives that the Society would like us to cover. First, to gain an understanding of where the retirement housing industry is today and the advantages of the CCRC industry has in being able to provide care to the frail senior population. Second, to learn about a specific example, the Senior Care Blue Program offered by Highmark that provides care to the frail senior population. Then finally, to learn about the geriatric care management system that has been developed by Denise and HRA.

Ms. Jill Krueger: I want to begin by saying most of my career I spent with CCRCs. In the early 1980s when I really began my career, life care was the big deal and the most prominent form of contracting for CCRCs. There are so many similarities obviously between life care and managed care and Medicare, HMOs, and all that, and hopefully, we'll kind of go through that and help you see that.

About two years ago, I got a call asking me to be on the board of a publicly-traded assisted living company. I thought it would be a really great opportunity to see the other side of the spectrum. A lot of the CCRCs are for-profits, full continuums. As you know, the assisted living industry is highly leveraged, Wall Street-financed, publicly traded, and I wanted to kind of see the dichotomy between the two. It's been a great experience and, hopefully, I can bring some of that into our conversation.

I want to start by talking about the industry as I see it. I've been in this business now for 18 years and I've never really seen it the way it is. What really shook us up was prospective payment system (PPS). While most think PPS was just an awful thing, I think it was a very necessary thing. We wouldn't be here if we wouldn't have had PPS. That goes back to the fact that before PPS, as senior care providers, particularly in the field of Medicare but also in some of the other fields, we had no accountability. Basically, Medicare paid us whatever we spent, and no one asked about how good we did or what our outcomes were. Basically, costs were not at issue, outcomes were not at issue. Quality is always an issue, but nonetheless, if you take cost out of the equation and you take the ability to demonstrate how good you do, you don't have a whole lot of accountability.

When I started at HRA four years ago, I got a dose of reality. I'd always been a consultant and I always had theories on things. I took the next step and said, "Okay, theories are great but what's the real world?" Quite frankly, four years ago, I'd sit in a room with 25 directors of nursing (DONs), and then 25 CFOs an hour later, and found out they don't talk. Basically, they'd say to the DONs, "Well, why are you spending all this money on this supply when you could buy this supply?" The DONs said, "Nobody ever told me what a particular supply costs. How would I know that?"

Why would they know that? Who cared? It didn't matter. You send the bill to Medicare. They pay you back and it really, in my opinion, was quite broken. I think the whole idea of prospective payment, and being accountable as being providers is a good thing and I think that over time you'll see the survival of the fittest, and that the providers that really know what they're doing and have good systems in place will be the ones that do very well in the long run. Basically, we had that whole issue of accountability and then what you see obviously is the reduced payment forcing inefficient operators out of business. They turned the Titanic around on a dime.

The other thing you saw was, and I think this is what really has hurt our industry, we were forced to be accountable. There were no systems in place and even if you look to technology today, if you look to software, there's little available in our industry because it's just not a big industry. It will be and it's getting bigger every year, but there's not a lot of money that's invested. There's not a lot of talent historically in our industry, a lot of human talent, human resources. To go from this day where you could be totally unaccountable to the next day where you have to be totally accountable and really have a tight payment, forced not only inefficient providers out of business, but also large providers that just couldn't get the systems in place to be sophisticated quickly enough.

The third area that hurt the nursing home industry was at the same time PPS came into effect, if you looked at our industry, it was hugely consolidating. There were lots of acquisitions going. Lots of the for-profit chains were just buying facilities all over. If you recall, a lot of the for-profit publicly-traded companies had pharmacy divisions and therapy divisions. Well, I was just looking at a nursing home company in central Illinois that's probably got about $100 million of nursing revenue and $20 million of ancillary revenue so what happened when these publicly-traded companies were acquiring facilities and valuing them, they were determining the value, not only based on the nursing home, but how much revenue the pharmacy and the therapy was going to bring in. When PPS came along and forced salary equivalency into therapy and then also took the pharmacy costs way down, they had overpaid for these facilities and they can't dig out now because the nursing home values are in the tank. So that's the reason why Sun Health, for example, is in bankruptcy and some of the others, it was just timing in terms of just changing the rules overnight.

The other aspect of senior care, it's a good and a bad thing, is this huge growth in assisted living. It has dramatically affected nursing home census, absolutely dramatically. Gary said I'm on the Continuing Care Accreditation Commission. We accredit the finest retirement communities in the country. Almost every retirement community has a nursing component. I am watching some of the strongest retirement communities really sliding financially because their nursing home piece is empty or the occupancy is declining because people are opting to stay home, they're opting to go into assisted living. It's a good thing. It's a more pleasant environment. It cost less. It's more efficient in terms of how we spend our money, but if you look at most nursing homes, 80% of our population is in a nursing home; I'm talking about in the licensed area, in custodial.

Denise developed a tool about four years ago, which she'll talk about, that allows us to assess a patient and determine what level of care he or she should be in. Roughly, and I've seen this statistic all over industry, 30–40% of people in nursing homes don't need to be in nursing homes. They can be in assisted living. Why are they in nursing homes? Because Medicaid pays for nursing homes, but it doesn't pay for assisted living in some states. More and more states now have Medicaid waivers where the state will pay for the assisted living. But if 80% of my business is custodial and 40% of my custodial population doesn't need to be in my custodial population, I'm losing census. Guess what? Break even in a nursing home, in a custodial population, is 85-90% occupancy, sometimes it's over that, and we can't operate at 70-50%.

It's a huge strength and a lot of that has to do with regulation and nursing hours per patient day and all of that. But essentially, what you see is that the assisted living, and the people's choice to stay in their home has had a huge effect. That's why the for-profits went for the Medicare population—to bill as much Medicare as they could. The typical non-profit will have a Medicare census of about 10%, maybe 8-12% would be a good range. If you look at the for-profit companies, they were running about 40-60% Medicare because that's where the money was, and they also saw what was going to happen with their custodial population.

Again, a good strategy for nursing facilities is to aggressively pursue the higher acuity Medicare-type patient because we can do very well. We can provide good care at a lower cost than a hospital, as Judy will tell you, and still make money. We need to make money. If there's no margin, there can be no mission.

The other thing is it's a hugely competitive world, as you might imagine. If everyone's losing 40% of their custodial patients and everyone's trying to get into Medicare, we're all fighting to differentiate ourselves in the market. Competition is like I've never seen it. Basically, I think the strategically sound providers are focusing on specialization. Another good idea is to be innovative. Let's design programs that help people get healthy, sooner, quicker with a better quality of life. Then we need to be able to demonstrate the outcomes because we need to measure what we're doing. We can't tell you, a potential resident, "Come to my facility because it's better." You're not going to buy that. You're a more sophisticated consumer, both in terms of the patients, the families and the businesses, the managed care organizations, and everybody else that basically makes the choices as to where to send people.

The nursing home industry has taken a lot of hits since PPS. But I'll tell you what, the weak are going to disappear, and the strong will survive. There's a lot of good in my mind that comes out of PPS. The real challenge I think is just having the government get the number right. The idea is a good one, but the information is so hard to come by because we've been unsophisticated for our whole lives. Unfortunately, they killed the home health business for a while because they didn't know what to do with it. But that's life, I guess. That's part of the process.

With assisted living, again, there is a huge infusion of Wall Street money. You all know that and you've seen it. What you had there is very similar to the nursing home business of really unsophisticated business, Mom and Pop business, not a lot of systems, and not a lot of human resources. Then all of a sudden they go public and have to meet these huge earnings expectations and they fought to do it and what happened as anyone might suggest, is it results in poor performance. What I've seen in my time spent in the assisted living industry, is that it didn't have the systems in place, just like the nursing homes didn't, but they were so focused on growth, they weren't focused on strategy.

What makes this business work, what makes LTC work is volume. It's volume, volume, and volume. There are not big margins in our business, and what makes it efficient is geographic density. If you look at a lot of the for-profit nursing home chains, they've got a facility here, and a facility there, and a facility over there. The big deal now is clusters. We need clusters. That's why Health Resource Alliance works so well. I have 50 facilities in Chicago. We provide pharmacy and therapy and those services and we're very efficient with it. If I only had a handful of facilities, I'm not going to be efficient. I'm not going to get the same economy as a scale.

Same with assisted living, assisted living facilities can be big. Folks, we turn over 50% of our population every year. They're in; they're out. One of our biggest criticisms is we keep them in too long. They have to be small. I'm a big advocate

of maybe 60-100 assisted living units in an urban market. What we have at Assisted Living Concepts, which is the board I'm on, is a model of 40, but we can't do one 40-unit facility in the middle of Georgia. We've got to have geographic density so that we can share infrastructure management and all the other good stuff.

It's been hard on the assisted living because they just went and built wherever they could. Because the quicker they built, the better their earnings were, the better their stock price was, and it caught up. Basically now, assisted living can't access capital. Most of the companies that I see are now focusing away from new building, and on stabilization because they've got to stabilize the business. It just can't grow like it was. It's not realistic.

The other pieces and again, in terms of the audience I'm talking to, I'm not a believer in stand-alone assisted living. I believe in continuums of care and you'll see that as we go along. Assisted living is a very short time in a person's aging process, and so it's very difficult, unless you can offer independence and some nursing; they have to move too quickly in and out, which is very traumatic on an elderly population.

Back to stabilization. I do believe, and I'm seeing it from an inside standpoint, that as we stabilize operations and abandon new development, the systems will catch up. The human resources will catch up. It's just a cycle. Assisted living will be back in favor again with the strong, smart, sophisticated providers there and the weak, unsophisticated providers gone.

The other thing to know as you are with insurance companies and what have you, and your working with the state DOI, is that assisted living is a state product. It hugely depends on state regulation. State regulation pretty much drives where it can be a medical model or a social model. The state I'm most familiar with is Oregon. That's where Assisted Living Concepts is based, and the person who actually invented the Medicare waiver is on our board. It has assisted living statutes that are very flexible. You can almost provide nursing care and assisted living based on their regulations. What it did in the state of Oregon, it took the occupancy of nursing homes down about 12% in I think three years.

Other states are more highly regulated and will force more of a social model. Illinois happens to be one of those states. We have a heavy nursing home lobby. The nursing homes don't want the assisted living companies. It takes their census away so our regulation is such that you can't do very much in terms of keeping people there at higher acuity. The fact of the matter is, and it is a fact, that assisted living will typically cost 60-80% less than a nursing home stay. As you know, it's a more pleasant residential environment, less institutionalized.

Let's talk a little bit about CCRCs. I'm a big CCRC fan. Let me tell you I've got probably 48 facilities in HRA but a good 60% of those are CCRCs, no matter how big their nursing home component is, that it's full in this particular case. I have one facility that's 554 nursing beds, Lutheran Home. They're probably one of the largest and 100% full. They get people in; it's a feeder system. Basically, what

happens is the system is there, when people move from one level of care to the other, they don't change their physical environment; they don't change the faces they see. The social and the physical environment stand in tack, what changes is the type of care they provide. It's a much more pleasant and I think logical progression. Volume is the name of the game.

There has been massive consolidation in the LTC industry. It's just following the hospital industry, but we're all looking to grow and we're all looking to strengthen our financial position and because the name of the game is volume, many CCRCs are looking at community-based services. I've got this campus. I've got support services intact. I've got social workers. I've got physicians.

Let's now reach out into the community and not assume that the only way we can help an elderly person is to bring them to our campus. Let's go out into the community and provide our services there. It expands their service, it expands their size, leverages their infrastructure, and if you look at the CCAC reviews, probably every major CCRC multi-site organization is getting into community-based services.

The other thing you'll be happy to know and I think you do know, is that consumers are more sophisticated. They're requiring more choice and more information. What does that mean? Basically, it means there's a trend towards unbundling the life care component. Life care being in the CCRCs where we basically say you pay an entrance fee and a monthly fee and we'll take care of you for life no matter what level of care you're in. Well, guess what? A lot of people are going out and buying LTC insurance, so they don't want that. That's not a benefit to them. There are all different reasons why people don't necessarily want to be locked into the pre-paid health care. I think more than anything there are more options out there that they would like to choose.

The other thing that Judy and I talked a lot about when we first got involved with Senior Care Blue and Security Blue is there is a different mindset between an operator of a stand-alone nursing home and an operator of a CCRC. A stand-alone nursing home provider needs sick people to make money or custodial people. They need people in higher acuity, people who need nursing. The CCRCs are always of the mindset, let's keep them as independent as possible, because even if it's not full-life care, there's usually some sort of a discount to the person when they get into the nursing and when they get into the assisted living. Not only is it kind of the philosophy of CCRCs and what have you, but it's also a financial incentive. We all know financial incentives kind of make the world go around.

Last, but not least, in terms of the CCRCs, they are so great for managed care. I mean, you have access to this full continuum. You move people, you transition them from one level of care, they see the same people, it's the same housekeepers, the same waitresses, the same walls, and the same environment. We have support services so we watch them all the time. A lot of CCRCs have little bars on the door so if someone doesn't come out of their room for breakfast or by a certain time, the housekeeper sees that bar still up, they call someone, and someone checks on them. I mean, constant. I know you'd love to have this in all of your community-

based facilities so the support services are there. They eat well. They live in an environment where there are lots of activities and movement. You've got pretty stringent transfer policies and people are obviously in the lowest cost, most appropriate setting. There's always been a focus on prevention, on doing what's right to keep people out of moving forward. What we've done is a really terrible job of documenting it—showing you the difference.

My goal in life is to blow the actuarial tables out of the water, because I want to show you that we do a good job of keeping people healthy. We have a senior fit program at HRA in all of our buildings. It's an exercise program with strengthening. I want to prove to you that people are going to stay independent longer and in assisted living longer and not get to nursing until a lot later in their life, and that basically will improve their overall quality.

Senior care providers in this market are becoming much more than senior care providers. In Chicago, we're seeing a lot of hospitals pull out of the businesses that we want to be in: community-based senior programs, physician clinics, and outpatient rehabilitation, all the different types of programs and services that seniors need. Again, there's a movement nationally away from buildings. You don't have to come to the building to get the service. We can bring it to your home because home is usually where people want to be, and as long as they can afford it, we can do it. The whole community-based aspect is very much a private pay market. Again, we have to demonstrate what we do makes a difference. I can't tell you how sophisticated our consumers are in terms of basically saying, "Okay, well, that's great, I'm sure you do all those good things. Can you show me some information that proves that you've got better clinical outcomes, that your senior fit program keeps people healthier longer, and keeps them independent in those types of things?"

We've got to be able to measure to get the competitive edge. Judy has her skilled nursing network in Pittsburgh, that's what she's trying to look at. "Okay, I don't want to tell providers how to manage care." My feeling is that's our job. We, as providers, need to manage care. She should be able to say, "Hum, you're doing a good job or you're doing a bad job and if you're doing a bad job, you're out of my network because I want the ones that are doing a good job." But we shouldn't have the insurance companies telling us how to manage care; that's our job.

I think probably our biggest opportunity is to not waste money. We wasted a lot money and we still do. We can do things a lot better. The second thing we need to prove is that prevention and wellness save money. You do understand right now the government doesn't pay us for prevention and wellness. That's why we like managed care. That's why we like Medicare HMOs because we have more flexibility with how we spend our money. Once we can prove that all these beautiful things basically keep people healthier, happier, and living a better quality of life. Hopefully, some day that will be where we can spend the money. Right now, the only money and the only opportunity we have with that is in the private pay sector.

Dr. Judith Black: First of all, I wanted to mention our product is called Security Blue. It is a Medicare HMO in Pittsburgh. It started back in 1995 and it now has

over 152,000 members. You might say, "Well, what am I really going to talk about?" One of the questions that I had when I was thinking about this was, could an LTC provider and a health plan collaborate? I think all of us could say yes to that; but could it be a win-win situation? What I'd like you to do is come away with your own conclusions about whether or not this could be a win-win situation.

Jill mentioned about the CCRC and I thought what I would do before I talk specifically about Senior Care Blue is talk a little bit about what's going on in the nation. There are four cornerstones of care management; resident, family, and provider education, preventative health and advance directives, chronic illness management, and acute illness management.

One of the participants stated that they had a relative that was in four CCRCs; I was wondering if perhaps part of the issue may had been that nobody really identified what the goals were for your relative or what he wanted for care. Clearly, there are a lot of different issues, so I think resident, family, and provider education is key.

We talked about the management of chronic illness and acute illness without fragmenting the care of the older adult. Now, those of us who have older relatives or who have a background in health care know that for a long time we have always proposed that these are the cornerstones. But finally, the health plans in managed care are coming around to recognize that these truly are the cornerstones.

Of the population-based models that are out there the Evercare Model may be one of the best known. The Evercare Model actually started with about 1,000 members. It's up to 15,000 members in 8 different states and they use a nurse practitioner physician team model. It's by United Health Care. The Fallon Organization is a little different, it's in Massachusetts, and this is actually where the physicians take risks for these members that are in this Medicare/HMO, and working together with a nurse practitioner team. The Fairview Program is sort of a hybrid. I didn't want to go into a lot of details about these programs, but what I wanted to share with you is that all three of these programs used the team approach, nurse practitioner and medical doctor. They were not in a CCRC as far as I am aware of, but they have shown that these individuals in these homes have less feeding tubes, more of their pneumonias can be taken care of in the nursing home without being transferred to the hospital. There is a much higher likelihood that these members have advanced care planning or advanced directives completed. Not only did they do that, but also they've been successful with utilization. Patients in the Evercare Nursing Home in Boston had a marked decrease in their hospital admit rate and no change in their mortality rate.

Now, what about the HMOs? There have been some studies that looked at the HMOs. One study found that the average sized HMO had about 25,000 members. The number of members who were in the LTC facility ranged from about 145 to 400. What they found was that they had more primary care, and that there was a potential to reduce emergency room visits.

Chad Bolt, who's done a lot of writing about geriatric care from Minnesota wrote an editorial saying LTC is in its infancy, basically saying that you couldn't make definite conclusions from this, but it appeared that with this nurse practitioner-M.D. team, that there's more education of the nursing staff, there is more primary care and there are advantages.

Ms. Krueger: Judy, can I just interject? What's she saying is so important for everyone to understand. A nursing home is not a nursing home, is not a nursing home, and that the competency level of the nurses is so critical to the quality of care and the ability to really manage care. Nurses are very hard to come by. Directors of nursing are even harder to come by. There is a lack of management skills in terms of the nursing department, so a good strong nursing staff with a nurse practitioner physician can do amazing things.

Dr. Black: I was reading *The Journal of American Geriatrics Society* which looked at a continuing care community in the Los Angeles area, and again it was a nurse practitioner-M.D. team that was able to save costs. An interesting part about this particular article was that they had like two control groups. They had 700 patients, 400 in one and 300 in another and where they had the geriatrition model, and they significantly charged a lot more money. But if the provider would have been capitated for those members for a year, it looked like the annual risk pool would be about $9.1 million positive. There is a great opportunity as we look at CCRCs in the future.

Why should we establish a care management program for the frail elderly? Some of you already alluded to this. First of all, it's high cost. We need to reduce medical costs and we need to improve the quality. About 3.1% of Security Blue membership (152,000 members) now are in an institution, and 6% of Security Blue medical costs are for these institutionalized members. There's no question that for Security Blue, these members are more costly than our other members. Not only that, if you look at the revenues, the care costs are 26% higher than the revenue for those members in skilled nursing facilities. For personal care it's even more dramatic, 88% higher than the revenue.

When Highmark got into this Medicare HMO market in 1996 they decided that they really needed to do something innovative for care for our elderly. Senior Management went out to Minnesota and looked at the Evercare Model and the Optage Model, came back and realized our network has 205 nursing facility contracts, 62 hospitals, 2,400 primary care physicians (PCPs), and 6,000 specialists so we knew that we could not do like an Evercare or Optage Model with a closed network.

We had to come up with another model. We created the Senior Care Blue Model. The reason to this was to improve the care to the frail elderly, contain the medical costs, and partner with an insurance and LTC industry. For once, the health plan recognized that they had no expertise in LTC, which they needed a partner who did. We partnered with a LTC facility called Presbyterian Senior Care, bid on several nursing homes and assisted living, and also happens to be the same group that Jill is consulting with in Pittsburgh, to help us develop this program.

Our goals for this program were basically the same as the goals that Jill has talked about for the CCRC and the ones that were emphasized as the four cornerstones in managed care.

What about our population? When the program first started, we had 3,000 members and presently we have 4,000 members. Initially, only 30% of our members were in skilled nursing facilities (SNFs), now they're 48%, and our average age is getting older.

What the program is doing is focusing on case managing. There are 13 case managers who work with the LTC facilities and collaborate with the physician and nurse team. They are looking at outcome focused model to create communications. If something goes awry, for example (low immunization rates at one facility) there can be an intervention with that facility through the physician and nurse team.

Finally, we have a program called Elevated Level of Care. It provides incentives to the facilities to keep the member at that facility. For example, if a member develops congestive heart failure and is managed at the facility, the facility can get a higher per-diem rate for the elevated level of care. Now I mentioned, we had 205 contracts. We only offer Elevated Level of Care at 20 of the facilities. What we wanted to make sure of was that the facilities really could manage these acute conditions appropriately so Elevated Level of Care is not offered to all of our facilities.

Ms. Krueger: Certain facilities decide to specialize in this Elevated Level of Care and really make an effort to attract higher competency-type nurses. For nurses who can handle the higher acuity along with that goes an incentive, a higher payment.

Dr. Black: Key to that is having a physician who comes there regularly to work with that team so that they can assess that patient the next day after the patient is kept at that facility.

Ms. Kruger: That's a good point. What Denise and I have found, in our facilities that are trying to take on the higher acuity patient, and are trying to avoid hospital re-admissions or ER visits, the physician is so critical. If they're there everyday, it's amazing what can be done. We see huge overutilization, for example, of medication, simply because of the inability to discontinue them when the physician gets in only once a week. The patient could have been off an IV on day two but instead he or she is off on day eight, because the physician only comes once every seven days.

Dr. Black: Or even worse, if the patient has a side effect from the medication, the physicians called, and over the phone gives another medication to treat the side effect of a medication.

Ms. Kruger: That's what happens.

Dr. Black: The Senior Care Blue started back in 1998. In 1999 we looked at the program critically because it was supposed to get a two-to-one return on investment on this joint liability company that was created. We didn't get that two-to-one return, but we did contain medical costs in comparison to our other Security Blue members and we really had a proactive approach with providers. They really liked this because now they had the case manager on site, they weren't calling downtown and being put on hold on the telephone forever, so the providers received it very well.

But we knew we had to refocus. In 2000 there has been about a 6% incidence of gastrointestinal bleeds. There are six preventable diseases which account for almost half of the in-patient days so this is the area that we need to focus on in preventing those re-admissions to the hospital and doing a better job of managing.

We decided that we really wanted to put a push to educate members and families about LTC: what to expect, what are their goals, to make sure everyone was in sync. Our PCPs are capitated. They also get fee-for-service for visiting patients in nursing homes. Many of them didn't know that. We went out to educate the PCPs. To remind them that yes, you can get fee for service for seeing your patients in the nursing homes. We're also trying to encourage a SNFs concept, where there are certain physicians that really focus and caring for patients in the nursing homes.

We have this enhanced care management along the continuum, and we have the physician identified at each of those facilities that we're working closely with. We've now targeted 50 of the 205 facilities to work closely with. There's a nurse team leader and a Senior Care Blue case manager who work together as a team to enhance the care along the continuum. We have found for those facilities that are continuing care communities that this works much better for us. They have an invested interest in working with us; that has been one of our most positive experiences when we have that team at a CCRC. With that we're going to turn it over to Denise who's going to talk about the geriatric care management program that we're utilizing which was an important part of our refocusing strategy.

Ms. Krueger: Let me just add that the big missing link between what Judy was talking about in terms of all the four cornerstones of care management and what I stated, was basically being able to prove that what they're doing makes a difference and prove it on a timely basis. What we decided in working together intensely over the last year was that it was data and information that was going to connect the dots and that's really where the geriatric care management of the Senior Health Information System comes in.

Ms. Denise Wassenaar: I have to say this is my first time speaking in front of all the "numbers" people. I always get to speak in front of all clinical people so this is kind of fun. I think it really represents how we should be looking at information. Typically we look at it at a patient level and that would be looking at the individual person when they're within a facility and that can be within the total continuum of care, assisted living, the independent living, and the skilled nursing.

When you start looking at the facility information, it's important to look at how the facility is doing as a whole, and that's typically where it stops in our industry. Facilities look at themselves, except those that might be part of a major organization that has multi-facilities. We're attempting to get the information assessed at the network level, which would be looking at a broader scope than just looking at themselves. Because if you look at, for example, your ER utilization as yourself, you might think it's okay and even if you compare it over time, you have nothing to really compare it to. I'll tell you having been in this industry for a number of years, those that practice within the LTC setting are unaccustomed to looking at numbers outside of their own facilities. This is something that's new to the population.

Lastly, I will describe outcome information at the industry level. Unfortunately, our industry doesn't have a lot of numbers to look at, at this particular level. The areas that we concentrate on are, as Judy had mentioned, advanced directives. We're looking at immunization rates and the reason that there's such a focus on immunization is, of course, to keep the elderly healthy, to prevent hospitalizations and this is a big initiative of the healthy people 2010. We're currently collecting information on that. What sometimes puts us at a difficult juncture is where the Health Care Financing Administration (HCFA) is. It hasn't quite figured out how to collect immunization information. So everyone is immunizing everyone but we don't have anyway to collect information on the efficacy of that initiative. That's what we're hoping to do with some of the things that we're collecting information on. I've been working with trying to get a grant from HCFA, and found that it just takes too long and it doesn't really want to look at anything out of the box. A real challenge for us in the future could be to get industry standards.

The Geriatric Care Management System was developed approximately three to four years ago, and as with any system, it's a process and evolution. We're continuously finding ways to improve it primarily with the assistance of the Senior Care Blue group in Pittsburgh. They're giving us a really good perspective on what providers are looking for as we collect information. Again, the only standardized information that is currently being collected for the senior population is in home health with the Outcome and Assessment Information Set (OASIS) and in skilled nursing with the Minimum Data Set (MDS). There is no requirement for any type of standardization, specifically, in assisted living or independent living. The information that's currently being collected, is through your insurance companies, which would be claim information, and that which is required on both the OASIS and the MDS. Outside of that, there isn't much.

As you know from dealing with numbers (it's one thing I do like about numbers), it's a real tangible thing. If you don't have a standard way of collecting information or to do formulas, you don't get good output information. What goes in as garbage comes out as garbage. It's really hard to draw any conclusions from information that is not standardized in some way. As mentioned, it was developed over four years and we did include all representatives from the senior care market so that we would be designing a system that would be meeting their needs and not just our needs. The focus of the system looks at efficiency and effectiveness.

Again, not to bad mouth the industry that we work in, but there hasn't been any incentive to be effective or to measure efficiency. With Medicare, they got paid for whatever they did, so there wasn't any incentive for being efficient. From a private-pay perspective, there has never been any type of accountability for the industry itself. I would say recently that accountability is increasing because of the consumer knowledge that's currently available.

We're also looking at the effectiveness. I've worked with many nurses and physicians who do not want to change things because it's the way they've always done it. Even though the research says, "Oh, this is a great way to do things," they don't want to change the methodology of practicing medicine or health care. Until we can give measurements back to show that something is more effective than the way they use to do it, they will continue to do things the way that they did before. Again, the only way to show that is through good information. What we're looking at is again looking at a standardized way to present our output information. Currently, the standard methodology would be using the International Classification of Diseases-9th Revision (ICD-9) codes, which are specific for skilled nursing. We don't get into diagnostic-related groups because those aren't used in skilled nursing. Those are only acute care based. The common procedural terminology codes are the physician codes, but with the HIPAA rules, we're looking at doing the same standardization of information as what's required under HIPAA.

The other difference between our system and some that are currently in place is that this provides real time data. You're able to generate a report based on what's happening now rather than looking at information retrospectively. Going back to those two instruments that I mentioned before, the OASIS and the MDS, those are both retrospective reviews and that's something completed over time. What we realized is that if you're really going to be managing care, you have to know what's happening now. It doesn't help to know what happened maybe a month or two ago and then go back and try to change it. We need to know what happens now.

I tend to be a very objective person. Maybe I should have been with numbers rather than the clinical. Clinical tends to be very subjective. Subjective is what you tell me. The objective information doesn't lie. When we take a temperature, we know what the temperature is. Our system is based on very objective, measurable information and it's very outcome focused and some of it is clinical, some of it is financial. We're getting into the financial piece, as Jill will probably attest with me, historically it's been very difficult to capture actual costs of care. Everybody knows what they charge and I know the revenue, but it's really hard to get at that cost per day.

Ms. Krueger: Let me just interject on that. Our unit cost is so simple. Our field of LTC senior care is not rocket science. I mean a unit cost of a nurse or a food service or a housekeeping department, what's really critical is the utilization. Basically, what types of drugs are being used and why and how does that blend with the co-morbidities of the patient and that type of thing, so the focus here is really away from the cost. If you have a unit cost, there's really no mystery to that. It's just basically how are we treating the individual patient based on the specific diagnosis and the co-morbidity.

Ms. Wassenaar: These are some of the reports that we currently generate from the information that we receive from all of the facilities that use the system and those that also are in the Pittsburgh area.

We can look at number of admits per facility. Right now, we're focusing on the residents with immunization and what will be unique with us is that we will be able to track re-hospitalization rates. We will be able to measure the efficacy of immunizing everyone because it's a very costly endeavor, and as you know, right now we're dealing with a major shortage of the flu vaccine. The research that I've been reading is that sometimes it doesn't support immunizing those that are over 85 years old, that they don't have the immune system to respond to the antibiotics so that hasn't been really tested well because we don't have the information. We're looking at how many people end up in the hospital even though they've been vaccinated.

The residents with advanced directives. Again, looking at those that have done planning for the future, and that's a scary topic that a lot of the elderly don't want to go into primarily because sometimes of the family perspectives. We're really looking at educating on advanced directives. One area that we focused on is therapeutic utilization. Again, government has paid for therapy for all their Medicare population in skilled facilities, however, they have never requested any type of accountability for how well they did. Everyone gets paid for the therapy amount under a particular Resource Utilization Group (RUGS) category, but there's no way to measure what happened as a result of that. Also, there's no standard out there for how much therapy should be given for a particular diagnosis and it's been pretty much whatever they've experienced in the past.

The other thing that we're looking at is medication utilization and the efficacy of that. We're seeing an over utilization of antibiotics, some of the H2 antagonists which would be the anti-ulcer drugs. One example that we found is that there was a 32% overutilization of the anti-ulcer drugs in our facilities resulting in a net of about $1.4 million that could have been decreased with just proper management of medications.

I'm also looking at average length of stay within the Medicare units. But these are all different reports that can be generated from the information system.

Ms. Krueger: One of my favorites was that physician practice pattern we did about three years ago. It was manual before we had the electronic system, looking at medications per patient in our 40 facilities. Basically, we knew that the average medication per patient is about six to eight. When we ran our population, which was an older population, we were running I think, almost eight. We were at the high end of the average. Interestingly enough, we had two very savvy managed care physicians that were running 3.52 and 3.53 medications average per person and their hospital days per thousand were lower than any other physician in the survey. We probably had 50 or 60.

We had a pocket of physicians in the northwest suburbs with average medication per patient 18 to 22, and they were all kind of in a pocket. Now, you can't take this

information and go to your doctor and say, "You're an idiot, why are you doing this?" But you can certainly ask, "why?" Because demographically, those facilities were no different than any other facility. Imagine the average prescription cost is about $25 per month. If I'm on 20 of those and I need to be on 5, I could probably cure the Medicare deficit just on over utilization of medication, so it's a big deal.

Ms. Wassenaar: It's typical with HCFA. I believe in paying for prescriptions for the senior population because it is such a private population, however, we really should be looking at how many medications it is getting simultaneously.

I just want to focus on two tools that I didn't discuss before which would be the acuity tool and the continuum tool. These were both designed through the HRA and research tested. The acuity tool actually measures nursing hours per patient day based on services needed and again, the federal government had requested that the RUGS system be used for measuring acuity within skilled facilities. However, as you know the RUGS system was developed for a Medicare reimbursement system, and doesn't translate necessarily into an acuity system. We do have in place now an acuity system that we can actually get how many hours per patient day, how much does it really cost and then translate that to cost per day for the skilled facilities.

Ms. Krueger: Talk about the acuity on the Medicare unit being lower than the acuity on the custodial unit.

Ms. Wassenaar: I did a consulting job for one of our big CCRCs and we looked primarily at the skilled facility and it was the perception of the administration that Medicare acuity is higher than your custodial and the numbers did not support that at all. In fact, the Medicare unit was lightest out of the skilled facility. The Medicare population themselves is not complex that resides in a skilled facility. The complexity of the Medicare population lies in the documentation requirements mandated by the federal government. It wasn't that hours-per-patient day were not being spent on direct care, they were being spent on non-direct care and the numbers supported that.

What we really found that was interesting is that the special care unit, those with Alzheimer's was the most acute out of the facility. Of course, that acuity increased at nighttime because with Alzheimer's their cognitive level definitely decreases in the evening time. It increased the nursing hours-per-patient day. The perception many times of the administrators is that with Alzheimer's patients, because they're up and about and they're in a confined unit, they don't need as much as care as the Medicare unit, so most of the resources are driven towards the Medicare unit when in fact most of the resources are utilized on the custodial population that is are really frail, activities-of-daily-living (ADL) dependent, tube feeders, and cognitively impaired. They by far had the highest acuity that requires the most staff time. It was good to have an instrument that was valid and reliable. It's been research tested for three years and really did demonstrate through numbers what the actual acuity was within the facility rather than being, the subjective information of, "Oh, I think the acuity is going higher." When you challenge someone to say how you

can define acuity, you find that again there are just variations of how it can be defined.

Another area that really focused us into developing the continuum scale is the subjectivity of staff moving someone from independent living, assisted living, and skilled nursing. From a LTC insurance perspective where there is a defined payment for each of those levels, my concern is always on who's making that decision? and how is that decision being made? This particular instrument takes a finite amount of information and translates it into a score that determines or at least gives an objective perspective of where someone should be within a continuum of care based on their financial ability and the abilities of the facilities to provide that care. I can tell you from researching it for the last four years that there isn't an instrument out there that will collectively give you that type of information. It just doesn't exist. Maybe in the future more will be developed, but right now there's not an objective way to determine whether someone should be in one level of care versus the other.

Ms. Krueger: We started with maybe 20 facilities at the beginning, they all had six levels of care. That was the good news. They had the independent, maybe two levels of assisted, two levels of skilled; the high acuity was the good news. The bad news is none of them were the same, so we were basically at 180 levels of care. I said, "I don't think managed care is going to negotiate 180 rates," and in fact, they weren't.

That's really when we set out to be able to put people in buckets, but we had to do it without a license and without walls. It was based on what services they need, then the facility determines where they go, what walls they get surrounded by. But what happens in CCRCs is the aging and place phenomenon where the nurses and caregivers don't want to move people from one level because it's traumatic. Instead, they keep providing more services to them where they are, but then they can't go to the families and say, "We need you to pay more money," because the family would say, "Well, they're still in the independent living." Basically, this gave us objectivity to say, "Your mother's condition has changed from a "14 to a 22." We can leave her here but these are all of the additional services that she requires." So now you're more appropriately matching the utilization of the service and the cost.

Ms. Wassenaar: What I found in my experience is that when a decision's been made to move someone from one level of care to the other, particularly independent to assisted living, it's based on the determination of that nursing staff and the facility. I've seen many residents that had to be transferred because they didn't have the right personality and they had the same difficulty of someone else who had a great personality. A lot of times a decision is not made on doing so many ADLs or what their cognitive level is. It's like, "Oh, we really like them." One physician looked at my tool and said, "Oh, this is great. This is what I've been looking for." He's a medical director of a big CCRC and he said, "but you didn't allow for persona," and I said "I controlled for persona, because persona is the difficult part". It causes a lot of problems when decisions are based on personality and whether they like the family or not. This did provide objectivity to facilities on

helping to make that decision. The other components of it are just support documents that will help facilities maybe provide the care in more clinical fashion.

The benefits of the reports are being able to look at case mix, pricing, staffing patterns, and physician practice patterns. I am really amazed that the federal government did not put anything on the MDS or the OASIS that would identify physicians and how they practice. On the MDS alone, you have 666 items that are being captured and not one of those can be tied back to a physician. They look at how many medicines are being ordered, what type of therapy, and how many visits the physician makes, but there is no way to go back and identify which physicians are good and which physicians may not be practicing within standards. We can do that though.

Ms. Krueger: When we get back to product differentiation and sophistication, let me tell you physicians make a huge difference in our facilities. A good physician or a good medical director is going to make or break our facilities, particularly, as we seek to attract more of the higher acuity patients.

Ms. Wassenaar: We can definitely tell the difference in our facilities that the physicians are committed to and Judy will probably attest to that also. The commitment to the facilities translates into quality care. I mean there are no doubts about it, we have the data to support that.

Looking at clinical outcomes. We can look at re-hospitalizations, lengths of stay, ER visits, and as I mentioned before, we really use the ICD-9 code as our basis for all the stratification of the information.

Dr. Black: As you can gather, we were really excited with Senior Care Blue when we learned about HRA tool and how to work with them and we actually started using the tool in March 2000. Some of the things that we found one were that some of our facilities have over 25% incidence of wounds. It automatically was a marker that goes to the Senior Care Blue case manager, the nurse team leader, and the physician leader from that facility to look at their institutions. Maybe those wounds were appropriate but maybe they weren't. Even more distressing, particularly for those who have experience with the frail elderly, one of the facilities had a 66% incidence of tube feedings. Now, tube feedings at the end of life does nothing to prolong life, and actually can be associated with a lot of complications. It was a big red flag for us to go back and look to see whether this is appropriate or not.

We also looked at advance care directives. About 55% overall had advance directives. So far we've been very pleased with the information. Part of the challenge has been making sure we get it all collected appropriately.

What are the opportunities for Senior Care Blue for the coming year? First, advance directive planning or advance care planning. It's not enough to have a living will that says if "I am terminally ill, I don't want anything or I want everything." We need to know who's making the decisions and what are the goals for the care that lets the patient or the families understand the problems, where's

the nursing staff, and come together as a team to put together the plan with the member. We need what we call an activated patient family that's informed and we need a care team working together.

Second, Denise has already alluded to the re-emphasis on immunization and the third is the management of congestive heart failure. We looked at claims cost and what we found was really staggering. As I mentioned, we now have 4,000 members in this program. These are people who have been in a nursing home for more than 30 days or had lived in personal care, 1,600 of them have a primary or secondary diagnosis of congestive heart failure (CHF). Those individuals who are in personal care cost 2.7 times the cost of those individuals in personal care who do not have CHF. If you're in a nursing home and you have CHF, the cost is 2.6 times the cost of members who are in a nursing home who do not have CHF. Now, you can say does that mean the challenge here is when you have that diagnosis of CHF that really is more a marker of frailty. It tells you, "Yes, these patients are going to have a lot of claims costs." What it doesn't tell you is exactly what services do these members need. That's our challenge as we move forward.

We also looked at a scorecard comparison study before Senior Care Blue and after Senior Care Blue. So they looked at members the years before they enrolled in Senior Care Blue, they looked at approximately 1,000 members. This was done by the Graduate School of Public Health and what they found was that there was some decrease in costs, and looking at the quality of life and access, the numbers were very, very small but the findings did suggest that Senior Care Blue, the managed care did not impact negatively on quality of life or health status. It may have actually facilitated access to care. That was sort of exciting for us.

How are we measuring the success? Well, first of all is reducing overall costs per member, per month. Now, in order to do that requires that we pay physicians more. We need to have more physicians going to the nursing home and doing primary care in the nursing home so that we can reduce hospitalizations. The part of the reason for that is shown in Table 1, and actually Gary helped us with this. In the Milliman & Robertson moderately managed bed days per 1,000, you could look at where we were in December 1999 and you may wonder how we're still in business. Part of that is we have very good rates with our contracting, but you know contracting can only go so far. We do need to keep moving forward on those areas of the opportunities.

TABLE 1
COMPARISON DATA OF BEDS DAYS PER 1,000

	December 1999	**Milliman & Robertson**
SNF		
Acute	5,500	3,784
Skilled	23,000	19,430
PCH		
Acute	6,261	3,293
Skilled	3,958	3,958

Critical success factors. Your comment earlier about how to take care of the frail elderly requires a commitment that this is a team approach, that there is communication, that there's timely feedback of information and that's how we're going to be successful. Yes, we can be successful in taking care of the frail elderly, but the question that I asked at the beginning is, can a health plan and a LTC provider have a joint venture that's a win, win? There have been challenges. First, there was a limited amount of money put up at the beginning for this joint venture by the LTC facility and Highmark, which has billions of dollars of reserve appropriately put up most of the money. It foots all of the administrative costs appropriately. You may ask and Highmark may come back and say, "Well, why should we continue this partnership?" I think there's a lot of value in continuing to have credibility by working with an LTC and their expertise continues to be of value to us as we move forward.

I'm going to turn it back over to Jill for other challenges, but I want to share this with you. There is a 90-year-old woman who was about 80 when I first met her. She was living at home and she was an environmentalist and loved to collect things. Her rooms had boxes to the ceiling, but she was becoming confused. She came in for a geriatric assessment at St. Margaret's where I was working at the time. She had no family in the area. She had a lawyer and a caretaker who lived in a house on her property who were taking care of her. We were able to keep her in her own home for a number of years until the point of time where she would tell her friend who lived in this house, who was about 68 at the time, "I need to go home". She no longer recognized her home. He would take her in the car and drive her around and then take her back to her home and then she'd be okay. But what happened to her was she developed pain with a compression fracture and ended up in the hospital. She went to a CCRC nursing home for a while and then ended up in personal care, actually at the LTC facility that we have our partnership with. She subsequently developed pneumonia and ended up in the hospital. She had an advance directive that said she didn't want a respirator and she didn't want a lot of intensive care and she had a very severe pneumonia. She had a sister that lived out of town that was requiring that everything be done, including a ventilator if she needed it. There were a lot of issues to work through and I'm happy to report that she went back to the nursing home, the skilled facility, very weak, on oxygen but has recovered enough that she is now back in her personal care home doing relatively well. The issues with the advanced directives have been worked through. This is just the success story that I wanted to share with you because all of us are going to be this age someday.

Ms. Krueger: In summary, we talked a lot today about all the different levels of care, the continuum. We focused a lot on the skilled nursing because that's where a lot of the inefficiencies and dollars are, but I really think there are two keys to success. It goes back all the way into the independent side and being a frail elderly person. One key is this whole teamwork concept that Judy spoke of. The team not only involves the physician, nurse practitioner, and the care management, but the pharmacists, therapists, and the family, and just being able to communicate.

What I found from working with these two geriatric specialists is that as we get older, our health problems are not simple. They're not just physical. They're social

and there are a lot of different things going on. We need all the team members to be involved in the care planning and I even missed the social component. But secondly, it's just being smarter and more sophisticated, recognizing the issues as they arise so that we can react appropriately and make sure that the elderly people get the care they need, when they need it.

I think the whole information and data and all that is really going to lead us where we need to go. Unfortunately, the government isn't providing the resources that we need, but they're doing what they can do. Some of us that are out there on the cutting edge need to be persistent and keep going to try and make the payers understand that there is a lot to caring for the elderly. There's a lot of better ways to do things than we had in the past. There's a lot of room for improvements.