Recommendations for
Task Force on Health Planning Reform

The Place of Long Term Care in the
Health Planning Process of the Future

By
Dennis Bozzi, President of Life Services Network of Illinois
Pat Comstock, Executive Director of the Health Care Council of Illinois
David Voepel, Executive Director of the Illinois Health Care Association
Terry Sullivan, Executive Director of the Illinois Council on Long Term Care

The long term care associations of Illinois assembled a task force of key participants to work through our diverse opinions and concerns on matters prior to submitting this joint report. This long term care task force continues to function and offers our expertise and assistance as you begin the process of sifting through the hours and hours of information you have received and work toward your final recommended changes. Consequently you may consider this report a succinct Executive Overview

Since its inception, the primary focus for healthcare planning by the Illinois Health Facilities Planning Board has been centered on the hospital delivery system. The Planning Board rules and regulations are focused on hospital concerns, and the Certificate of Need application process is primarily developed based on hospital requirements. Nursing homes have been faced with trying to fit themselves into a system that was never designed for them in the first place.

The long term care associations of Illinois have five conceptual recommendations for the role of nursing homes in the healthcare planning process based on our experience with Planning Board procedures of the past thirty years, our understanding of the realities of today's healthcare delivery system, and our studied projection of how the senior care marketplace may evolve.

Our first recommendation is the primary structural recommendation, from which the other four naturally flow.

Recommendation #1:

Recognizing the significant differences between the hospital and nursing home delivery systems, nursing homes should be separate from the hospital planning process.

Nursing homes should either have a separate, simpler Planning Act, with a board and staff knowledgeable in long term care. Additional, we would recommend a more concise set of regulations and a clearer Certificate of Need application and approval process. At the very least, an alternative structure may be for long term care to have its own separate long term care sub-committee under the current CON structure.

We also recommend a three-year transition study under the reformed planning board process to carefully evaluate whether long term care needs to be part of the current planning process at all.

The healthcare market place for the elderly and disabled in Illinois is very different than the market for hospitals. The delivery system for nursing homes is more straightforward and less complicated than hospitals. The organizational, financial and ownership structure for nursing homes is much simpler and less multi-faceted than that of hospitals. The opening, closing, expansion, modernization or change of ownership of a nursing home has far less impact upon the overall healthcare delivery system of an area than that of a hospital.

Consequently, the planning board regulations needed for hospitals are far more complex than those needed for nursing homes, but nursing homes have had to comply with all of these regulations.

This “one size fits all” approach to planning set off the chain of events we have in place today. We have a single Certificate of Need application process when requirements for some projects are far more detailed than others.

The organizational structure and financing of hospitals is a far more complicated process than those of nursing homes, but nursing homes have had to comply with the same review criteria.

By a law meant for hospitals, nursing homes must also file an annual capital expenditure report for projects over one million dollars. No nursing home meets this standard, as even Planning Board staff acknowledges, but every year, the Planning Board requires 1,000 Illinois nursing homes to file a useless capital expenditure report.

Evaluations of nursing home applications are made by Health Facilities Planning staff with more experience in hospital environments. Decisions about nursing home applications are made by a Planning Board with no expertise in post-acute care, senior care alternatives, or the ever-evolving senior services marketplace.

Medicaid reimbursement rates for nursing homes have made it difficult for long term care facilities to renovate their buildings. The expansion of home and community-based services has impacted facility census. Market forces make it critical for nursing homes to retool, renovate and reinvent themselves for the care they will deliver in the future.

It is time that the healthcare planning process for nursing homes include people sensitive to the unique nature of the services provided in our facilities. It is time that the long term care Certificate of Need application process to be evaluated by people who have a broad understanding of the unique, dynamic and emerging voice of the senior care marketplace.

At the very least, if a separate planning process for long term care is not feasible, there should be at least two long term care representatives on a reconstituted planning board. In whatever format, the planning board should reinstitute the long term care sub-committee composed of association representatives to restore regular communication between the planning board and the long term care profession.

It is our hope that establishing a separate board, or at the very least a long term care sub-committee, to deal specifically with long term care projects will streamline the process and make meetings more focused on specific kinds of projects. Fewer meetings would be required for the long term care segment of the planning process. This separation from the hospital planning process over the next three years will more clearly determine whether, in fact, long term care facilities in fact need to be part of a formal planning process at all.

Recommendation #2:

The Older Adult Services Act encourages the replacement, modernization, conversion or service changes of existing long term care beds to better serve a more sophisticated consumer marketplace.

Projects under the capital expenditure threshold (currently $8.8 million) that involve no increase in beds are already subject to extensive project review through the Public Health licensure process and do not need to be duplicated by the planning board.

Projects over the capital expenditure threshold that involve no increase in beds should be subject to a streamlined CON review process (within sixty days). There should be no occupancy requirements for modernization.

Long term care in Illinois is supported by an aging infrastructure that no longer adequately reflects the latest in national safety codes, technology or the expanding expectations of an educated consumer. A revolution in our understanding of the impact that the environment has on a person's recovery, independence, and mental outlook is taking place. Original federal architectural standards from fifty years ago that required nursing homes to be built to look like institutional "mini-hospitals" are being replaced by smaller, greener, person-centered care environments that create a more home-like environment.

Under the Illinois Older Adults Services Act, the state's public policy encourages the regeneration and conversion of older nursing home buildings. The Health Facilities Planning process should facilitate that, not put red tape and roadblocks in front of modernization. Where there is no increase in beds and the project is under the capital expenditure threshold, the current IDPH licensure architectural review process should be sufficient oversight. A duplicative CON process is an unnecessary road block to state mandated modernization. For similar projects over the capital expenditure threshold, the application process for modernization of a nursing home does not need to be as detailed and microscopic as when building a brand new facility or adding beds. This application should be simplified and the decision process streamlined.

Past occupancy history is a relevant issue when a facility is proposing an expansion of beds, but the current standard of requiring a historical 90% occupancy is irrelevant to the purpose of modernization. A facility often drops below 90% occupancy because there are other more modern facilities to choose from. In this case, the regulation actually prohibits modernization. In addition to improving the residents' privacy and quality of life, converting a low occupancy facility to private rooms may, in fact, be an astute business decision reflecting market trends and consumer choice.

Recommendation #3:

The square footage maximums for long term care bedrooms and cost per square foot caps should be eliminated to reflect consumer-driven market trends.

The current square footage maximums were mandated more than thirty years ago at a time when the institutional model was encouraged. Multiple occupancy rooms were the standard. In recent years, we have seen the benefits of single beds rooms in reducing infection rates, improving recovery times and increasing physical and emotional well-being. The average assisted living apartment already exceeds the maximum allowable space for nursing home rooms, allowing little opportunity to satisfy consumer preference for larger and more private living space. The concept of maximum square footage and maximum cost per square foot is outdated and should be eliminated. Let the sophisticated healthcare consumer in the marketplace dictate the size of their living space.

Recommendation #4:

As in five other states, facilities should be able to buy or sell existing excess CON and license capacity and relocate those beds from one facility to another within the planning area or market area where the beds being sold.

In just about all the planning areas in Illinois it is almost impossible to build a new facility because of the calculated bed need formula. At the same time an average of 20% of all long term care beds in Illinois go unoccupied. However, facility managers are unwilling to downsize unoccupied beds or give up licensed capacity due, in part, to the equity investment in a certificate of need. Downsizing a certificate of need reduces the potential of selling the facility at the original investment, which is based

on the number of beds in the facility. A facility that was bought at 100 beds and then sold at 80 beds has lost 20% of its value.

If, however, as in five other states, facilities are allowed to sell part of their investment in beds to someone else in the area, downsizing makes good business sense for everyone involved. A facility with unused beds can "sell" them and then have the resources to modernize and convert that space from used beds to more private space for residents or greater senior service resources for the community. Unused beds will be closed or converted and newer facilities that address consumer needs and preferences can be built, without any expansion or increase of the overall existing pool of beds in an area. This is a logical market-driven alternative already proven to work.

In Illinois any such approach should also consider the unique differences of the Continuing Care Retirement Communities (CCRCs) in how they affect the healthcare marketplace.

Recommendation #5:

The current bed-need formula for long term care based solely on demographics is outdated and not reflective of the rapidly changing and innovative variety of senior services that did not exist thirty years ago. Two possible scenarios would be a significant improvement over the current system:

- **The development of a comprehensive utilization determination process that reflects the contemporary community-based approaches to senior and disability services, the increasing short-stay turnover in skilled facilities, the state-supported encouragement of innovative trends in consumer choice, and senior residential alternatives such as Assisted Living, Supportive Living Facilities and Continuing Care Retirement Communities; or**

- **Rather than a complicated bed need formula, let current nursing home occupancy in the marketplace and consumer need dictate the future expansion of long term care beds.**

When the bed need formula for nursing homes was first developed thirty years ago, it was an entirely different healthcare environment. Nursing homes were the primary, if not the only, senior care service program in an area. Since the 1980's we have seen an explosion of home care and community services, the dramatic expansion of assisted and supportive living, and the unique, integrated approach of Continuing Care Retirements Centers. These healthcare and residential alternatives to nursing home care have significantly influenced nursing home occupancy in the past fifteen years. Additionally, there has been a tremendous shift in the type of clientele in skilled facilities today. With hospitals seeking earlier discharges, skilled facilities have naturally become a valued resource in the marketplace for short-term stays. Post acute care utilization of skilled bed is not currently within the bed need formula.

A bed need formula based only static demographic data does not and cannot reflect a very fluid healthcare marketplace for senior services, the dramatic development of innovative approaches for senior living, or the need for some of the medically complex specialty services offered in today's skilled nursing facilities.

The bed need formula for nursing homes should be updated annually. At one point the bed need formula for nursing homes had not been updated in over eight years. We cannot be making planning decisions for today's rapidly changing marketplace based on old and irrelevant data.

All these changes in the continuum of senior services has had an impact on the occupancy of nursing facilities. Regardless of the analysis of demographics and services, in reality, the average nursing facility occupancy in a planning area is a measurable marketplace benchmark of whether additional beds are needed. An alternative possibility to a bed need formula is a model similar to Missouri that assesses the marketplace need for additional beds based on average occupancy of facilities in the planning area.

The Older Adult Services Act requires the Department of Public Health to work with the long term care profession to revise the bed need calculation. This Act was signed in 2004 and to date this work has not been a priority.

Conclusion:

The planning process for long term care should reflect the new realities of senior care, consumer preference, and the senior marketplace.

With these recommendations, we can help modernize the senior services delivery system in Illinois to reflect rapidly developing and changing trends in demographics and consumer choice.

With these recommendations, we can have a planning process for long term care overseen by a planning board and staff with more than a superficial knowledge of the post-acute marketplace.

With these recommendations, we can have clear, efficient, focused and concise Certificate of Need application and approval process that accomplishes the planning goals for senior services already enunciated in Illinois Older Adults Services Act.

Just as hospitals, nursing homes provide their own unique set of services and we should have a separate planning process that reflects that.