

MODELS FOR INTEGRATING AND MANAGING ACUTE AND LONG TERM CARE SERVICES IN RURAL AREAS

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EXECUTIVE SUMMARY

INTRODUCTION

Post-acute and long term care services for older persons and persons with serious disabilities are responsible for an ever-larger share of the costs of the Medicare and Medicaid programs. The need to control demand and expenditures has led states and the federal government to seek new managed care strategies, such as capitated financing and coordinated case management, that integrate the financing and delivery of primary care, acute and long term care services. Integration and managed care are viewed as encouraging a substitution of less costly and more appropriate home and community-based services for high cost medical and long term care services which have been heavily funded under fee-for-service financing systems.

From a rural perspective, the development of organizational and delivery systems which better integrate and manage primary, acute and long term care services may help address long-standing problems of limited availability of and access to long term care services. Over the past decade, many rural hospitals have developed or acquired post-acute care services such as home health agencies and/or skilled nursing facilities as a strategy for managing their inpatient use and diversifying their revenue base. And some rural hospitals have ventured into the world of long term care as well, offering assisted living, adult day service programs, respite programs, or sponsoring meal sites for older persons. The growing involvement of rural hospitals in the post-acute and long term care services may provide important opportunities to develop more integrated acute and long term care systems in these communities. Notwithstanding the significant challenges, there are emerging examples of rural networks and managed long term care programs that offer important insights into the opportunities and challenges of using these approaches in rural settings.

This paper discusses the concept of integrated acute (medical) and long term care service networks, some of the model programs that have been demonstrated, the challenges that health care providers, state policymakers, and others have faced in developing these new integrated structures, and the future of integrated approaches in rural areas. The paper updates and expands upon key findings, insights, and conclusions from a recent study of several of these programs (Coburn et al. 1997).

WHY INTEGRATE?

Integration has become a paradigm for health care providers seeking to successfully compete in the rapidly expanding managed care marketplace. The pursuit

of integration has been premised on the assumption of both economic and clinical benefits. In theory, integrated models of financing and service delivery produce greater efficiency and cost savings (Shortell and Hull 1996). By bringing the various components of the health system together, it is presumed that integrated systems can achieve economies of scale and cost reductions in both administrative and clinical areas. In addition, better care management systems are expected to produce both cost savings through reductions in inappropriate care and improvements in the quality of care and outcomes (Gilles et al. 1993). For purchasers, including state Medicaid programs, integration of financing (Medicare and Medicaid) and service delivery (primary, acute and long term care) is seen as a way of aligning parts of the health system which, under fee-for-service payment arrangements, have tended to be cost-shifted from one payer to another. For consumers, integration is assumed to produce more convenient, accessible, and clinically effective systems by reducing the degree of service and system fragmentation that characterize much of the medical and long term care financing and delivery systems.

THE RURAL ISSUES AND QUESTIONS

Despite growing interest in integrated models of acute and long term care financing and service delivery, there are still relatively few operational examples of such programs to learn from. Rural models are even harder to find (Coburn et al. 1998). Nevertheless, the experience of selected program models in Arizona, Wisconsin, Illinois and other states, which are profiled in this paper, illustrate some of the critical issues that states and rural communities must consider as they contemplate ways of redesigning the financing and delivery of services to achieve better integration, access and quality. Although many of these issues can be characterized as “barriers” to integrated financing and service delivery approaches in rural areas, there are some which, based on the experience to date, may also represent opportunities.

Integration costs money: The development of integrated acute and long term care programs is expensive, requiring an intensive investment of capital and organizational leadership that is often lacking in rural areas (Kane, Illston, and Miller 1992). For example, it has been estimated that PACE programs require between \$1-1.5 million in start-up capital to cover the fixed costs of facility renovations and the initial operating losses that inevitable occur as the program moves to full enrollment (State Workgroup on PACE 1999). The development of the organizational, administrative and clinical systems needed to integrate and manage care, especially in a capitated or risk-based financing system, is well beyond the capacity of the average rural provider or health system.

Rural providers have limited managed care experience: Coupled with the problem of the large capital investments needed to develop these programs is the reality that most rural providers have had very limited experience with managed care and therefore are not likely to be inclined or prepared to participate in managed care programs for high risk, vulnerable populations such as the frail elderly.

Limited services and service delivery mechanisms in rural areas: To adequately address the complex health care and social support needs of frail, older persons, programs that seek to integrate acute and long term care services in rural areas must deal with the common service limitations in many rural areas. Access to specialty services, such as physical therapists, psychiatrists, and transportation is among the

most significant hurdles that must be overcome. The experience to date suggests that rural integrated programs are most likely to be developed through partnerships between rural medical and long term care service providers and larger organizations such as county health systems, hospitals, and/or managed care organizations. The model of urban-based providers reaching out into surrounding rural areas to establish local satellite programs is one that may fit in a number of rural areas. In this way, the rural sites may gain access to a broader range of specialty and other services than could be developed locally.

Rural means small: What are the advantages and disadvantages of the small population base of most rural areas? On the one hand, a small population base of most rural areas makes it difficult if not impossible to consider financing strategies that shift a substantial portion of the financial risk for health care use and costs to rural providers. The small numbers of beneficiaries, together with the unpredictable and volatile nature of health care needs and use in a small population (and especially with a population such as the frail elderly), make such strategies impractical. But there may also be some benefits of small population size that could be an advantage for rural communities and providers. In smaller communities where medical and long term care service providers are likely to know their clients and provider colleagues better, care management across systems may be easier to achieve than in urban settings. Moreover, in smaller communities, health and long term care providers must work together on a regular basis, which may make it possible to achieve cooperation more easily than in more complex organizational environments.

Aligning the incentives and professional culture: There are few incentives for communities, medical and long term care providers, or health plans to develop programs that integrate long term care into the continuum of primary and acute care services. The incentives for hospitals under the Medicare PPS and continued cost reimbursement of post-acute care (until the recent BBA changes) propelled hospitals and health systems to add home health care and, in some cases, skilled nursing facility care to their continuum of health services. Few have ventured into the arena of non-medical home care, residential care, and other long term care services, however. The primary reason is that there are few financial or other incentives for doing so. It is hard to overestimate the importance of state long term care policies in shaping the strategies that health plans and providers will take in forming service networks that better integrate the delivery of primary, acute, and long term care services.

Do organizational and ownership structure matter? The organizational structure differs significantly among integration initiatives and the experience to date suggests that structure may be important in facilitating the development of both functional and clinical integration, two critical, necessary conditions for effective managed care organizations. In rural areas, however, the problems that distance pose for the integration of clinical and administrative services may be more important than organizational and ownership structure. Physical proximity and, preferably, co-location of providers is highly desirable in encouraging effective communication. Where this is not possible, information systems and communication technologies become important. Long distances among providers make the care management process more challenging.