LeadingAge PEAK Leadership Conference

The Evolution of Continuing Care at Home Programs: Keys to Success

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Program Overview & History of CCaH

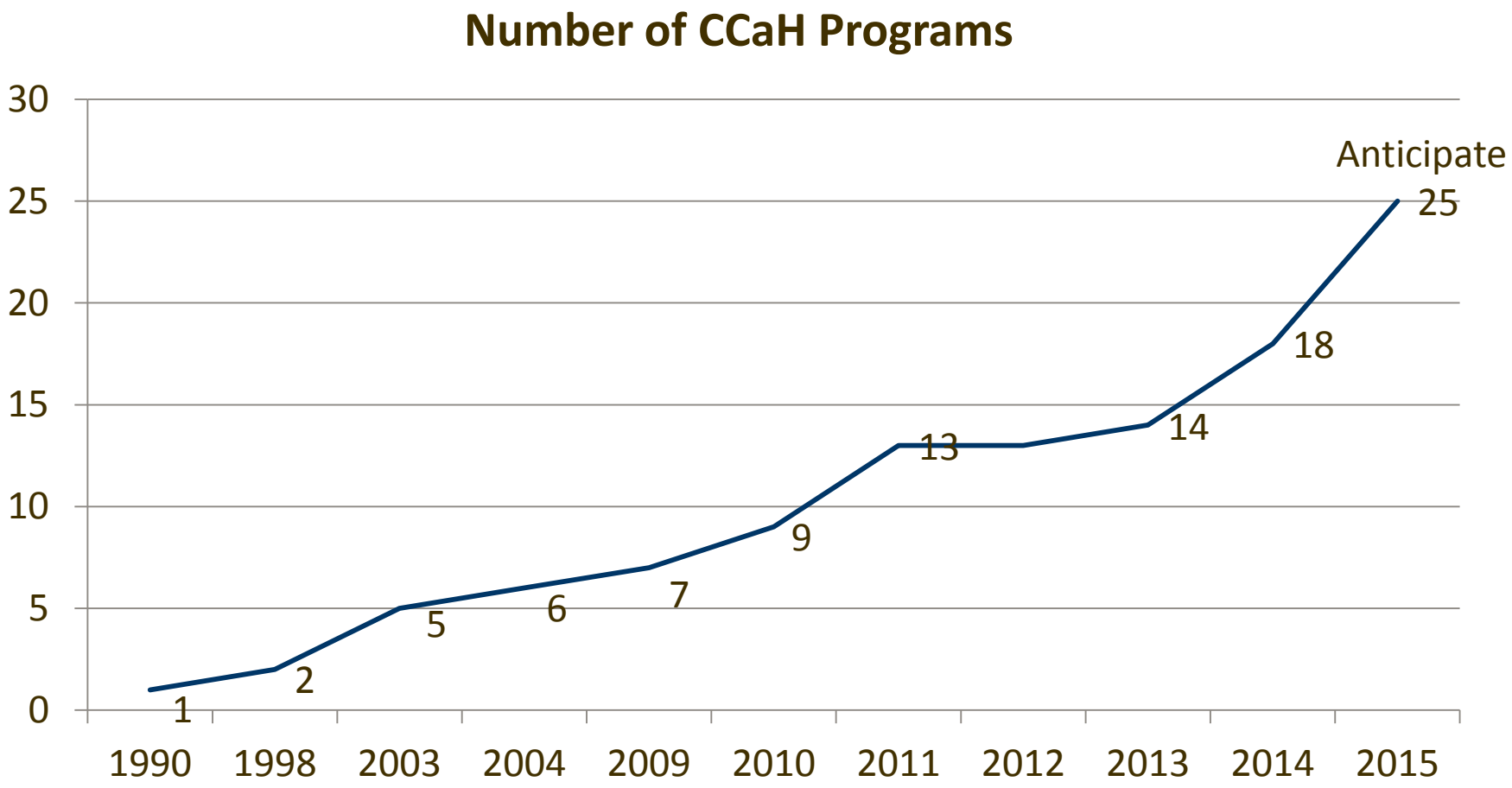
Continuing Care at Home

- CCRC Without Walls
- Life Care Model – entry fee with promise of future care
- Began in 1990 as a Type A pricing model; entry fee and monthly fees for guarantee of future care
- Has developed over time into a variety of pricing options that include
  - co-pays
  - flexible service packages
  - waiting periods
  - life time limits

Continuing Care at Home

- Programs offer a package of services designed to provide a continuum of care for people who want the same security that a CCRC offers, but want to remain in their homes for as long as possible
- Programs vary in size from 18 to 2,300 members depending upon:
  - Size of market/density of age and income households
  - Portability
  - Contract options/price
  - Reputation of sponsor
  - Open panel of AL and SNF providers
  - State regulations

Growth of Continuing Care at Home



Why now?

- Economic downturn caused many CCRCs to look for new sources of revenue
- Traditional campus providers have become more comfortable expanding services off campus
- Just like with CCRCs in the 1970s, it has taken time for an innovation to gain traction
- Legislative efforts have taken time and energy
- Affordable Care Act has focused attention on the impact of care management and access to a continuum of care

Result

- Increase in operating programs and those in development
- For-profit interest is starting to peak
- First ever conference of providers in 2013
- First ever gathering of providers at LeadingAge annual conference in 2013
- LeadingAge started a listserv to enhance communication and support among member operators
- Several collaborations in development:
  - Benchmarks
  - Customer Satisfaction

Lessons Learned

#1 Do your homework

Prior to launching your program:

- **Conduct** market research, including primary consumer research, to determine whether Continuing Care at Home (CCaH) will be successful in your market area
- **Understand** the regulatory issues in your state
- **Reach out** to operators of successful CCaH programs and learn from their experience
- **Register** for the LeadingAge CCaH listserv and communicate with others

#2 Know your numbers

- An actuarial study is necessary to determine pricing based upon your program model.
- Understanding how large your program could become based on market research, what services you will provide for program members, the costs of those services, your staffing, and expenses is critical to the integrity of the pricing.
- Ideally, actuaries should be consulted on a regular basis once your program is operational to test the pricing based on the unique qualities of your membership and any changes in the costs of services.

#3 Don’t scrimp on staff

- Your CCaH staff is the only tangible component of the program. It is critical that you have a full complement of staff on board the day you launch your program.
- We recommend you begin with an executive manager, care coordinator, sales person, and administrative assistant.
- Prospective members want assurance the sponsor is committed to the program. They need to meet and trust the staff and they want to know the care coordinator will be there for them if they have a need.

#4 Marketing+Sales=Membership

- CCaH may be a new concept in your market area. Budget plenty of marketing dollars to increase awareness of your program and educate your target market.
- You will never have as much interest in the program as you do when you launch. It is important to be prepared to manage the sales process so as not to squander the opportunity.
- Membership growth in the early years, before service dollars are spent, is critical to the long-term financial health of the program.

#5 Don’t bend the admission rules

- Applicants who already have a need for services, or those with a diagnosis of a degenerative disease such as Alzheimer’s Disease, Parkinson’s, ALS, or MS would not qualify for membership.
- The admissions process typically consists of a review of a financial application, a home inspection, several years of medical records, and a functional assessment.
- Do not compromise by allowing someone who is not qualified join the program.
- We always recommend the CCaH program provide alternatives for the applicant who does not qualify for the CCaH program.

#6 Care management Begins on Day 1

- The day a person joins CCaH, a meeting with his/her care manager should be scheduled. It is critical that this relationship begins when the member is healthy.
- CCaH staff walk a fine line balancing the strong sense of independence members often have with the program's need to maintain contact.
- It is the care management that truly differentiates CCaH from other long-term care alternatives, and has the most impact on service utilization, and ultimately, on the members' abilities to remain in their homes longer.

#7 Create a Community of Members

What makes a CCaH program special are the connections members make to staff and other members:

- Staying connected through CCaH sponsored programming is essential
- Programming can include social activities, educational programming, wellness seminars, trips, and more
- Some CCaH programs integrate this aspect of their program with their sponsor and allow members to access CCRC campus amenities

#8 Don’t allow service creep

- As the years go by, it is important that staff provide only those services outlined in the member agreement and included in the actuarial pricing study.
- For example, if you decide to broaden your definition of transportation or include special extras like meals on demand or a monthly massage, a new actuarial pricing study should be done to include the cost of these services into the pricing model.

#9 Periodically test pricing

- It is critical for CCaH programs, similar to CCRCs, to have actuaries conduct a study periodically to determine whether the pricing is adequate to cover the program's future obligation.
- Recommended best practice is every two to three years.

#10 Expense Increases = Fee Increases

- Annual monthly fee increases should be determined based upon the costs of services.
- If the cost of services, including care management, increase from year to year, then the monthly fees need to increase in order to maintain pricing integrity.

Does CCaH Compete With the Sponsoring CCRC?

- Survey of the membership of Longwood at Home after ten years of operation
- 191 responses out of 275 members
- Members considered several options before joining the At Home Program, including:
  - long-term care insurance (51.3%)
  - doing nothing (32.5%)
  - retirement community (36.6)
- Only 29 or 16.7 percent said they were on a retirement community wait list before joining the Longwood at Home program. Of those, 22 or 75.8 percent were on the Longwood at Oakmont wait list.

The Decision To Join Longwood at Home

- Answers varied greatly regarding why they did not choose to move into a retirement community. The most frequent responses included:
  - Did not want to leave our home; and
  - the at-home program answered our needs better.
- If membership in Longwood at Home had not been an option, most respondents said they would have:
  - purchased long-term care insurance (25.4%);
  - stayed home with no formal plan (22.8%); or
  - didn't know what they would have done (29.1%).

The Decision To Join Longwood at Home

- Only 16.4% or 31 of the respondents indicated they would have moved into a retirement community if Longwood at Home was not an option. This translates to about 23.5 possible move-ins or 2 each year to Longwood at Oakmont.
- Longwood at Home staff tracked the number of members who have moved to independent living at Longwood at Oakmont - 21 total since 2003, approximately 2 per year.

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