Strategic Planning in Long-Term Care

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INTRODUCTION

Within the health care community, the elderly population has been viewed as a market segment that requires special attention because of its large impact on resource requirements and because of the aging of American society. In 1950, 16.9 percent of the American population was over 55 years old. In 1980, 20.9 percent of the population was over 55 years old. Table 32-1 indicates that the trend toward an older population will increase dramatically from the year 2000 to 2050. In the year 2000, 22.0 percent of the population will be over 55 years old.[1] The graying of the American population is one of the most significant demographic changes of the 20th and 21st centuries[2]. Despite the difficulties facing health care organizations today, the planning process must begin to deal with the health care needs of members of this market segment, the so-called baby boomers, as they being to march past age 65 in the year 2010.

Table 32-2 indicates that the payment amounts for Medicare and Medicaid have grown at an average annual rate of 9.7 percent, from $88 billion in 1983, to $153.1 billion in 1989. Nursing home expenditures have grown from $2.1 billion in 1965 to $43.1 billion in 1988. Medicare normally represents 35-45 percent of a hospital's revenues, and Medicaid represents in excess of 40 percent of a nursing home's revenues. The percentage of Medicare and Medicaid reimbursement by type of service is shown in Table 32-3. Medicare outpatient service payments grew at a compound growth rate of 21.8 percent from 1966 to 1984, and Medicaid outpatient services grew at a compound growth rate of 17.2 percent from 1973 to 1985. Medicare home health services have grown at a compound growth rate of 22.8 percent from 1969 to 1984, and Medicaid home health services have grown at a compound growth rate of 37.1 percent from 1973 to 1985[3]. These rates of increase cannot be sustained for an elderly population that is growing and a tax base to fund these expenditures that is shrinking.

Strategic planning has as one of its goals the allocation of scarce resources among competing objectives. In the 1980s the planning processes undertaken emphasized improving market share. However, given the historically low operating margins of healthcare organizations and the desire on the part of the federal government, the state governments, and employers to hold down the rate of increase in health care expenditures, the 1990s planning processes will place more of an emphasis on the financial viability of strategic plans. "Financially driven strategic planning is based upon the assumption that the results of the planning efforts should improve the organization's financial position."[4]

Table 32-1 Actual and Projected Growth of the Elderly Population, 1900-2050

Year	Total Population*	55-64 * Population	55-64 Percentage	65 and over * Population	65 and over Percentage	85 and over * Population	85 and over Percentage
1900	76,303	4,009	5.3	3,084	4.0	123	0.2
1950	150,697	13,295	8.8	12,270	8.1	577	0.4
1980	226,505	21,700	9.6	25,544	11.3	2,240	1.0
1990	249,731	29,090	8.4	31,799	12.7	3,461	1.4
2000	267,990	23,779	8.9	35,036	13.1	5,136	1.9
2010	283,141	34,828	12.3	39,269	13.9	6,818	2.4
2020	296,339	40,243	13.6	51,386	17.3	7,337	2.5
2030	304,339	33,965	11.2	64,345	21.1	8,801	2.9
2040	307,952	34,664	11.3	66,643	21.6	12,946	4.2
2050	308,856	37,276	12.1	67,081	21.7	16,063	5.2

*Population is given in thousands.
Source: U.S. Senate special Committee on Aging in Conjunction with the American Association of Retired Persons, *Aging America: Trends and Predictions*, 1984.

Table 32-2 Medicare and Medicaid Reimbursements, 1983-1989 (in billions)

Year	Total Payments	Medicare Payments	Medicaid Payments
1983	$88.0	$55.6	$32.2
1984	94.8	60.9	33.9
1985	107.1	69.6	37.5
1986	115.1	74.2	40.9
1987	125.2	77.7	47.5
1988	138.0	87.1	50.9
1989	153.1	98.4	54.7
Percent Growth Per Year	9.70%	10.00%	9.10%

Source: Health Care Financing Administration, *Health Care Financing, Program Statistics, Medicare and Medicaid Data Book, 1988*, U.S. D.H.H.S. Pub. No. 03270, 1988.

Table 32-3 Medicare and Medicaid Reimbursement by Type of Service

Service	Medicare (1984)	Medicaid (1985)
Hospital Inpatient	65.0%	28.4%
Physician	25.0	6.3
Outpatient	6.3	4.8
Home Health/Other	2.9	17.0
Nursing Home	.8	43.5

Source: Health Care Financing Administration, *HealthCare Financing, Program Statistics, Medicare and Medicaid Data Book*, 1988, U.S. D.H.H.S. Pub. No. 03270, 1988.

THE NURSING HOME INDUSTRY

The ability of the nursing home industry to adequately provide services to the elderly population in the future is not clear. Nursing homes today rely on Medicaid for 50-60 percent of their total revenues, according to Fitch Investor Services, Inc.[5] Fitch is one of the three rating agencies that evaluate the creditworthiness of health care organizations, and it is the only rating agency that maintains a set of standards to evaluate the ability of nursing homes, continuing care retirement communities, and other housing options for the elderly to acquire debt in the capital markets. Given the growth in the elderly population, it is reasonable to assume that the demand for nursing homes and housing for the elderly will require significant capital investment, since most nursing homes are operating near capacity, as shown in Table 32-4.

The primary factors determining whether a health care organization will have the ability to obtain debt in the capital markets are the payor mix, the management, and the service area competition.[6] Although the demographic trends indicate that the demand for nursing homes and elderly housing should be strong, the present reliance on Medicaid for financing long-term care is at best an inadequate solution. The financial stress placed upon state governments to fund Medicaid has resulted in significant cutbacks in Medicaid funding in most states. This is clearly demonstrated in Table 32-5, which shows that nursing home expenditures as a percentage of total health expenditures have declined since 1980. This decline was due, in part, to the passage of the Omnibus Budget Reconciliation Act of 1987 (OBRA '87), which eliminated the distinction between skilled nursing facility (SNF) beds and intermediate care facility (ICF) beds and ultimately required higher staffing ratios in nursing homes. Another significant reason for the slower growth in nursing home expenditures was the funding of home health services by Medicare and Medicaid and other payers. Home health will continue to grow in the 1990s, but it is expected that the significant increase in the over 75 population will reverse the decline in the relative size of nursing home expenditures shown in Table 32-5. Economic forecasters have projected that national health expenditures as a percentage of gross national product will continue to grow form 12 percent in 1990 to 13 percent in 1994.[7] As the population ages, a larger percentage of the health care expenditures will be spent for long-term care services.

Table 32-4 Number of Nursing Homes, Beds, and Residents, 1967-1986

	1967	1976	1986
Nursing Homes	14,488	16,426	17,122
Beds (in thousands)	765	1,318	1,568
Residents (in thousands)	696	1,215	1,437
Occupancy Rates	91.0%	92.2%	91.6%
Beds per 1,000 (+65)	40.7	57.5	53.8

Source: Health care Investment Analysis, Inc. and Arthur Anderson, *The Guide to the Nursing Home Industry*, 1990

Table 32-5 Nursing Home Expenditures as a Percentage of National Health Care Expenditures

	Expenditures (in billions)		Nursing Home/
	Nursing Home	National Health Care	National Health Care
1960	$0.5	$23.7	2.11%
1965	2.1	35.8	5.87%
1970	4.7	65.1	7.22%
1975	10.1	116.8	8.65%
1980	20.6	219.4	9.39%
1985	35.2	425.0	8.28%
1988	43.1	539.9	7.98%

Source: Health care Investment Analysis, Inc. and Arthur Anderson, *The Guide to the Nursing Home Industry*, 1990

Support health care services for the elderly varies significantly by state. Table 32-6 indicates the number of beds per 1,000 persons over 65 and the net revenue per resident day in 1988. It shows that each state supports the funding of nursing home beds and the availability of nursing home beds based upon the political climate within each state. The Midwestern states appear to have more beds available for persons over 65 than the rest of the country. The payment rates per resident day appear to mirror the cost of living within the geographic area. The most striking statistic is that 50 percent of the elderly are located within ten states (California, Florida, Illinois, Massachusetts, Michigan, New Jersey, New York, Ohio, Pennsylvania, and Texas).

Table 32-7 summarizes some national performance indicators for nursing homes. According to these data, the average nursing home has 100 beds, a Medicaid mix of 61.86 percent, a loss from operations of $1.08 per day, and a debt to asset ratio of 57.00 percent. In order to be successful in the nursing home industry in the 1990s and beyond, it will be necessary to develop a plan that is responsive to the critical issues in the specific environment (e.g., demographics, reimbursement, payer mix, and competition) so as to accomplish the organization's mission. Without financial viability, an organization's goals and objectives cannot be achieved, and it is clear that financing for long-term care will be particularly vulnerable when the baby boomers near retirement age.

STRATEGIC PLANNING PROCESS

Strategic planning is the process of allocating the financial and human resources of an organization to meet its goals and objectives. The planning process evaluates the products and services of the organization, the markets the organization serves, the structure and financial capability of the organization, and the mission statement and then makes an assessment of the alternative strategic choices available to the organization. Based upon an assessment of these factors and others, the health care organization develops regarding it's markets, products, and services, strategies that allocate its resources in the most effective manner. Figure 32-1 provides a schematic of the planning process that health care organizations have typically followed. In order to serve the long-term care or elderly market most successfully, it is critical to know the elderly market.

Table 32-6 Nursing Home Statistics by State, 1988

State	Net Revenue per Resident Day	Beds per 1,000 Persons Aged 65+	Population Over 65 (1980) (in thousands)	Rank (1980)
Alabama	$41.19	42.9	440	19
Alaska	na	40.0	12	50
Arizona	na	36.5	307	28
Arkansas	na	58.0	312	27
California	57.62	38.4	2,214	1
Colorado	55.30	60.0	247	33
Connecticut	74.45	65.8	365	26
Delaware	62.40	53.5	59	47
Florida	63.24	27.5	1,688	3
Georgia	39.18	58.2	517	16
Hawaii	88.69	16.8	76	45
Idaho	53.95	45.8	94	41
Illinois	42.66	86.9	1,262	6
Indiana	54.87	86.4	585	13
Iowa	38.13	84.4	388	24
Kansas	38.27	87.1	306	29
Kentucky	42.96	62.3	410	21
Louisiana	34.98	70.7	404	22
Maine	62.89	53.9	141	36
Maryland	60.94	52.8	396	23
Massachusetts	70.72	63.5	727	10
Michigan	50.49	44.7	912	8
Minnesota	53.82	84.7	480	18
Mississippi	38.60	53.9	289	31
Missouri	51.50	68.8	648	11
Montana	50.27	61.6	85	43
Nebraska	Na	77.2	206	35
Nevada	60.45	26.5	66	46
New Hampshire	71.32	62.6	103	40
New Jersey	75.12	42.7	860	9
New Mexico	61.17	45.7	116	38
New York	82.68	41.7	2,161	2
North Carolina	53.06	32.9	603	12
North Dakota	54.70	74.2	80	44
Ohio	53.50	67.3	1,169	7
Oklahoma	54.59	72.7	376	25
Oregon	54.32	38.0	303	30
Pennsylvania	65.04	48.3	1,531	4
Rhode Island	55.37	63.9	127	37
South Carolina	44.11	33.1	287	32
South Dakota	Na	80.9	91	42
Tennessee	40.06	53.4	518	15
Texas	38.68	61.6	1,371	5
Utah	54.01	47.9	109	39
Vermont	63.77	57.8	58	48
Virginia	57.07	39.3	505	17
Washington	58.82	54.0	432	20
West Virginia	55.41	36.0	238	34
Wisconsin	53.20	86.7	564	14
Wyoming	51.76	60.8	37	49
United States	**51.27**	**53.6**		

Source: U.S. Senate Special Committee on Aging in Conjunction with the American Association of Retired Persons, *Aging America, Trends and Projections*, 1984, and Health Care Investment Analysis, Inc. and Arthur Anderson, *The Guide to the Nursing Home Industry*, 1990.

Table 32.7 Nursing Home Industry National Average

Indicator	Median Value
Beds	99
Occupancy Rate	95.61%
Medicaid Percentage	61.86%
Net Revenue per Resident Day	$51.27
Expense per Resident Day	$52.35
FTEs per Average Daily Census	0.74
Total Profit Margin	1.20%
Current Ratio	1.42
Average Age of Plant (years)	7.45
Debt Service Coverage Ratio	1.21
Long-Term Debt: Total Assets (%)	57.00%

Source: Health Care Investment Analysts, Inc. and Arthur Anderson, *The Guide to the Nursing Home Industry*, 1990

Environmental Assessment

Internal Profile

The internal profile evaluates the past utilization and financial performance of the organization. It indicates the kind of patients the organization has historically served, where the patients have historically lived, and what referral patterns exist. Based upon this information, the historical service area is defined. The internal profile also outlines the organization's human resources (i.e., managers, nurses, physicians, and other health care professionals). The human resource profile might include a description of the perceptions that employees, community members, and clinicians have of the organization based upon interviews with key individuals within the organization and from the community. Perceptions can have as much influence on an organization as facts.

One of the most critical components of the internal profile is a description of the financial capacity of the health care organization, including a list of its SWOTs (strengths, weaknesses, opportunities, and threats). This capability defines the limits within which decision-making should occur. After evaluating the internal data and preparing the internal profile, management should be able to define the strengths and weaknesses of the organization based upon its present position. See Exhibit 32-1 for a list of the most important data to include in the internal profile of a long-term care facility.

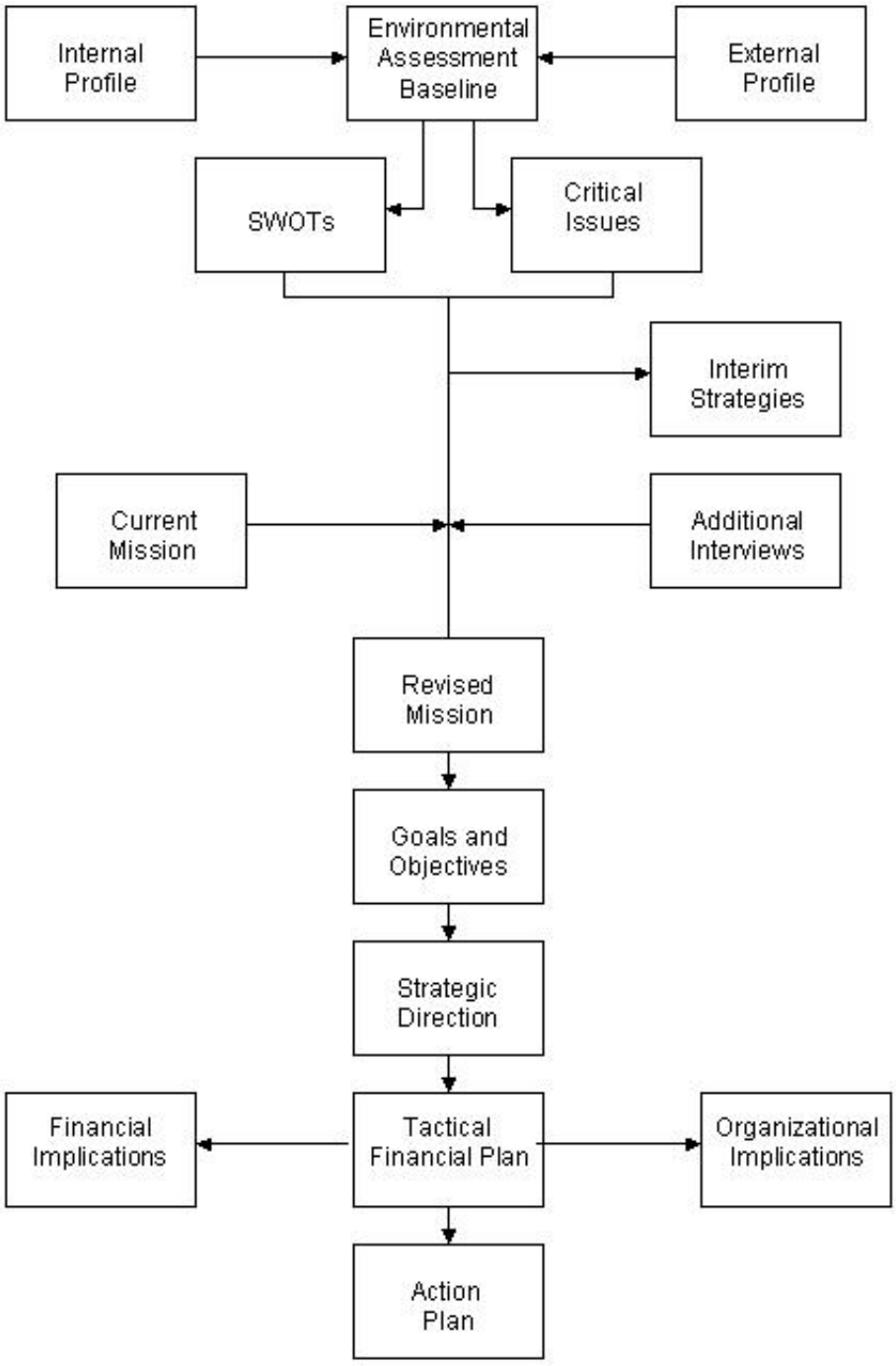

Figure 32-1 Overview of the planning Process

External Profile

The external profile of the elderly market should focus on the items listed in Exhibit 32-2. After evaluating the external factors affecting the health care organization's environment, the planning group should be able to make an assessment of the opportunities and threats that the health care or long-term care organization currently faces.

Exhibit 32-1 Internal Profile Date of Special Relevance for Long-Term Care Facilities

1. Patient Profile
    - Demographics
    - Patient Origin
2. Elderly utilization by service
3. Elderly utilization by physician
4. Elderly utilization by DRG
5. Discharge and planning experience
    - Administratively necessary days and experience
    - Policies and procedures experience
    - Placement success or failure
    - Service gaps

Exhibit 32-2 External Profile Date of Special Relevance for Long-Term Care Facilities

1. Service area demographics
    a. Population by type, by age, by area; historical and projected; age groups 55-64, 65-74, 75-84, 85+
    b. Sex
    c. Marital status
    d. Home ownership
    e. Income
    f. Employment
    g. Race and ethnic characteristics
    h. Third-party payer mix changes
2. Sociographics
    a. Living situations
    b. Support systems
3. Health status

4. Competitor profile
    - Types of competitors
        - Other hospitals (elderly utilization, elderly programs)
        - Long-term care facilities
        - Home health agencies
        - Ambulatory care facilities
        - Physicians
    - Utilization by service
    - Market share by service and by area
    - Charge structure of competitors
    - Known future plans for expansion or contraction
    - Existing referral patterns for competitors
5. Nuances of the elderly market
    - Elderly culture
    - History of programs for the elderly
    - Factors of importance to the elderly
        - Family and friends
        - Social activities
        - Financial concerns
        - Independent living
    - Preferred characteristics of particular programs
6. Evaluation of unmet health needs
    - Current
    - Projected
7. Health care human resources availability
    - Nurses
    - Technicians
    - Managers
    - Physicians
8. Regulatory changes
    - Certificate of need laws
    - Reimbursement changes
        - Medicaid
        - Medicare
        - Long-term care insurance
        - Home health
        - Managed care programs
        - Other payers
    - Third-party payer mix changes
9. Technology changes
10. Political environment
    - State government's future plans
    - Federal government's future plans
    - Insurance companies' future plans
    - Managed care companies' future plans
    - Organization support within political structure
    - Licensing requirements

The Elderly Market

The elderly market is heterogeneous and has many levels of segmentation. It includes the following dualities: independent living versus assisted living; living alone versus family or group living; fully functional versus functionally limited; good health versus chronic medical problems; full faculties versus mental impairment; affluent versus economically disadvantaged and employed versus retired.

People in this multi-segmented market are seeking a wide range of services, and therefore many opportunities exist for long-term care providers. Among the desired services are daily living support services provided in the home, social services for the independent healthy, care for chronic conditions in an outpatient setting, complete care in a residential setting, intensive inpatient care for the acutely ill, and caring support for the dying.

Services currently provided to the elderly are often not designed for the elderly. In order to provide appropriate services, health care organizations serving the elderly must be sensitive to the characteristics, needs, and preferences of those being served. Accessibility problems, including transportation, scheduling, and spatial configuration problems, should be addressed. Many services needed by the elderly are currently not provided, primarily because of lack of funding or because of the high cost of providing the service.

Additionally, the provision of services to the elderly usually occurs in the absence of coordinated care planning and management. This is unfortunate, since many providers may be involved, such as a hospital, physician, nursing home, home health agency, or day-care program. In additional, appropriate providers of acceptable quality may not be available, and reimbursement is not consistent across providers (and is even nonexistent for many). The lack of coordinated care planning and management leads to suboptimal care for some elderly patients and a discharge crisis for many hospitals. Physicians can play a key role in the successful provision of services to elderly patients, a role based upon the faith elderly patients have in their physicians.

The range of service required by the elderly is associated with a range of sources of payment: Medicare, Medicaid, supplemental (Medigap) insurance, long-term care insurance, and private payment. In order to maintain financial viability, health care organizations serving the elderly must be knowledgeable about reimbursement, have the ability to market to the private-pay market segment, and manage efficiently within narrow constraints. The provision of services to the elderly is strongly influenced by regulation. As the baby boomers age, this voting block, along with organizations like the American Association of Retired Persons (AAR), will impact regulation that affects funding for services to the elderly population.

What services and products can health care organizations provide to the elderly market? Table 32-8 presents a matrix consisting of care sites versus elderly

patient care status and identifies some of the services that have been offered. Table 32-9 presents a matrix showing the typical payers for the services listed in Table 32-8. Providing services to the elderly community requires that the reimbursement for cost-efficient services be improved. Recently, long-term care insurance added home health care as a benefit, which allows the elderly to plan financially for care in the home. Health care planning for the elderly must anticipate the changing reimbursement and insurance climate in order to be in a position to provide the services that will be necessary.

Critical Issues and Planning Assumptions

If there are immediate threats to the health care or long-term care organization providing services to the elderly, interim strategies should be developed. In the absence of immediate problems, the focus should be on the future. Using an analysis of the strengths, weaknesses, opportunities, and threats, the organization should identify the critical issues confronting the organization and develop the planning assumptions that will be used to develop alternative strategies. The planning assumptions also define the criteria for the analysis of alternative strategies (Exhibit 32-3).

The Organization's Mission, Goals and Objectives

A mission statement defines the purpose of the organization. A mission statement can be very simple and short or it can be very specific. For example, it might include a lengthy description of the organization's goals, functions, and services, the community it services, and its relationship to other providers. In order for the mission statement to have any significance, it must be understandable to the employees of the organization and the market it serves. The mission statement should provide the foundation for future growth consistent with the values and beliefs of the people who run the organization. Two sample mission statements follow:

> The organization will provide a full range of primary and secondary health services to the service area population, along with selected tertiary programs.
>
> The organization will provide a continuum of services to the senior residents of the area, coordinating services as needed to ensure optimal care. This continuum may include acute care, long-term care, and supportive home and community services.

Table 32-8 The Elderly Market Service Matrix

	Care Status					
Care Site	***Independent Good Health***	***Chronic Condition***	***Acute Illness***	***Rehabilitation Recovery Assistance***	***Permanent Living Assistance***	***Terminal Illness***
Specialized Facility				Rehabilitation hospital	Alzheimer's psychiatric hospital	Hospice
Residential	CCRC Retirement community	CCRD Congregate living Assisted living		Skilled nursing facility	Skilled nursing facility Rest home Respite	Skilled nursing facility
Inpatient Facility	Membership programs	Membership programs	Diagnosis Treatment	Transition Unit	Swing beds	End-stage care
Outpatient Facility	Routine maintenance Education	Diagnosis and treatment of disease Information	Follow-up	Outpatient rehabilitation		
Community	Social activities Health screening	Social activities Day care Monitoring			Family counseling	Family counseling
Home	Services Transportation	ADL assistance Home health Durable medical equipment				

Table 32-9 The Elderly Market Payment Matrix

	Care Status					
Care Site	***Independent Good Health***	***Chronic Condition***	***Acute Illness***	***Rehabilitation Recovery Assistance***	***Permanent Living Assistance***	***Terminal Illness***
Specialized Facility				Medicare Medicaid Commercial insurance	Medicaid Private pay Grants	Medicare Private Pay
Residential	Private pay	Private pay		Medicare Medicaid LTC insurance Commercial insurance	Private pay Medicaid LTC insurance Commercial insurance	
Inpatient Facility	Private pay	Private pay	Medicare Medicaid Commercial insurance Private pay	Private pay	Medicare	
Outpatient Facility	Medicare Commercial insurance Private pay	Medicare Commercial insurance Private pay	Medicare Commercial insurance Private pay	Medicare Medicaid		
Community	Private pay	Private pay Medicaid			Private pay	Private pay
Home	Private pay	Medicare Private pay LTC insurance	Medicare Private pay		Medicare Private pay	

Note: The payment sources are continually changing; however, the above payers have historically been the primary payers.

Exhibit 32-3 Criteria for the Analysis of Strategies

- Consistency with mission and values
- Fulfillment of goals and objectives
- Market demand or unmet need
- Impact on market reputation
- Impact on market share
- Impact on competition
- Barriers to entry
- Partnership potential
- Impact on health care professionals
  - Physicians
  - Nurses
  - Technicians
- Need for new health care professionals
  - Physicians
  - Nurses
  - Technicians
- Fit within product portfolio
- Resources required (capital, human, other)
- Management expertise
- Capacity issues
- Financial impact
  - Reimbursement changes
  - Insurance changes
  - Profitability potential
  - Cash flow requirements
  - Financing requirements
- Control
- Degree of risk
- Responsibility and timing

The strategic planning process will generally not change the purpose of the organization. The goals and objectives set by the organization to accomplish the mission will change as the environment changes. This can easily be seen in today's increasingly competitive health care environment. As the environment changes, it will become necessary to determine whether the organization can accomplish its original mission. For example, many health care organizations were established to provide a full range of health care services. Because of the greater competition, some can no longer provide the full range of services and remain financially viable.

A detailed set of goals are established that determine what must be done in order to accomplish the mission of the organization. The objectives of the organization

include measures of performance that allow management to determine whether the goals have been achieved. The goals and objectives follow from the mission and further define the direction of the organization. Three sample objectives follow:

> To capture ___ percent of the long-term care market as defined by skilled nursing beds.
>
> To serve at least ___ percent of the elderly acute care market.
>
> To reduce the annual number of administratively necessary days by ___ percent.

Strategic Direction and Action Plans

The long-term care organization must evaluate the alternative strategies using the criteria for analysis established previously. The selection of a set of strategies to follow will be based upon both subjective and objective criteria. If individual strategies meet the requirements for the criteria for analysis but the sum of several strategies is no within the ability of the organization, then the organization must develop a method to rank the strategies and ration the organization's capital and human resources in the most efficient way possible.

The strategic planning process must identify short-term, intermediate-term, and long-term strategies. For those strategies that can be implemented immediately, action plans (or business plans) need to be prepared. Appendix 32-A contains an outline of elements that might be included in an action plan.

STRATEGIC IMPERATIVES IN LONG-TERM CARE

At the beginning of this chapter, it was noted that the elderly population will require more health care services because of two factors: the increase in the absolute numbers of the elderly population, and the increase in longevity of the elderly population. Additionally, the federal government, the state governments, employers, HMOs, and other payers will pressure the health care system to control the rate of increase in health care expenditures. These trends are in conflict with each other and will bankrupt the system if reasonable alternatives are not developed[8].

The role of strategic planning in a health care or long-term care organization is to deal with the realities of the present and anticipate which changes will occur in the future. However, without changes in the financing system for health care services for the elderly, reasonable access cannot be ensured by health care or long-term care organizations as they exist today. The financial vulnerability of the long-term care industry will require planners to focus on the financial viability of the services being offered if the organizations are to accomplish their mission.

NOTES

1. U.S. Senate Special Committee on Aging and the American Association of Retired Persons, *Aging America, Trends and Projections* (Washington, D.C.: Government Printing Office, 1984).
2. Ibid.
3. U.S. Department of Health and Human Services, *Health Care Financing Administration, Health Care Financing, Program Statistics, Medicare and Medicaid Data Book*, 1988, HCFA pub. No. 03270 (Baltimore: HCFA, 1988), 7, 10-11.
4. M.C. Jennings, What is Financially Driven Strategic Planning? *Topics in Health Care Financing* (Gaithersburg, Md.: Aspen Publishers, 1988), 1-8
5. Fitch Investor Services, *Not-for-Profit Nursing Home Rating Guidelines* (New York: Fitch Investors Services, 1991).
6. Ibid.
7. Bernstein Research, *The Future of Healthcare Delivery in America* (New York: Sanford C. Bernstein and Co., April 1990).
8. J. Tedesco, *Financing Quality Care for the Elderly* (Chicago: The Hospital Research and Educational Trust, 1985), 20-21.

Long-Term Care Action Plan Elements

I. Definition of strategy
    a. What type of service will be provided by the organization?
    b. What needs will be met by the service?
    c. Who will operate the business? What provider?
    d. What services or products will be offered?
        i. To which segments?
        ii. When?
        iii. Where?
        iv. At what price?
    e. Are there any special constraints or limitations?
    f. What results are expected?
    g. What guidelines exist to monitor performance?
II. Primary market research
    a. Techniques
        i. Surveys
        ii. Focus groups
        iii. Interviews
    b. Populations
        i. Physicians
        ii. Consumers
        iii. Patients
        iv. Referral sources
        v. Discharge placements
III. Secondary data sources
    a. Census data
    b. Home health agencies
    c. Senior centers
    d. State agencies
    e. Trade associations
    f. Churches and synagogues
IV. Internal data sources (health care system or long-term care provider)
    a. Patient origin
    b. Age profile (segmented by sex, area, 5-year increments)
    c. Payers
    d. Physicians serving the elderly
    e. Referral sources
    f. Admissions/days/ALOS
    g. Outpatient Visits
    h. DRGs
V. Market analysis or plan
    a. Product or service definition
        i. Place description
    b. Target market segments
        i. Description
        ii. Size

iii. Future trends
c. Competitor profile
i. Current and anticipated
ii. Performance and image
iii. Future plans
iv. Potential threats
d. Regulatory climate
i. Favorable or unfavorable
ii. Future changes
e. Price determination
f. Promotional plan
i. Media selection
1. Print
2. TV
3. Radio
ii. Direct mail
1. Timing
2. Target audiences
3. Budget

Development of Demand Projections

VI. Organizational structure
a. Long-term care facility (system)
b. Hospital cost center
c. Separate corporation, hospital owned and operated
d. Joint venture
i. Physicians
ii. Another hospital
iii. Developer
iv. Long-term care provider
v. Other
e. Management contract
i. By hospital
ii. For hospital
f. Lease arrangement
VII. Legal and regulatory requirements
a. Contractual arrangements
i. Partners
ii. Management firms
iii. Vendors
b. Licensing requirements
c. Certificate of need
VIII. Resource requirements
a. Personnel
i. Development
ii. Operations (clinical, management, and marketing)

- b. Facility
    - i. Space
    - ii. Construction
    - iii. Utilities
- c. Equipment
- d. Supplies
- e. Marketing
    - i. Upfront
    - ii. Ongoing
- f. Outside professional services
    - i. Legal
    - ii. Accounting
    - iii. Architectural

IX. Projected financial performance
- a. Costs
    - i. Project costs
    - ii. Operating expenses
- b. Revenues
    - i. Demand projections
    - ii. Reimbursement assumptions
    - iii. Private-pay assumptions
- c. Financing needs
    - i. Project financing
    - ii. Working capital
- d. Financing sources
    - i. Mortgage
    - ii. Bond issue
    - iii. Sponsor equity
    - iv. Grants
    - v. Philanthropy

X. Incremental financial forecasts (five years)
- a. Income statements
- b. Cash Flow statements
- c. Balance sheets

Assessment of Financial Feasibility of Action Plan