2022 TOP TRENDS IN AGING SERVICES

Health Dimensions Group
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INTRODUCTION

As a national thought leader in post-acute, long-term care, and senior living, Health Dimensions Group (HDG) is in a unique position to consider current and emerging trends affecting the aging services profession. Each year, we release our look into the next year, our Top Trends publication. The broad experience of working with our own managed communities, combined with our advisement work with a wide variety of senior living organizations, health systems, and industry partners throughout the nation, has allowed us to develop deep knowledge and insight to drive organizational success.

We know that history can repeat itself, and we certainly have seen that through the emergence of the Delta and Omicron COVID-19 variants. But history also allows us to learn and improve. As senior care and living providers, we care deeply about the older adults in our care and services and have joined our colleagues across the industry in doing all we can to protect and care for our residents. What was once the world’s frantic response to an unknown threat has become sophisticated management of an infectious disease, and this evolution to management has been the same in our profession. Nonetheless, we know that consumer and market demand for traditional skilled and long-term care continues to decline—COVID-19 didn’t help the cause— and more and more people are turning to home care, assisted living, Program for All-inclusive Care for the Elderly (PACE), and other home- and community-based services (HCBS). State and national policy is reinforcing these trends.

The care and treatment of an even more acutely ill population in all care settings requires the support of a talented, experienced, and technically savvy management team and staff. Regulations change daily, and with them increased state and federal scrutiny. Employees who are qualified for and committed to our profession are in grave shortage. Why should those in this limited pool choose to work for your organization? You must create an employee experience that is so exceptional that other providers pale in comparison.

Your culture and values must be positive, inspiring, and encouraging— the “why” must wow.

2022 and beyond will bring with it hope and optimism for those who can reflect on history and also quickly pivot to new strategies, repositioning themselves to drive success. Your triumph will lie in innovation, as well as going back to the basics, including creating a customer experience that is helpful, dignified, predictive, and personable. And this is only possible by building a dynamic team that shows up every single day to provide the very best to all customers—be they residents and patients, families and loved ones, referral sources, community partners, payors, or vendors.

With the monumental changes of the past year as context, HDG presents the 2022 Top Trends. We encourage you to reflect on these trends as you develop your long-term strategic plan and operational plans for the year ahead.

We are seeing an upward shift in acuity ripple through the entire continuum.
TREND 1: NECESSITY OF NOVEL WORKFORCE STRATEGIES

Workforce challenges are not new to long-term care. But now the puzzle has become more complex with the addition of new pieces such as enhanced infection control, OSHA surveys, vaccine mandates, and COVID-19 fatigue that are driving people from the industry altogether.

According to research by the American Health Care Association and the National Center for Assisted Living (AHCA/NCAL), 99 percent of nursing homes and 96 percent of assisted living (AL) communities said they are facing some degree of staffing shortage. Furthermore, 59 percent of nursing homes and 30 percent of AL communities characterized their staffing situation as “severe.”

We need to quickly come to terms with the fact that employee expectations have shifted. Employees want more: work/life balance, a better culture, attractive compensation and benefit offerings, opportunities for development, and flexibility.

Changes need to be made at a state and federal level to make it possible for providers to invest in critical workforce solutions. But big changes need to be made at the local level as well. Organizations can’t just raise wages, though significant raises may be necessary in certain markets and scenarios. It will be just as important to invest in robust training for workers to feel competent in their current role—or provide them with a clear path for advancement—in addition to development programs that focus on the whole person. Develop a close relationship with workforce training programs, including having them on-site if space permits. Investing in technology...
that improves workflow of the direct care staff will serve to fill critical workforce gaps. Enlisting interim leadership to fill those gaps will also be key, as it will allow providers to find and train the right permanent leader. There also needs to be a commitment to diversity, equity, and inclusion strategies that are sustainable and scalable throughout the organization.

We also need to re-examine how we are doing with the basics. You need to understand your organization’s current strategy for attracting talent. Start with your job postings and make sure you stand out in a sea of ads. Be authentic in letting people know something great about the job, your organization, or what you are looking for in order to spark their interest. Evaluate what your hiring process looks like. Make sure it’s easy! Being able to swiftly hire and onboard new employees will ensure you don’t lose candidates just because someone else got to them first. This means having an easy-to-use online platform, and once the candidate applies, you need someone managing the system in real time. That’s what it takes in today’s market.

Engaging and retaining your employees is about culture. If you want your culture to say, “We value our people,” you need to first decide what that looks like and then take action to implement it. Put together a workforce planning committee; as they say, it takes a village, and that’s especially true when it comes to keeping your top people and attracting new talent.

**TREND 2: COVID-19 EVOLUTION FROM PANDEMIC TO ENDEMIC**

With widely available and effective vaccinations, as well as increased immunity from the highly contagious Delta variant, the immediate threat of hospitalization and death from COVID-19 for the vaccinated greatly decreased during 2021, causing us all to breathe a sigh of relief.

We have learned that the immediate host response of active antibodies appears to wane over time, meaning that even some people who have been vaccinated or who have natural immunity can get re-infected and possibly be contagious for a certain period of time. The good news is that longer-term immunity from B cells and T cells appears to be relatively durable and protect those with healthy immune systems from severe illness.

What about bonuses? We are seeing a multitude of different bonuses—shift, sign-on, emergency, etc. One newer trend is retention bonuses that reward people for sticking around. Don’t forget benefits. Understand what your employees want beyond the standard health insurance, 401K, and PTO. Maybe it is a stipend for student loan payments, childcare, or other expenses. Perhaps transportation solutions would be attractive. In some cases, providers are looking at building or subsidizing affordable housing for their staff, either on a temporary or permanent basis. Listen to your employees and get creative.

What makes up a shift in your organization’s current strategy for attracting talent? How can you make sure your job postings stand out in a sea of ads? What is the hiring process like? Is it easy for candidates to apply and onboard? What can you do to ensure you don’t lose candidates to other job opportunities? These and other dynamics have given rise to the notion that COVID-19 will shift from “pandemic to endemic.” In other words, COVID-19 could become a circulating, though less lethal, virus that creates the need for ongoing vigilance and a new normal.

It also means that those persons at risk—namely immunocompromised persons of any age and frail elders—will need ongoing protection in the form of boosters and robust infection control measures.

We are also learning more and more about a cohort of people who have had COVID-19 and have a lingering and somewhat variable set of ongoing symptoms after the initial acute phase of illness is
over. These symptoms include shortness of breath, fatigue, brain fog, chronic cough, headaches, and other symptoms that overlap with many other illnesses. These people are known as “long haulers,” and the National Institutes of Health (NIH) released grant funding in September 2021 to study this population. As 2022 unfolds, we expect insights.

The consequences of the pandemic for society at large, and aging services providers in particular, have been breathtaking. Strategies to age in place and provide safe and secure living environments for high-risk persons have become paramount, and this will continue to be the case. Congregate settings have taken a massive hit, despite heroic efforts by the staff and leadership of many communities.

Along the way, there have been tectonic shifts in the health care system.

Hospitalizations covered by Medicare sharply contracted in the second quarter of 2020. In many markets, Medicare-covered inpatient and outpatient hospital care was over 40 percent lower than the 2019 baseline. This was due to a drop in elective care, as well as reduced activity overall. After the second quarter of 2020, utilization in many service lines in the Medicare program rebounded, but in many cases ended up below 2019 levels by the end of the year (e.g., inpatient -13 percent, outpatient -8 percent). See Figure 1 below.

Interestingly, Medicare payment levels rebounded quicker and higher than utilization for certain service lines, including skilled nursing facility (SNF) and hospice. In the case of SNF care, extra payment for isolation care under the Patient-Driven Payment Model (PDPM) and use of the three-day waiver (about 15 percent of claims) were instrumental in

![Figure 1: 2020 Medicare Claims Compared to 2019 Baseline by Service Line](image)

Source: Data from Medicare’s common working file as of claims submitted by April 23, 2021
Notes: Physician/supplier services includes Ambulatory Surgical Centers (ASC), non-ASC, Part B drugs, and non-Part B drugs. Outpatient facility services include dialysis and non-dialysis. The difference between physician/supplier services and outpatient facility services is that physician/supplier services include physician payment, while outpatient facility services include facility payment.
offsetting utilization declines. Other service lines, such as inpatient hospital care, did not fare so well, ending 2020 in a deficit compared to 2019.

The shifting utilization and payment data during 2020 and 2021 illustrates the need for expert analysis and careful consideration of timing issues as data trends are interpreted and recommended courses of action are pursued.

The infection control procedures implemented during the pandemic also had some positive outcomes. In a five-month period from 2020 to 2021, flu cases dropped precipitously, going from over 26 percent of respiratory specimens tested to a paltry 0.2 percent—a 92 percent drop. 3

Telemedicine and telemonitoring have achieved scale and widespread adoption in many sectors, including mental health, primary care, and for management of high-risk chronic illness patients. Use of telemedicine has tended to level off when COVID-19 outbreaks decline, but achieving the right balance between in-person and remote visitation will be an ongoing challenge in 2022.

TREND 3: PAYMENT AND REGULATORY POLICIES UNDERGOING RAPID CHANGE

In the fourth quarter of 2021, the U.S. Department of Health & Human Services (HHS) thankfully released another round of $17 billion in funding for all providers and an additional $8.5 billion in funding for rural providers through the Provider Relief Fund. While this relief was a welcome emergency brake on financial disaster, it also signaled the possible beginning of the end of large subsidies for providers. In addition, providers have had to begin reporting expenses and lost revenues to allow government to decide how much of the CARES Act funding they may retain and how much must be paid back. Compounding matters has been a dizzying array of policy changes and program overlap, which now requires a level of financial acumen and administrative staffing not previously necessary.

Looking to the future, we see challenges and opportunities.

The Medicare Part A hospital trust fund is projected to be insolvent by 2026, only the second such time we have been this close in over 30 years. This will create downward price pressure on Medicare, which includes the reinstatement of the 2 percent sequestration adjustment and possible imposition of provider cuts, such as the potential for a 5 percent cut to Medicare Part A skilled nursing rates to keep the PDPM budget-neutral, as originally intended. A proposed rule will come out in Spring 2022 on this topic.

Value-based care and Alternative Payment Models (APMs) will return with a vengeance, starting with the Home Health Value-Based Purchasing (HHVBP) model taking effect in January 2023, with 2022 as a practice year. HHVBP will create up to a 5 percent plus/minus rate adjustment based on performance on a series of metrics, including claims data, patient satisfaction, and outcome measures. While this new program may be a challenge for some Home Health Agencies (HHAs), it will ultimately help HHAs in those 41 states that were not part of the original pilot learn how to live in a value-based world.

The same may be coming for skilled nursing. Recently, the Medicare Payment Advisory Commission reviewed the SNF Value-Based Purchasing (VBP) adjustment and recommended a series of changes to make it more impactful and expand the metrics beyond just 30-day readmissions. One only needs to look at the HHVBP to see the direction this policy is going.

In 2021, the Center for Medicare & Medicaid Innovation within CMS released a white paper titled “Innovation Strategy Refresh.” This paper outlines some of the lessons learned over the last 10 years...

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of APM development and lays out ambitious goals, including aligning Medicare APMs (such as bundling and accountable care organizations) with other payors and having all Medicare beneficiaries and most people on Medicaid in some type of accountable care relationship by 2030.

This paper reaffirms the current administration’s commitment to increase value-based care—and it is a strong signal to providers to get ready. This will mean integrating primary care, reducing avoidable hospitalizations, promoting wellness, increasing preventive measures, shortening lengths of stay, and increasing care in the community. It also means moving to a deeper understanding of risk and creating more formal arrangements (such as gainsharing) among value-based payors and providers to align incentives and drive outcomes.

Along the same lines, the penetration of Medicare Advantage plans quietly exceeded 40 percent of Medicare enrollees in 2021 and is on its way to 50 percent. Meanwhile, for the last several years, Medicare Advantage plans have been offering supplemental benefits, such as transportation and day care, in addition to their promise of lower premiums.

According to The Commonwealth Fund, adoption of supplemental benefits was “relatively limited in the first year: only 6 percent of Medicare Advantage plans offered these benefits in 2020. However, plans offering additional, primarily health-related supplemental benefits increased substantially between 2018 and 2020, including meal provision (20% of plans to 46% of plans), transportation (19% to 35%), in-home support services (8% to 16%), and acupuncture (11% to 20%).”

Medicare Advantage Special Needs Plans (SNPs) continue to be a growing presence, with dual-eligible SNPs by far the largest form of SNPs (see Figure 2). These plans are hotbeds for value-based arrangements and increasingly represent an opportunity for SNF and AL providers to share savings with payors by helping to manage the health care utilization and quality of life for seniors and disabled within their sphere of influence.

According to Kaiser Family Foundation, 95 percent of individual Medicare Advantage plans and 92 percent of SNPs will offer telehealth benefits. Three-quarters of individual Medicare Advantage plans and two-thirds of SNPs will provide remote access technologies.

Figure 2: Number of Beneficiaries in Special Needs Plans, 2010-2021

<table>
<thead>
<tr>
<th>Year</th>
<th>D-SNPs</th>
<th>C-SNPs</th>
<th>I-SNPs</th>
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<tr>
<td>2021</td>
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</tbody>
</table>

NOTE: Numbers may not sum to the total due to rounding.
SOURCE: KFF analysis of CMS Medicare Advantage Enrollment Files, 2010-2021. • PNG
Meanwhile, due to funding from the COVID-19 relief bills and the rebounding economy during 2021, many states are running budgetary surpluses for the first time in years. Some states have effectuated sizable increases to Medicaid rates for nursing homes (e.g., Wisconsin and Connecticut), in addition to investing in HCBS. Many states are linking rate increases to quality metrics and workforce incentives. Ideally, payment increases will also need to focus on incentivizing capital investment and promoting private rooms.

Providers should expect to see increased regulatory scrutiny. Infection control will remain a prominent focus, but CMS will also be seeking other things from providers, such as:

- More nuanced approach to visitation
- Achieving full vaccination compliance
- Getting back to non-COVID compliance and resumption of surveys nationwide
- Staffing levels and staffing quality

While it is possible that some regulatory waivers could be turned into permanent policy, providers need to plan on the eventual expiration of most waivers when the Public Health Emergency is over, and some maybe sooner. Important waivers include: three-day prior hospital stay for Medicare coverage for skilled nursing, nurse aide training and competency requirements, and hospital discharge planning rules under the IMPACT Act that require sharing of quality and resource use data about post-acute providers with persons about to be discharged from the hospital.

**TREND 4: MARKETPLACE AND PUBLIC POLICY PREFERENCE FOR HCBS AND INTEGRATED CARE**

The growth of the low-income senior population in need of comprehensive care continues to stress federal and state budgets and create challenges for organizations in their mission to improve quality of life for seniors in their communities. PACE operates on the belief that seniors with chronic care needs, and their families, are better served in the community rather than an institutional setting whenever possible. PACE has proven to enhance the quality of life of the dual-eligible population by providing comprehensive, coordinated care that allows older adults with chronic care needs to maintain independence in their homes, avoiding or delaying permanent placement in long-term care settings, at a lower cost for state and federal government than the traditional fee-for-service model.

Approximately half of the 141 active PACE programs have opened since 2010, averaging about four new programs per year over the last five years. The COVID-19 pandemic has highlighted the strengths of the PACE model of care for the frail elderly population with complex medical needs compared with institutional settings such as skilled nursing and AL facilities. Interest in PACE has increased substantially due to its flexibility in maintaining care for its participants. While most senior service organizations saw a decline in new development and services this past year, PACE continued to grow in both enrollment and new providers. As the gold standard of care among HCBS, PACE will continue to grow and flourish, regardless of when we get back to “normal.”

The American Rescue Plan, signed into law by President Biden in March 2021, contains provisions that increase funding for Medicaid HCBS. Included in the $1.9 trillion legislative package is an increase to the Federal Medical Assistance Percentages (FMAPs) for certain Medicaid HCBS by 10 percent.
through March 2024. Among the services eligible for inclusion in this additional funding is PACE. This provision may result in states developing or expanding PACE through new PACE organizations (POs) or additional funding for existing POs.

Other pending federal legislation, including the PACE Plus Act and PACE Part D Choice Act, would expand access to PACE across the country by making PACE development less restrictive and providing states with financial incentives to develop and expand PACE. These bills were developed in recognition of the fact that the PACE model of care can be a framework to serve other populations outside of the current PACE eligibility guidelines.

In the past year, we have seen expansion efforts in states that currently have PACE, such as California, Florida, Indiana, Louisiana, Maryland, New Jersey, and Virginia. In addition, PACE is under development in states that do not currently have PACE, such as Illinois, Kentucky, and Missouri.

With interest and support at an all-time high, now is the time to explore the feasibility of development or expansion of PACE, whether as a sole sponsor or in partnership with other organizations.

**TREND 5: INCREASING OPERATIONAL COMPLEXITY AND FINANCIAL CHALLENGES DRIVING CONSOLIDATION AND THIRD-PARTY MANAGEMENT**

Historical and new challenges in the senior care industry—including complexities in payment models, increased regulatory scrutiny, rising competition along the continuum, and home-based care trends—have converged to create operational, financial, and sustainability challenges never seen before.

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**Figure 3: 30 States Have Adopted PACE as a Model of Care**

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[Map showing 30 states with PACE adoption]
This convergence, combined with the end of many stimulus programs for the sector, has pushed many operations to the brink of survival.

For many in the industry, the warning lights on the dashboard have been flashing on and off for years, often with limited interventions. The pressures of the COVID-19 pandemic have forced operational and strategic intervention focused on immediate survival needs over other longer-run considerations.

Based on an analysis conducted by AHCA/NCAL, over a two-year period from 2020 to 2021, nursing homes will experience $60 billion in increased COVID-related costs and lose $34 billion in revenue (prior to COVID-related relief). A recent study by LeadingAge stated that 550 SNFs closed between 2015 and 2019. In 2020 alone, a total of 143 SNFs shut their doors.

During these times of increased complexity and heightened challenges, senior care organizations simply cannot afford to ignore warning lights any longer. Delayed reactions have resulted in devastating outcomes for many organizations, their employees, and those they serve, as well as lenders, investors, and the broader health care system.

Providers, lenders, landlords, and investors must react and take swift action. For some, the solution may simply reside within tactical, creative, and innovative ways to reshape their day-to-day operations in the form of revenue enhancements and expense reductions. This may seem elementary on the surface, but many organizations are unable to see opportunities that lie dormant within their own operations, are stuck in the ways of the past, and haven’t taken the necessary steps to reshape their core business.

For others, the action will need to be more strategic. Leaders must move quickly to eliminate service lines that are not producing desired outcomes, draining financial, operational, and human resources along the way. Organizations must examine markets to determine if new service opportunities can replace revenue stream voids, and explore how fresh partnerships, joint ventures, consolidations, or divestitures could help to ensure the business and mission survive.

The last several years have seen a migration away from freestanding or self-managed senior living communities to a merged affiliation or third-party manager relationship. If this is the right solution for your organization, you’ll want to consider a management partner with local/regional knowledge who will be candid about your organization and ask tough questions. Cultural and values alignment are vital to avoid undue stresses and challenges. Do your homework and seek a definitive sense of what your third-party manager can and will provide before you move forward with such an important partnership.

Learn more about choosing a third-party manager in HDG’s blog post, “10 Things to Consider When Selecting a Third-Party Management Company.”

The bottom line is that the warning lights are still flashing and ignoring them is no longer an option. Provider challenges and troubled situations will likely continue, so swift, bold, and definitive action will be required.

TREND 6: MEDICALIZATION OF SENIOR LIVING CONTINUES

We continue to see rising acuity levels in senior living residents. The majority of residents in AL are now age 85 or older; a decade ago it was closer to 80. People in this setting have complex and costly medical needs. Today in the U.S., over 6 million people have Alzheimer’s and other dementias; that number is expected to double between now and 2050.
Over the last several years, many states have made changes to their AL regulations. These changes include adding language around abuse and neglect investigation and reporting requirements, emergency preparedness plans, and staffing requirements. Some states are also adding enhanced licenses that allow residents with Alzheimer’s and related dementias and higher acuity to age in place.

When state regulations do not allow for senior living communities to directly provide a higher level of care, AL providers are finding ways to partner with home health agencies and other providers for additional services, including skilled nursing care, therapy (physical, occupational, and speech), mental health care, pharmacy, dental, and hospice. The future will also likely see many senior living communities partner with accountable care organizations (ACOs) and managed care organizations (MCOs) that offer a care coordination approach to provide lower-cost care to residents in their current setting.

Providers will need to evaluate their technology, physical plant, and current clinical capabilities to create strategies to respond to increasing acuity in their settings, to provide great care, and to be competitive in the marketplace. Providers must then operationalize these strategies too, which will likely include extensive training for staff and the development of new provider partnerships to allow people to age in place.

With the addition of more care coordination in senior living, AL communities can be expected to capture increasing SNF market share. There has also been a shift in expectations on the consumer side in
the wake of the COVID-19 pandemic: Not only do people want to age in place, but potential residents want assurance that a community can meet the needs of the whole person in a setting that is safe.

**TREND 7: REPOSITIONING FOR THE FUTURE**

As a provider in the post-COVID world, there is a reality that consumer preferences and demand for services in the post-acute arena have been significantly disrupted—at least into the foreseeable future. Now that the pandemic has transitioned from a patient health to a workforce crisis, operators are left standing with greatly diminished occupancy levels that require rapid retooling, or right-sizing, of their operations to survive the day and reposition for new market realities.

The path forward will likely require a recalibration of the services you offer the market(s). Organizations fortunate enough to offer an array of health care and housing services have a unique competitive advantage, as they can more easily adapt to the change in consumer demand. This recalibration will need to take into consideration a combination of both new revenue realities and variable cost mitigation. This process can be painful at times, but survival will likely depend on it.

The occupancy downturn left many providers with excess capacity—so much so that many are considering converting semiprivate rooms into private rooms (for a variety of patient benefits) and/or closing units to consolidate the service footprint and gain greater staff efficiencies. Before making any final decision regarding the reconfiguration of operating space, it is worth the investment of a demand analysis to re-evaluate the market to ensure you have a clear vision as to what future demand will look like. It is also important to understand the current labor market’s impact on size and services available in your market, as in addition to consumer demand changes, there are service-limiting factors arising from the workforce crisis.

Along with a reconfiguration of the operational footprint, another imperative is to quickly pivot to cost control. During the height of the pandemic, it was not uncommon for SNFs to lose as much as 15 percentage points of occupancy—or perhaps more—with AL provider occupancies faring slightly better. In addition, despite the three-day hospital stay emergency waiver, premium payor mix plummeted once the initial wave of COVID-positive cases resolved in outbreak centers.

Given the dramatic decline in occupancies, leaders in the profession must now take immediate action to benchmark their expenses on a per patient day basis to re-establish a viable operating scenario where, at least for the time being, expenses are right-sized to the revenue flow at hand.

Recently, HDG assisted a client who was considering downsizing their footprint and moving to private rooms. After performing a thorough market assessment that confirmed that the market had an oversupply of skilled nursing, HDG analyzed the fixed and variable costs for the client to assess the impact of reduced size on financial performance. Concurrently, we compared their operational cost centers to benchmarks, adjusted for acuity and wages, and identified several areas that needed to be addressed to help offset the impact of fixed costs on a smaller revenue base. This analysis was instrumental to helping the client make the necessary changes and investments to move onto a sustainable path.

Once operations are stabilized to the new normal, providers will find a way to re-evaluate their care and service offerings to better align with their market(s). At the front and center of this effort...
is an understanding of where opportunities are presenting from local acute care referring partners. At HDG, we call this hospital “pain points” analysis—looking at which clinical categories are experiencing unduly long inpatient lengths of stay.

Once referring hospital pain points are identified, providers should quickly assess their market to determine who is active in this programming space and fill any service voids that may exist. Once revalidated with hospital leadership, immediate action should be taken to begin the process of program development, focusing on clinical staff competencies to ensure alignment with the needs of those admissions with diagnoses different than what may have been admitted in the past. Over the last year, we have seen providers make forays into dialysis, respiratory therapy, wound care, and IV medications, to name some of the categories.

Opportunities abound for those willing and able to set themselves free from the past 18 months and plot a new course. Future success won’t come easy, but it is in reach.

**TREND 8: STRATEGIC SALES AND MARKETING**

One of the most important building blocks in regrowing census and occupancy is a robust sales and marketing strategic plan. The operative word here is strategic. No longer will a cookie-cutter plan meet a community’s needs and drive growth. Instead, the plan must be based on real-time market data and competitive analysis. For HDG clients, we are seeing the market environment, competitor pricing, and incentives change sometimes on a week-to-week basis.

A sales and marketing strategic plan should strive for innovation but also balance this with the basics that have always been important to driving census numbers. Timely responsiveness to referral sources and having corresponding technology to support that communication continues to be crucial. Moreover, there is no cutting-edge substitute for high-quality customer service—it is essential to supporting an effective growth plan.

Lastly, be mindful of both digital and more traditional outreach options. While digital strategies will continue to gain prominence and importance in senior care and living, they may or may not be the most effective choice for your market. Healthcare is local, and so is senior living. It is essential to know your market and select tactics that best drive business to your community. In some markets, the most effective approaches may be more traditional, including options such as direct mail and billboards.

So as you consider your sales and marketing roster, select team members who not only have strong marketing skills, but also know the market well and are interested in data and research.
CONCLUSION

More than ever before, success in 2022 will require leaders to balance multiple priorities. From ensuring an engaged, committed, and stable workforce, to shoring up or creating a seamless referral and move-in process, aging services professionals must balance the basics with innovation. Furthermore, the continuing evolution of the COVID-19 pandemic and the need to address patient and resident acuity will remain a challenge in 2022. It is essential that your leadership team take a hard and honest look at, and have a deep understanding of, your market forces. The operative word here will be “courage.” Responding with incremental changes will not be enough. Hard choices will be necessary to best position your organization for future financial and operational success.

As a leading senior care and living management and consulting organization, Health Dimensions Group is in a unique position to develop and help operationalize a strong strategic and operational plan. To learn more about our services, please contact us at info@hdgi1.com or call 763.537.5700.

ABOUT HEALTH DIMENSIONS GROUP

Minneapolis-based Health Dimensions Group (HDG) is a leading management and consulting firm, providing services to post-acute, long-term care, and senior living providers, as well as hospitals and health systems across the nation. HDG has been serving health care organizations for more than 20 years with a firm commitment to its values of hospitality, stewardship, integrity, respect, and humor.
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