MAUN-LEMKE
*Changing the Results of Healthcare*
SOLUTIONS
*The Newsletter for Healthcare & Human Services*

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It can't be denied that the post-acute marketplace has changed and is continuing to evolve. Post-acute providers are participating in ACO's, developing healthcare alliances and managed care partnerships. It's becoming more and more competitive to earn a *seat at the table*. So, how do you ***showcase your value*** when courting these business opportunities? Are there methods to highlight your expertise with specialty care offerings, even if you are not a member of an alliance? Absolutely! There are viable and lucrative avenues available even if your organization is not included as a member of an ACO, Managed Care or Hospital partnership relationship.


**Clint Maun, CSP** specializes, consults and presents strategic sessions on how to Quantitatively define your organization's ***Value Proposition***. By utilizing the three components of **Quality**, **Outcomes** and **Cost**, Clint will show you how to develop a systematic measurement of success you can capitalize on in the marketplace. You can achieve the desired quality and financial results to position your organization for sustained success in this changing post-acute care arena.

For more information on these programs or to customize a session that provides your desired strategic goals, please contact Kathy Cain, Vice President, at 800-356-2233 or **tellmemore@maunlemke.com**.

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## The Leading Edge

## Assessing the Need for Home & Community-Based Programs

As we age, chronic health conditions become more and more commonplace. In fact, it's estimated that 92 percent of people over age 65 live with at least one chronic health condition, such as diabetes, heart disease, arthritis, or cancer. With such staggering numbers, it's become critical for older adults to learn about these conditions, and more importantly how to manage them. Indeed, the demand for information and alternative services such as adult day services has increased exponentially over the past several years, as older adults aim to manage these conditions, while still achieving a level of independent living. With the right knowledge, resources, and services at their disposal, older adults have a much better chance to stay healthy, active, and engaged in their communities.

This in and of itself has created opportunities for new and current healthcare organizations to develop or expand services like home-based and/or community-based programs. These programs can include:

- Adult day services, medical and/or social
- Case management (or *care* management)
- Home-care agencies
- Home-health agencies (Medicare-certified)
- Hospice
- Meals programs: home-delivered and congregate
- PACE (Programs of All-Inclusive Care for the Elderly)
- Senior centers
- Transportation: para-transit and community

To better position your organization for the future, it's key to understand this market and create a strategy that will enable you to effectively meet this growing demand. The rest of this article will focus on how you can begin to assess the need for adult day services and home and community-based service programs and whether it's something your organization should pursue.

**Understanding the Demand for Services: A Go-To Plan**
Understanding your local market and community is the first step in establishing home and community-based service programs. A thorough community assessment will provide you with a snapshot of critical factors, such as the need and potential utilization of a certain service or program as well as what new service or program would be most successful.

There are several ways to attain a community assessment. Here are just a few ideas to get you started:

- **Start with a simple Google search.** Yes, it can be that easy! You can gain a quick understanding of current and expected future trends on a national, state, and local level. This information can help you build a solid project foundation. Data that can help you validate the need for services include demographic information from the national census, available for review at **www.census.gov**.

- **Conduct interviews or focus groups.** Gather feedback and input from as

many different patients, prospects, agencies, and stakeholders as you can. You can try contacting other agencies that deliver services to the same target population(s). These agencies could also serve as primary sources of referrals or potential collaborators and include agencies on aging, centers for independent living, discharge planners and social services professionals of local hospitals or health care facilities, and/or mental health service providers (just to name a few).

Here are a few key questions to consider in these interview or focus groups:

- Do you perceive a need for the service in this area?
- Would you refer your clients/family members/ friends to this service?
- What would you want the service to look like if your family needed it?
- What would make the service more accessible for your clients/family/friends?
- Do you know someone who needs daytime supervision but stays home alone?
- How familiar are you with adult day services?

- **Check out the competition.** Visit other organizations already providing home or community-based programs or services. Observe them in action. Review their services and markets to determine if they are competitors or potential collaborators. Determine what is unique about how the competition provides services and what your organization would or could do differently.

Please take note that this is not meant to be an exhaustive list or how-to, but rather a starting point for further research into new services and programs. The demand for home and community-based services is increasing daily. Some providers are fearful or blind to these changes, but the hope is that with the right information and plan, you can embrace the change and take advantage of new opportunities.

*"True success is overcoming the fear of being unsuccessful."*
*—Paul Sweeney*

## Communication Corner

### Key Findings & Data on the Hospital Readmissions Reduction Program

The Hospital Readmissions Reduction Program was passed in March 2010 as part of the Affordable Care Act (ACA). The program was created in an effort to address the costs and poor outcomes of hospital readmissions. To be sure, hospital readmissions within 30 days after discharge are very costly, accounting for more than $17 billion in avoidable Medicare expenditures. Since October 2012, the program has penalized hospitals with higher-than-expected 30-day readmission rates for selected clinical conditions. In 2013 and 2014, these conditions were acute myocardial infarction, heart failure, and pneumonia. Total hip or knee replacement and chronic obstructive pulmonary disease (COPD) were added in 2015.

The program also penalizes hospitals that have readmission rates that are higher than

would be expected on the basis of readmission performance over three previous years. For example, 2015 penalties are based on readmissions from July 2010 through June 2013. So, how is this program doing? Is it making an impact? Are costs going down? Despite the importance of readmissions, there has been little study of the effect of the program. Some data suggests that overall national rates of readmission decreased through 2012. There is also evidence that stays in observation units have increased during this same period. Indeed, critics of the Hospital Readmissions Reduction Program have worried that hospitals might be achieving reductions in readmissions by keeping returning patients in observation units rather than formally readmitting them to the hospital.

Researchers sought to explore some of these issues and help answer some of these questions, and their findings have been published in the *New England Journal of Medicine*. The study, titled "Readmissions, Observation, and the Hospital Readmissions Reduction Program" revealed four key findings. Here's a quick snapshot of those discoveries:

1. Readmission rates for both targeted and nontargeted conditions began to fall faster in April 2010, after the passage of the ACA, than before. Readmission rates continued to decline from October 2012 through May 2015, albeit at a slower rate. From 2007 to 2015, risk-adjusted rates of readmission for targeted conditions declined from 21.5% to 17.8%, and rates for nontargeted conditions declined from 15.3% to 13.1%.

2. The passage of the ACA was associated with a more substantial decline in readmissions beginning in April 2010 for targeted than for nontargeted conditions.

3. The rate of observation-service use for both types of conditions was increasing throughout the study periods.

4. There was no significant association within hospitals between increases in observation-service use and reductions in readmissions during the implementation period.

The researchers noted that the design of the study limited the ability to draw a firm causal link between the Hospital Readmissions Reduction Program and the outcomes of interest. However, they do think it's likely that hospitals responded at different times to the incentives from the program to reduce readmissions.

The scientists ultimately concluded that the Hospital Readmissions Reduction Program seems to have a broad effect on care, especially for targeted conditions. In the study period, readmission rates continued to fall for targeted and nontargeted conditions. They did not see large changes in the trends of observation-service use associated with the passage of the ACA, and hospitals with greater reductions in readmission rates were no more likely to increase their observation-service use than other hospitals.

*"Quick decisions are unsafe decisions."*
*—Sophocles*

## News You Can Use

### OIG Report Finds Occupancy Down but Complaints Up in Nursing Homes

A new federal report reveals that while nursing home occupancy dropped between 2011 and 2015, complaints were up by a third during the same years. The report from the Office of Inspector General Report from the Department of Health and Human Services (OIG) states that in 2011, there were 47,279 complaints, which had risen to 62,790 by 2015. More than half were prioritized as high priority or resulting in immediate jeopardy, triggering onsite investigations within 10 working days. The report concluded that a third of the complaints were substantiated.

The increase may not reflect declining care quality, authors suggested. Instead, it may reflect better options for filing and tracking the reports. More than half of complaints related to quality of care/treatment or resident/patient/client neglect. Examples given included a lack of blood glucose strips for a patient with high blood sugar who was later found deceased, and a resident who called for assistance after a bowel movement and wasn't helped until three and a half hours later.

Read the **full OIG report for further details**.

*"The more you praise and celebrate your life,*
*the more there is in life to celebrate."*
*—Oprah Winfrey*

## Just For Fun

### They asked what?!

The following questions from lawyers were taken from official court records nationwide!

1. Was that the same nose you broke as a child?
2. Now, doctor, isn' it true that when a person dies in his sleep, in most cases he just passes quietly away and doesn't know anything about it until the next morning?
3. Was it you or your brother who was killed in the war?
4. The youngest son, the 20-year-old, how old is he?
5. Were you alone or by yourself?

6. Were you present when that picture was taken?

7. Were you present in court this morning when you were sworn in?

8. Lawyer: She had three children, right?
   A: Yes.
   Lawyer: How many were boys?
   A: None.
   Lawyer: Were there girls?

9. Lawyer : You don't know what it was ?
   A : No
   Lawyer : And you didn't know what it looked like ?
   A: No
   Lawyer : But can you at least describe it?

10. Lawyer: You say that the stairs went down to the basement?
    A: Yes.
    Lawyer: And these stairs, did they go up also?

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**MaunLemke.com**
**ClintMaun.com**

**ClintCast.com**
**CareCrowdVT.org**

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