Home Care 100 Think Tank

Big Ideas for the Next Decade

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Home Care 100 Think Tank: Big Ideas for the Next Decade

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Earlier this year, Lincoln Healthcare Events invited a group of leading home care and hospice providers and suppliers to participate in a Big Ideas Think Tank, with the goal of helping stimulate entrepreneurial activity by envisioning future business opportunities that are big, out of the box, and actionable.

This concept paper is a compilation of the top four ideas from the Think Tank which were discussed, and developed by thirteen home care executives. Participants outlined the opportunities, challenges and ways to connect their 'Big Idea' vision to an executable strategy.

You'll find that almost all of the ideas have a consistent theme of coordinating healthcare services and settings, and keeping patients and caregivers in a seamless circle of care. Most of these ideas don't require inventing anything new, but combining resources across disciplines and sectors. Some of the biggest opportunities in home care lie in the areas between silos, and we should start thinking horizontally and exploring new business models to take advantage of them.

The ideas were also presented during the 2010 Home Care 100 Conference, which focused on "Leading in a Changing World" – discovering ways to meet the challenges of our evolving environment and emerging with stronger and more effective organizations.

Home Care 100 is a forum for a cross section of home care and hospice leaders to network, learn, and develop strategies as they consider the future. We hope you'll consider joining us next year at The Ritz Carlton Laguna Niguel, CA from February 13-15. Attendance has sold out for the past three years so space will be limited in 2011.

I hope you find these 'big ideas' interesting and practical as you continue to develop entrepreneurial thinking and innovation within your organizations.

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Big Idea #1: Chronic Care Management / Care Transitions Program

DEFINITION

Chronic Care Management refers to the treatment, oversight and education of an ongoing condition which does not improve rapidly but rather endures – sometimes gradually worsening or sometimes stabilizing. It requires a combination of attentive oversight; management of episodic, acute or other medical interventions; and navigating the ports of entry into the silos of our healthcare system as their care needs change. For example, a patient may move from PCP care to hospital to SNF to skilled home health. Each of these shifts is defined as a care transition. According to the 2009 Almanac of Chronic Care Disease, treatment of chronic care diseases was responsible for more than 75% of total health spending in 2007.

While physician primary care practices are critical players in chronic disease prevention and management, home health providers are even more significant, as their operations lend themselves to incorporating evidence-based programs of chronic care management, which have been shown to reduce ER visits, hospitalizations and re-hospitalizations.

DEVELOPING A CHRONIC CARE PROGRAM

Three chronic care management programs are seen as immediate opportunities for home health agencies: Care Transitions Intervention, Guided Care and CareWise Services. Care Transitions and Guided Care (both are National Quality Forum approved) each address a different issue within chronic disease management, but synergistically the programs are expected to have a positive impact on reduction of healthcare expenses that is greater than any one of the programs alone.

- **Care Transitions Intervention (CTI):** A four week program focused on adults with chronic conditions and frequent hospitalizations/re-hospitalizations. The program begins when a patient has been hospitalized. Through one hospital visit, one home visit, and a series of follow-up telephone calls with a designated transition coach (typically a nurse or social worker) whose primary role is "to coach - not do", patients with chronic conditions develop improved capacity in the areas of medication management, personal health record keeping, red flags, and follow-up care with primary care providers and specialists. Research has shown CTI to reduce re-hospitalizations in 20, 90 and 180 days by more than one-third.

- **Guided Care:** An RN embedded in a primary care physicians' office assists two to four physicians in caring for 50-60 high risk patients with multiple chronic care conditions and complex medical needs. The RN uses a registry or EMR to conduct an assessment, create an evidence-based action plan, monitor patients proactively, support chronic disease self management, communicate with providers in all other settings, facilitate transitions as necessary, educate caregivers, and ease access to community services. After the first eight months of one recent study, Guided Care patients experienced 24 percent fewer hospital days, 37 percent fewer SNF days, 15 percent fewer ER visits and 29 percent fewer home health care episodes.

- **CareWise Services:** This service offering would leverage providers' care management expertise and spin a new side business that would be offered to families looking for assistance in managing a patients' chronic care issues. The goal is to decrease re -hospitalization and keep patients safely in their home. CareWise would be a private pay service that children, or the patient themselves, would pay for on a monthly retainer basis. They would be assigned a care management nurse who would establish the care plan and correspond with appropriate stakeholders. Through the use of tele-monitoring, telephone check-ins, home visits and referral management the provider is in a perfect position to leverage resources to offer this new service. It would appeal to this new buying client base who we know are highly motivated to stay in their home. This early connection with the provider will keep the client in the providers' circle of influence and, as needs change over time, providers will be there to offer the home health or hospice services that might be required.

PAYMENT FOR CHRONIC CARE MANAGEMENT

Today, payment to the home health agencies for conducting a CTI program and for organizing and managing a Guided Care program would come from one of four sources: Medicare Advantage Plan and/or HMO; Health Care System; Hospital; or Physician Practice.

For the most part, only Medicare Advantage plans and HMOs are financially incentivized to reduce hospitalizations, re-hospitalizations and ER visits. However, the healthcare reform bill includes payment penalties, beginning in 2012, for hospitals (and post acute providers) for avoidable re-hospitalizations. Thus, many hospitals already have begun considering how to manage patients at the highest risk for re-hospitalizations, especially patients with chronic diseases that result in the highest volumes of avoidable re-admissions (congestive heart failure, pneumonia, heart attack).

OPPORTUNITIES

Home health agencies are ideal platforms for organizing and administering Chronic Care Management programs – but home care must be viewed as part of a bigger system/process and not as a standalone entity. Reform will incentivize healthcare providers to organize Chronic Care Management programs that have been proven to reduce costs. Home health agencies that were early entrants, and have developed expertise in evidence-based programs such as CTI and Guided Care, will be ahead of the curve for this new business line and revenue source.

In order to have a strong Chronic Care Management program, providers must be willing to partner with a hospital and invest their own dollars. The vast majority of referrals for home health care emanate from hospital discharge planners and physician offices, and care is provided in the patients' home. Therefore, home health agencies develop a trusted working relationship within the three venues involved in CTI and Guided Care.

For CTI, the agency could convert one intake coordinator in the hospital to a transition coach, focusing on the patients at highest risk for re-admissions. If the patient is discharged immediately, or following a stay in a post acute setting with an order for home health care, the transition coach would work in concert with the home health agency's nurse case manager. The identification of hospitalized patients at high risk for re-admissions would be consistent with a home health agency's intake coordinator's role. Thus, the incremental cost to the home health agency for organizing and managing a CTI program would be less than the cost of one nurse or social worker FTE. Additionally, training is free and learning the program is inexpensive.

For Guided Care, while the RN coordinator would likely be employed by the physician practice in order to assure compliance with patient choice, the Chronic Care Management program would be overseen by the home health agency. Should a patient require home health services, the practice-employed RN would offer patients the required options; however, patients who select the managing home health agency would have a clear advantage in terms of care coordination.

CHALLENGES:

While Chronic Care Management presents an opportunity to advance home health as critical link in healthcare delivery, it is very complex to manage and execute. Funding can also be challenging as Chronic Care Management only works for home health agencies that receive bundled payments through reform or are hospital-based.

Big Idea #2: Concierge Services

DEFINITION:

Concierge Services is a division of home health that allows a provider to meet the psychosocial needs of people accessing medical services, and whose physical or mental status does not make them eligible for skilled home healthcare. Examples of this include companionship, housekeeping, tuck-in and get-up, and physician visit liaison.

Currently, some providers are offering Concierge Services in a regional perspective and some private duty companies are focusing on high end services. However, an unmet need still exists and very few are doing it from a scale perspective.

There is an upward trend toward Concierge Services and a lot of potential exists in this market because people are amassing their funds now to pay for these types of services in the future. People are focused on their own care and paying for it themselves – they are not considering Medicare as a primary funding option.

The think tank discussed several types of concierge opportunities:

"NEIGHBORHOOD CARE"

As more retirees cannot - or will not - relocate for retirement or cannot sell their home for ALF or CCRC space, more will remain in their homes. Neighborhood Care would offer subscriptions for a variety of services without requiring the purchase of a minimum number of hours, likely the only way the middle class could afford it. Using zip code and income information to identify neighborhoods, providers can offer Concierge Services coordinated by a social worker. Similar services are available in Europe and include wake up, help out of bed, dress, breakfast, and tuck-in services. Like ALFs, costs are kept down as staff is in a localized area requiring less drive time.

"BRIDGE CARE"

Social workers would gain certification as Geriatric Case Managers and Chronic Disease Managers, and act as a "Bridge" for support services in the local community. This structure takes private duty services out of the certified home health agency and places them in a lower cost structure. The "Bridge" could oversee private duty placement of aides, companions or homemakers; and offer assessments in the clients' homes. Social workers already have a community-based source of payment for a good deal of what they do now: assess, arrange services, tackle financial issues, address insurance issues. Bridge Care maximizes the role of social workers who best know how to "connect" services in the community and who know the "holes" to avoid.

Bridge Care could also be offered as an adjunct to physician practices to address the worried elderly (such as orthopod and cardiac patients) where staff does not have the time to attend to all issues and concerns. It is a way to connect to the community and support MD transitions.

"CIRCLE OF CARE"

One example of a provider who expanded their services beyond end-of-life care is Hope Healthcare Services. By applying palliative care skills to meet the needs of seriously ill children and adults they grew substantially with minimal administrative and infrastructure expansion. They implemented programs such as Hope Select Care (PACE); Hope Choices (a long term care diversion program); Hope Kids Care; Hope Connections (a community care program for the elderly); and an adult day health care. Hope was able to create new revenue streams, improve quality and continuity, reduce costs, expand coverage and enhance access. This circle of care can be replicated by other healthcare organizations, enabling more people with advanced illnesses to gracefully transition from futile and expensive treatments to quality care and services.

OPPORTUNITIES:

Today's seniors want and need an increasing list of potential non-Medicare services, including companion services, transportation services, meal preparation, schedule management, errand management, and more. Home health providers should consider creating a concierge division to address the real needs of patients who do not qualify for Medicare, or who want services that are not covered by Medicare.

The target population for concierge services are affluent markets such as high-end retirement communities and employers who want to offer an additional benefit to their work force. Also, in today's highly mobile society, the payer of the services may often be the son or daughter who live several states away from the actual consumer. The children of elderly parents are often relieved and more than willing to pay for their own peace-of-mind knowing that their remote loved one is receiving support care in the home.

Concierge Services allows the patient to remain within the "circle" of the home health agency when acute care is not needed, and to be referred back without an exacerbating event.

OTHER AREAS OF OPPORTUNITIES:

Private Equity companies are identifying opportunities in this area and buying companies poised to grow rapidly in this market (ex: Freedom Eldercare bought by Webster Capital).

Geriatric Care Management companies are also positioning themselves in a concierge service manner so there is an opportunity for synergy between these two models. Concierge Services could also be incorporated into a larger scale subscription model where consumers pay a regular monthly fee, semi-independent of actual services used.

CHALLENGES:

The first challenge to implementing Concierge Services is recognizing that it is a social model and that a client is not just a patient – to a large degree this service replaces their family and community. This model requires maximum "service" orientation, and addressing an individual's preference as well as need.

The home care industry must also determine how to scale this business model since there is a lot of pressure on margins for Medicare companies, and make it applicable to - and affordable for - the middle class. Currently, it's most applicable to the affluent; however, scalability could be created through franchising and standardization.

Additionally, the separation between Medicare (need service) and private pay (want service) needs to be determined. This market is not as big as the Medicare market, but Concierge Services could be a good growth engine for companies whose growth tapers off in the Medicare market. Most providers currently straddle Medicare and private pay/duty, but each is so inherently different that providers should ideally treat them each like different companies. For example, Medicare has lots of customer turnover while private pay has less turnover and fewer assessments.

Another challenge lies in identifying the target neighborhoods, and executing reasonably priced packages that are attractive. Social workers have community organization backgrounds - Activity Directors without walls - that would be helpful in launching this model.

Other challenges include the legal structure of the separate entity, the home health agency's comfort level with a non-medical model, keeping the social workers happy and connected, and ensuring trained/supervised staff.

Big Idea #3: Geriatric Care Management

DEFINITION:

Geriatric Care Management (GCM) is the process of planning and coordinating the care of the elderly and/or disabled to improve quality of life and maintain independence for as long as possible. Healthcare and psychological care are integrated with the best possible combination of services.

Both Chronic Care Management and Geriatric Care Management promote the independent living of the elderly. However, Chronic Care Management focuses on treating and living with one or more chronic diseases, while Geriatric Care Management focuses on the general daily living outside of treatment for a specific disease. Geriatric Care Management services include housing, socialization programs, financial and legal planning, and more.

A Geriatric Care Management plan tailored for each individual's circumstances is prepared after a comprehensive assessment. Professional geriatric care managers accomplish this by combining a working knowledge of health and psychology, human development, family dynamics, public and private resources, and funding sources while advocating for their clients throughout the continuum of care.

ADDING GCM INTO THE MEDICARE AGENCY:

Currently, geriatric care managers mainly want to work with private pay. However, real GCM should go beyond private pay home care and serve as a conduit for all chronic and acute healthcare needs of a patient (Post Acute Bundling). This would result in true advocacy and coordination of care where there isn't a conflict of interest related to fees.
GCM has real merit with wealthy and state-funded populations. From a Medicaid perspective, the standard is to provide the same or better levels of care for less cost.

Families will be increasingly taxed to take care of loved ones outside of the skilled Medicare benefit and will need representative help in far-away cities. Home health companies are ideally positioned to provide this service on a subscription basis (monthly, annually), index various services in packages (bronze, silver, gold, platinum), and craft services to care for the most affluent group to ever reach retirement age. This might include compliance training, home assessments and change recommendations, the distribution of convenience products or the recommendation of same, and the coordination of rental equipment.

Families could essentially 'rent an advocate' who coordinates various services to allow a patient to age in home and deal with acute episodes. This is not currently being done on a large scale an offers huge potential if it can be made affordable and accessible to middle class.

TYPES OF GCM:

1. Developing a PACE Program
PACE is not necessarily a new idea but it is new for home health. It focuses on the "sweet spot" for home health: keeping people in the lowest cost setting while delivering care they need in a safe environment.

2. Developing Private Pay Capitated Partnerships on Natural Recurring Retirement Communities (NORCs):
By developing options that create a non-institutional community within the larger community, home care providers can pick up patients earlier (before they are sick), tie in gap stop insurance, keep people out of institutions and begin providing the health, emotional and social networks they need to stay healthy longer. Local (large city) collaboration would be a good way to start exploring options and funding.

3. Developing a Home Health-Based Accountable Care Organization:
Physician involvement and oversight of home healthcare – from care plans through delivery – has traditionally been viewed as a challenge to continuity of care. However, the model of the Accountable Care Organization (ACO) may provide an opportunity for home health providers to position themselves more favorably with referring physicians and third-party payers.

Under an ACO model, home health agencies would form associations with other agencies and analyze physician referral patterns within their markets. Physicians who refer the majority of home care in a market would be identified as 'extended medical staff' of the agency and form an ACO that would track outcomes and clinical and quality improvements longitudinally. The ACO would then negotiate with managed care organizations (including Home Health Benefit Managers, private, Medicare Advantage and Medicaid HMO plans) for preferred positions to manage the cost of chronic conditions in the home with appropriate physician oversight. The ACO would share blinded physician-level outcomes data with their contracted payers for key chronic conditions, which would be used to determine which agencies would receive the physician's referral.

OPPORTUNITIES:

Geriatric Care Management has extraordinary growth potential. There is some overlap between GCM and private duty as some GCM are already doing private duty (but not vice versa). Due to reform, government is participating in healthcare more actively, and some people may want to opt out of government healthcare if they can afford their own private care. People want to return to their home as quickly and as safely as possible. Subscription models for at-home services, wrapping it with technology development and retro-fitting could make it ubiquitous (like cell phones - a service that used to be a luxury or considered extravagant is now a necessary part of everyday life).

In a cost containment world, specialization in one type of home health will take a back seat to coordination of services. Competitive advantage will accrue to companies that create and deploy a fully developed Geriatric Care Management program, which will offer true coordination of home care and other healthcare services. By offering GCM, not only will companies be able to direct patients to the most cost effective service options, they will be well positioned to capture the myriad of home care components.

With GCM in place, home care will be better positioned to be at the "top of the pyramid" for post-acute bundling. Home care can serve as a strong entry point for chronic care management; capture patients early in their clinical needs life cycle; generate a new revenue center; create competitive advantage by coordinating placement of patients in SNF, LTAC, inpatient rehab or home care; and assume responsibility with physicians for readmissions. Additionally, there is minimal capital expense involved in GCM and it involves a relatively easy roll-out.

CHALLENGES:

The biggest challenge facing GCM is coordination of services and payment, and avoiding friction within multi-disciplinary companies. Challenges also exist in managing risk and the margins of mass merchandising (vs. Medicare).

Big Idea #4: House Calls

DEFINITION:

House Calls are primary care house calls to the elderly homebound done by Nurse Practitioners (NPs) and collaborating physicians. Under this program, house calls become the alternative to primary care physicians (PCPs). Technology has made this approach to medical care possible. NPs can make approximately eight house calls a day, typically limited to a geographic area that allows for minimal "windshield time." The NPs carry a modern version of the physician's "black bag," which contains portable versions of all the technology available in an urgent care center and weighs less than 18 pounds.

OPPORTUNITIES:

House Calls fill a critical gap in the healthcare continuum, which is characterized by aging demographics, chronic disease, homebound elders, a shortage of PCPs, and PCPs who are declining new Medicare patients due to payment shortfalls. House Calls represent a significant opportunity to address this gap. A number of home care companies are currently doing House Calls and one is currently franchising.

In the past decade, there has been renewed interest in House Calls, using a Physician-Nurse Practitioner collaborative model. The targeted population for House Calls are homebound seniors, mostly living alone and too old or frail to get to and from their doctor's office, or whose doctors have retired. These seniors are the most vulnerable: no one monitoring their multiple medical issues, medications, or compliance with physician orders. With Medicare payments greater for House Calls than for office visits, and using an efficient and productive Nurse Practitioner model wherein the NP provides 80-85% of the house calls, this program can be profitable and also reduce avoidable hospitalizations and ER visits.

There is a synergy between House Calls and home health because House Calls present a valuable referral source. There is overlap in patient demographics and adding House Calls to an existing home health agency allows the agency to leverage back office services (scheduling, medical records, billing). It also enhances opportunities for identifying significant changes in patients' conditions that warrant a new home health episode.

Given the new 2010 rules regarding greater physician involvement in home health services, alignment of the home health agency with a PCP who also is interested in developing a House Calls program is a win-win. Under the current Medicare payment system, House Calls can be both a revenue generator and a source of new admissions for a home health agency. House Calls can expand PCP services to include diabetes education, sharp debridement of wounds and create scale via geography and deepen market penetration.

Studies and experience show operating margins at 15-20% for well-managed House Calls programs under current Medicare payment. Depending on in-house expertise, development costs may be as low as $50,000 (including working capital). Several studies focused on Medicare patients receiving House Calls as compared to patients not enrolled in a House Call program found that the House Call patients had fewer emergency room visits, hospitalizations, hospital days, admissions to SNFs and SNF days.

In a new world of healthcare delivery, wherein providers are rewarded for reducing avoidable hospitalizations/re-hospitalizations as well as costly ER visits, House Calls combined with home health services will be a critically important, synergistic program that shrinks costs and optimizes patient quality of life.

CHALLENGES:

House Calls are a lot like running a mobile physician practice, which is very different legally and regulatory than running a home health company. House Calls will require coordination with legal counsel to avoid regulatory issues related to inter-entity referrals. For example, one House Calls program is being reviewed by CMS because it owned the diagnostic testing used by House Calls staff.

Like a traveling PCP office, a home health agency would also need willing, actively collaborating physicians. Recruiting NPs may be challenging in some markets and the geographic areas served must also be limited.

Other Big Ideas

THE HOSPITAL AT HOME

Home care has arguable become too focused on treatments in the home which are maximally reimbursed. One way to innovate and break this mold is to use clinical sense. One project that makes sense clinically is treating acutely ill, older patients at home instead of at the hospital. This includes non life-threatening diagnoses such as pneumonia, heart failure, COPD, cellulitis.

Patients can be admitted from the hospital ER in the traditional manner as well as from evolving collection areas that include patients being followed at home and in AL/IL by a house call physician. Care consists of initial 24-hour care by a home care RN, and an admission plan and diagnosis by the house call physician. At home testing and diagnosis includes blood work, EKG, pulmonary function tests, oxygen, IV fluids, and IV antibiotics administered by the MD and RN who is on 24-hour call after the initial diagnosis and visit. Telemonitoring of EKG or vital signs are linked to an ER or PCP office. A pathway for care for each diagnosis is developed and evaluated. Outcome criteria flows from this pathway and costs are measured against hospital care.

Academic studies have looked at this alternative but have been limited and not picked up commercially. This model avoids hospitalizations and re-hospitalizations, improves outcomes by lowering iatrogenic diseases and lowers costs.

TRAINING AND EDUCATING NURSES

The training and education of nurses represents a huge missing link in a fragmented home care industry. It has been difficult to maintain consistency in this arena ever since specific home care training was dropped from nursing schools when the industry declined in the 90's and nursing schools became less responsive.

The home care industry would have to establish a curriculum to present to nursing schools, and a consistent home care education component could also be incorporated into physician curriculums (which have been more receptive). Regional learning centers are another solution, as are online front end schools (i.e. University of Phoenix), which could be combined with in-person training done by a group of partners that would have first rights on hiring.

The home health industry does not do an adequate job of training home health clinicians. Regardless of the amount of classroom or on-the-job training, the industry tends to hire highly qualified clinical professionals who have entered home health with a hospital background.

Clinicians in home health provide care under a physician's order, but the reality is that home health clinicians are required to think more independently and act more autonomously within the home than within the hospital. Additionally, home health clinicians are expected to manage not only patient care but the entire patient episode: coordination of care between disciplines, oversight of the home health aide, effective management of visits and clinical outcomes and conferencing and communicating care to all parties involved in the patient episode.

None of the above has addressed the critical importance of understanding the OASIS, clinical outcomes, Medicare policy and regulations, the Conditions of Participation that directly affect the scope of care under home health, the myriad of changes that the Centers for Medicaid and Medicare Services (CMS) release almost daily, and the sometimes quirky requirements of the Fiscal Intermediaries (FI) that are based by regions throughout the U.S.

Home health entrepreneurs would be wise to consider collaboration on a national Home Health University whereby clinicians attend and complete a curriculum that is specific to home health with a graduation complete with approved credentialing by the American Medical Association, CMS or other appropriate accrediting organizations.

TECHNOLOGY DEVELOPMENT

Today, technology is used primarily to transmit billing information or store static information. Getting out in front of technology development will create solutions that reduce costs, increase opportunities to age in place, and improve clinical communications and compliance with care plans across sites of service. In the coming decade, budgetary constraints and lack of caregivers in the context of escalating demand will drive the widespread deployment of health status monitoring technologies and patient communication protocols that reduce visits without negatively impacting outcomes. Picture an innocuous and inexpensive bracelet that monitors vital signs and wirelessly transmits via the Internet. If a patient falls outside of a prescribed range, an agency nurse can call the patient to discuss the situation and advise/educate the patient.

Technologies that can translate into business growth or increased profits include:

- Technology focused on making the physician's job easier and, thereby connecting physicians more closely to the agency to drive more business.
- Home monitoring solutions driven by potential frailty, issues of aging, and common ailments of potential customers in your market. Paid on monthly subscription.
- Connectivity with hospitals and other referral sources to minimize admission and ease patient transfer

HOME CARE/HOSPICE PROVIDER MODEL OF THE FUTURE: 5, 10, 15, AND 20 YEARS FROM TODAY

Operators need to think broader than home care, and think about "aging services" and about IT as a communication and monitoring source (especially if home health will be bundled in reform). This will require 'out-of-the box' technology beyond what current IT vendors have today, and include larger players/platforms (IBM, Intel, Search Engines, Google, FaceBook, Twitter, Blackberry, I-Phones, Web) who need to come together in a "think tank" environment to discuss needs based on expanding populations and coverage.

The goal would be to achieve total connectivity among all providers working with a patient to manage information and promote independent living. Home care and hospice providers would be put in a proactive position to establish an industry-wide strategic plan to present to legislators, regulators, payors, other post-acute providers and referral sources. Most operators do not currently have the resources and technology to devote to this area. However, the technology is there but it just has not been packaged nor has a business model emerged (like a Subscription or Life Care Management Model).

RENOVATION/REFITTING SERVICES

This service would leverage rehab staff, specifically OTs, who would partner with contractors who specialize in "aging in place" services and retooling homes to address ADL needs. This service could be established as a partnership or, for the more entrepreneurial provider, an opportunity to consider purchasing a remodeling company.

The OT would accompany the remodeler on the initial home visit to assess the needs of the patient and provide recommendations to the contractor, addressing both the physical and cognitive needs of the patient so that appropriate structural/design/equipment modifications to the home can be made. This would be a "new company" of the agency and would offer another avenue of revenue driven by the Medicare aged patients but paid for privately. This new service would allow the provider to ramp up and market aggressively; become known either through a partnership or individually; establish them in the marketplace; and use the 'CLASS Act' dollars to pay for this type of service as noted in the proposed rules (if dollars become available through the long term care benefit being proposed).

Funding is the biggest hurdle of this service. The concept is very straightforward under private pay but the bulk of people don't have funds (private pay price point = $15-20K). A recent AARP study indicated that 83% of people want to age in their home but would need to make structural changes in order to do so. Concerns exist about exploitation, so operators need to develop a national standard ('franchise' approach) and contractors need certifications to give referral sources a sense of comfort.

MENTAL HEALTH DIVISION

The current working U.S. citizen is the most "stressed-out" generation in American history. This phenomenon is evidenced by rates of alcoholism, drugs, crime, bankruptcies and depression. Baby boomers who are currently working will soon retire and that event will not eliminate these very real mental health issues. Even OASIS-C now requires a depression screening with anticipated best practice interventions to be implemented in the plan of care. Home health currently addresses mental health by utilizing Medical Social Workers (MSW) in the patient's plan of care, however these referrals are minimal. Entrepreneurs must prepare for the future influx of home health patients who have mental health issues that – if not properly addressed – will negatively impact physical health scores that will more than likely influence reimbursement under any type of future Pay-for-Performance structure.

This would not be a traditional home care model. Instead, it would be more of a 'wrap around' model which incorporates home care. Home care operators could also partner with behavioral health where a logical referral pattern would flow from psychiatrists identifying patients who need home health and vice versa.

The challenges facing this service are that mental health patients are difficult to serve and reimbursement depends on if psychiatric nurses are covered in the care plan. Managed care companies/payers have to come up with a home care benefit.

IMPLEMENTING THE OLMSTEAD ACT

The goal of the Olmstead Act is to keep people out of institutions and offer funding for community-based alternatives. The Olmstead Act requires that States administer their services and programs "in the most integrated setting appropriate to the needs of qualified individuals with disabilities" with no exclusion based on age. The Olmstead decision never intended to exclude elders from the freedom and options the act mandates be available, and the fact that many elders are dealing with physical, mental and emotional disabilities make them eligible to be covered. This important information has not reached elders, their caregivers or care managers who continue to ask for funding, not realizing that the Olmstead law is on their side. Particularly, the Olmstead Act is there in the case of frail elders who are already residing in nursing homes but are able to function outside if appropriate services are given.

In interpreting the Olmstead Case, the Supreme Court recognizes that an unjustified institutional isolation of persons with disabilities is a form of discrimination. This discrimination is reflected in two evident judgments: 1) "Institutional placements of people with disabilities who can live in, and benefit from, community settings perpetuates the unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life"; and 2) "confinement in an institution severely diminishes everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment." (Olmstead Act, 119 S.Ct. 2176, 2179, 2187). The Olmstead decision affects all persons in institutions and segregated settings regardless of age, and all individuals with disabilities who are at risk of institutionalization - including people with disabilities, regardless of age on waiting lists to receive community based services and support.

In order for home care to benefit from the Olmstead Act, there needs to be an industry-wide initiative to force the government to do what it says it was going to do: fund community-based options for people in nursing homes. A group of home care leaders would need to advocate for it at NAHC or file a lawsuit focusing on one state (and the rest will follow). However, this is an advocacy effort that does not have an immediate return for anyone.

POLITICAL ACTION

If political action is mandatory, then the home care industry would be ahead of the curve on influence in Washington. Challenge each NAHC member and each state association member to politically contribute to their respective PAC's as part of their membership or they are not members. One political initiative could be developing a comprehensive Home Care & Hospice Benefit for the Public Option, CO-OP (non-profit) and/or Commercial Payers for the new Expansion of Care Bucket for the uninsured population:

- Remove barriers that are specific to elderly population (i.e. homebound status)
- Redefine coverage criteria and think outside the box of a Medicare provider
- Prevent readmissions and ER visits which lead to readmissions.
- Promote preventive care and wellness at home
- Provide post acute care management
- Develop/expand home care benefits for pediatrics

Thank You to Our Partners

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**The views of this white paper do not necessarily reflect the views of these organizations, nor did they influence the Think Tank discussions in any way.*

2011 Home Care 100 Regional Roundtables

Leveraging Thought Leadership in Your Region

Home Care 100 *Regional Roundtables* allow small groups of CEOs and a visionary group of suppliers to come together to discuss the most pressing business issues in home care. These efficient and thought provoking discussions will explore implications of healthcare reform, consumer demographics, technological advances, financial markets and other top of mind issues.

By invitation, these *roundtables* provide a tremendously valuable opportunity to leverage the experiences and knowledge of your peers in a compact period of time.

SCHEDULE

Dates	City	Hotel	Availability
April 4-5, 2011	Atlanta, GA	The Ritz-Carlton, Buckhead	By Invitation
June 13-14, 2011	Cleveland, OH	The Ritz-Carlton, Cleveland	By Invitation
September 8-9, 2011	San Francisco, CA	The Ritz-Carlton, San Francisco	By Invitation

BENEFITS

- Participate in forward-thinking business discussions.
- Interact with peers in a setting that promotes open exchange of ideas and the spirit of collaboration.
- Find a new perspective on a problem that has been perplexing you.
- Gain insight into the latest strategic thinking of leading peers.
- Find new ways to incorporate best practices and progressive thinking into your own organization.

ATTENDANCE

Provider attendance is exclusively for CEOs from large home care and hospice operators and is limited to 15 executives. Supplier attendance is capped at ten executives.

PROGRAM FORMAT

Each all-inclusive *roundtable* begins with a dinner meeting at one of the area's top restaurants from approximately 7:30 to 10:00 p.m. The dinner will be a mix of networking and business discussions. The next morning we begin at breakfast from 7:30 to 8:30 a.m. followed by a business meeting from 8:30 to 11:00 a.m. Afterward, a summary of the meeting content will be published in a *Regional Roundtable* newsletter and circulated.

PARTICIPATION

Space is limited and by invitation only. Please contact Meredith Anastasio for availability and details:
(203) 644-1718 or manastasio@lincolnhc.com.

About Lincoln Healthcare Events

Lincoln Healthcare Events offers high-quality C-level leadership, networking and education programs for the healthcare industry. The company strives to positively impact the quality and effectiveness of the U.S.healthcare system by helping to educate and share best practices among its business leaders.

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February 13-15, 2011 ▪ Ritz-Carlton Laguna Niguel, CA
For Senior Management in Home Care & Hospice

HCap
WHERE HEALTHCARE MEETS CAPITAL

December 6-8, 2010 ▪ JW Marriott, Washington, D.C.
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October 23-25, 2011 ▪ Pinehurst Resort, NC
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