



Managing. Consulting. Caring...

 HEALTH
DIMENSIONS
GROUP

Strategies and Solutions for Home Care in an Accountable Care Organization

Jane Gorwin, Senior Home Care Consultant

Topics for Presentation and Discussion

- Home health, hospice, and private duty: providing solutions:
 - Care transitions program.
 - Home monitoring.
 - Partnerships: ACOs, hospitals, post-acute providers.
 - Data drives the details!

Getting into the Details: Strategies Home Care Can Offer to an Accountable Care Organization



Planning for 2012–2015

Payment and Delivery System Changes

Implications for Home Care Services

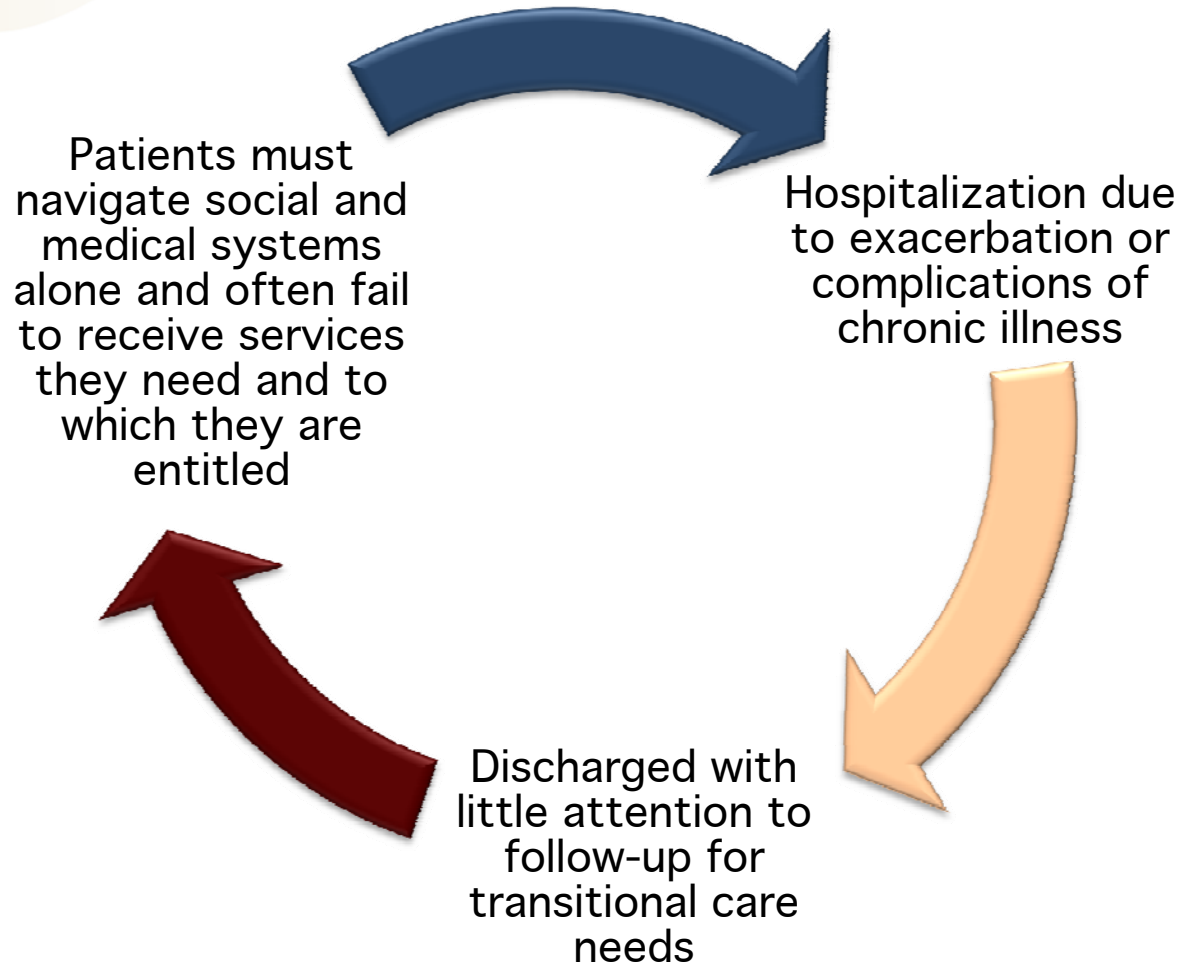
Reductions in hospital readmission rates and penalties

- Increased care coordination.
- Data-driven post-acute care (PAC) decisions.
- More home health technology.
- More effective use of hospice and palliative care.
- Non-medical personal and functional support.

Accountable care organizations and bundled payment

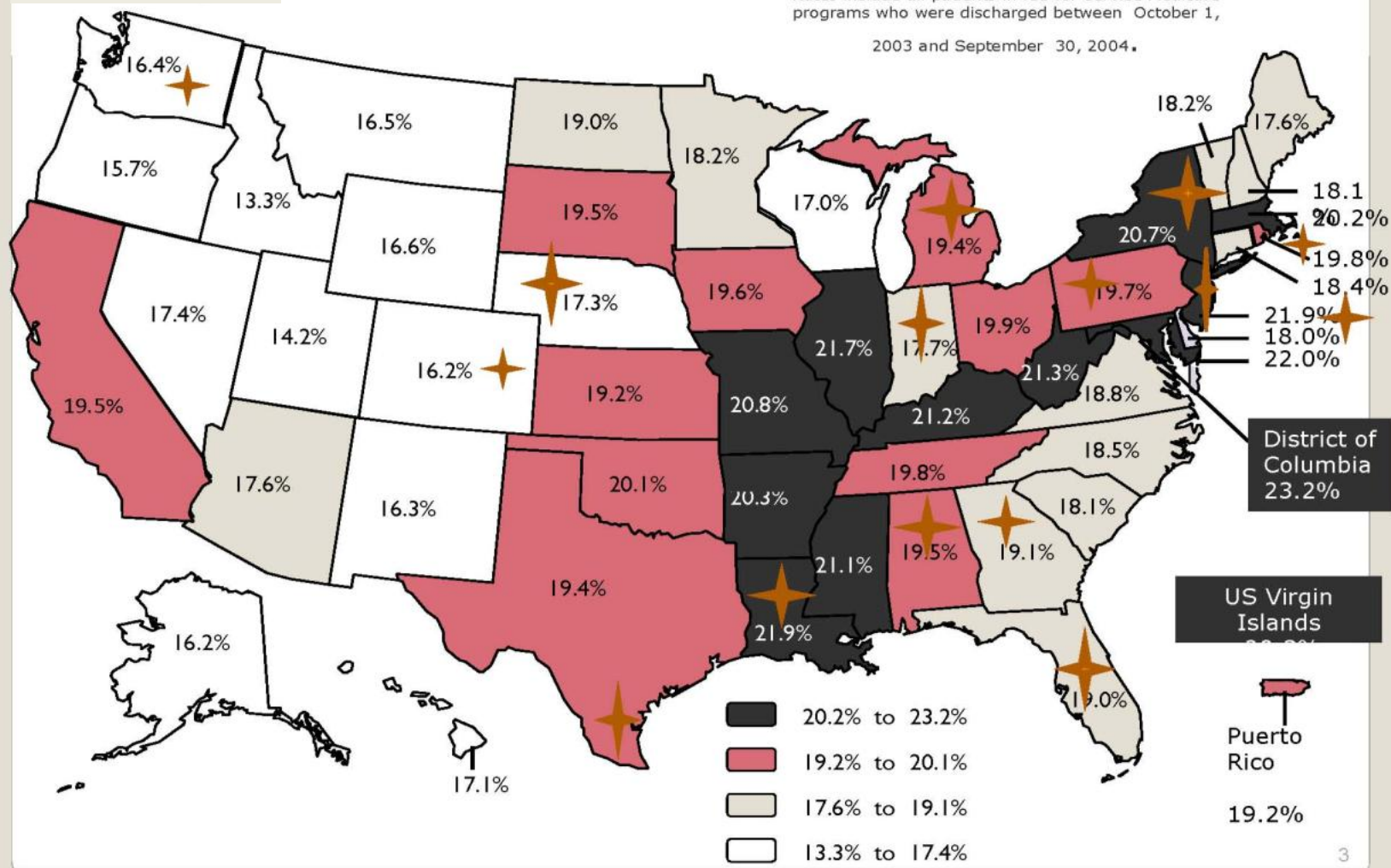
- Hospital-physician-post-acute partnerships essential.
- Greater home health-hospice electronic information and connectivity.
- Evidence-based care protocols.
- Fewer home health visits and more use of home technology.
- Bundled PAC payment, financial risk/gain sharing, capitated payments.
- Risk/gain sharing with suppliers, manufacturers, physicians.
- Home care will have leading role.

Need for a Solution: Broken Health Care System for Chronic Care Management



Rates of Rehospitalization Within 30 Days After Hospital Discharge

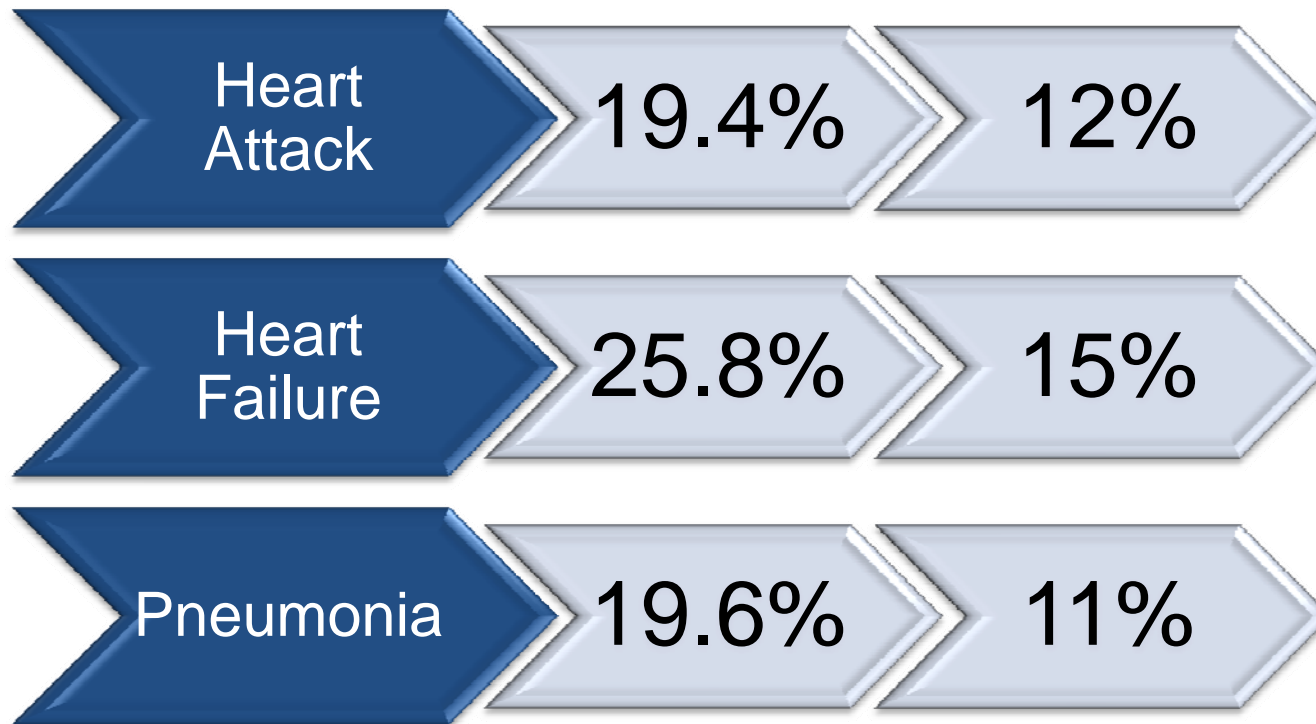
Rates include all patients in fee-for-service Medicare programs who were discharged between October 1, 2003 and September 30, 2004.



Jencks SF, Williams MV, Coleman, EA. Rehospitalizations among Patients in the Medicare Fee-for-Service Program. N Engl J Med 2009;360:1418-28.

Strategy

- Demonstrate your 30-day readmission rates by condition and your plans to continue to reduce.



Care Transitions Intervention (CTI)

- Focus of transition coach: support and teach self-management skills to improve the patient's ability to manage chronic disease and to navigate the health care system.
- Program initiated prior to hospital discharge and continues four weeks post-discharge.
- RN Transition Coach™ meets with patient in the hospital, completes home visit 48–72 hours post-discharge, and holds 2–3 telephone consultations within the first 30 days post-discharge.



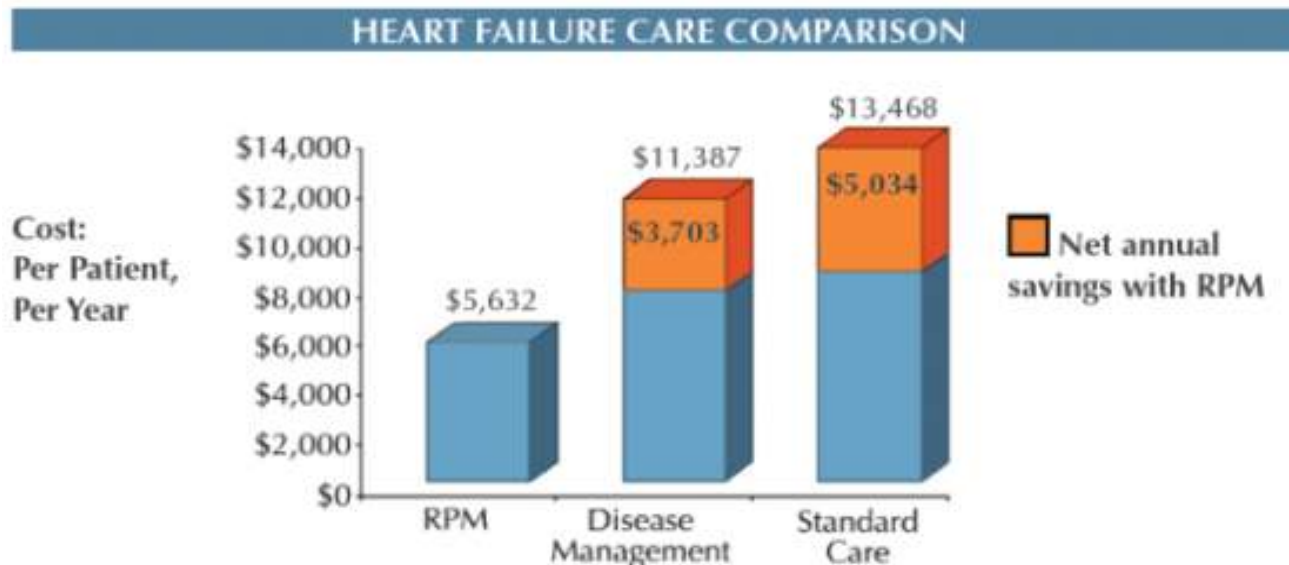
CTI: The Tools

- Key tools and processes include:
 - Personal health record (PHR).
 - Medication reconciliation.
 - Identification of personal health goals.
 - Identification of “red flags” associated with chronic disease.
 - Development of plan for early response to changes in disease condition.



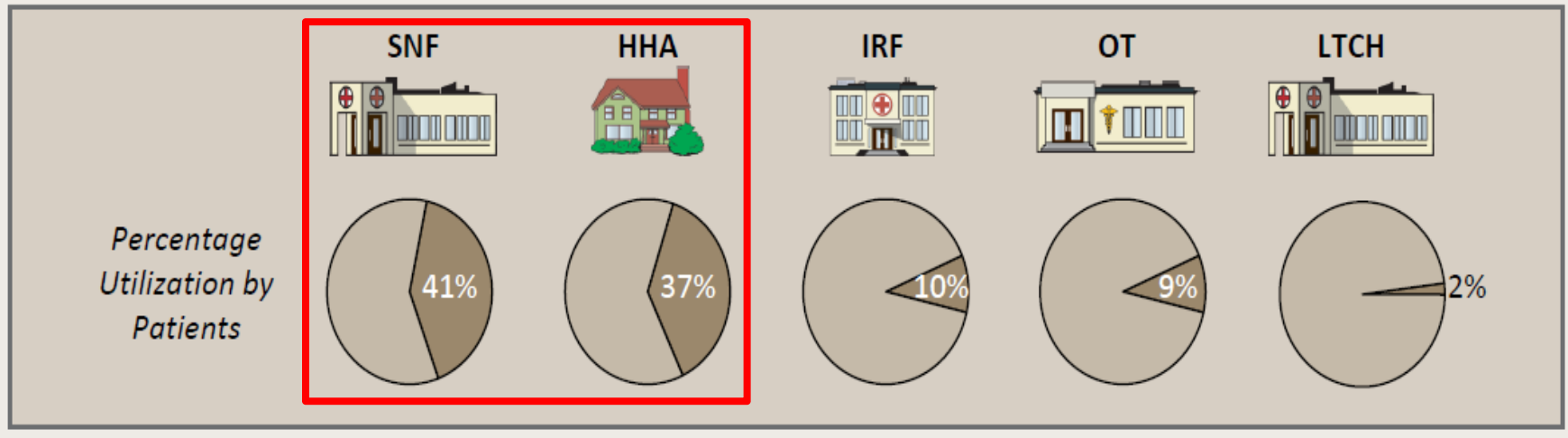
Solution 2: Remote Patient Monitoring (RPM)

- NEHI projections of savings using RPM:
 - 60% reduction in hospital readmissions from standard care alone.
 - 50% reduction in hospital readmissions from DM.
 - Prevent 460,000–627,000 heart failure-related hospital readmissions/year.
 - NEHI estimates an annual national cost savings of up to \$6.4 billion.



Solution 3: Value-Based Hospital and PAC Partnerships

Hospital Discharges to PAC Providers

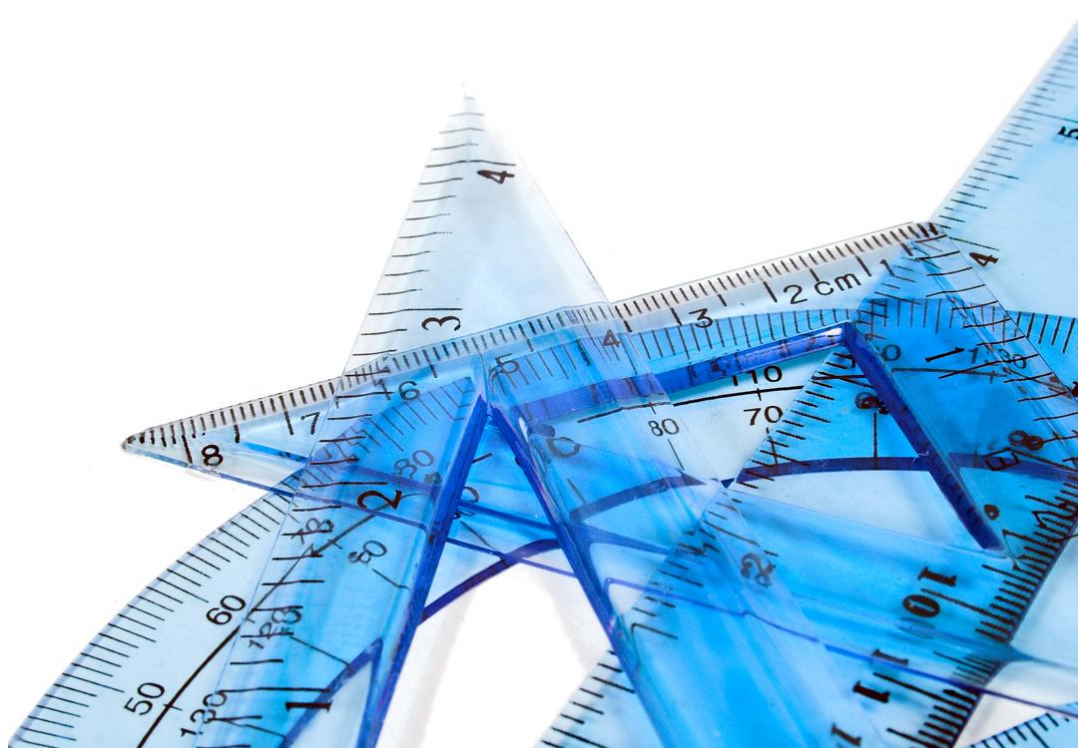


Value-Based Partnership Essentials

- Considerations for determining their partners:
 - Quality, cost performance of agency.
 - Current referrals to agency.
 - Use of technology; ability to share clinical and financial information.
 - Geographic coverage area.
 - Strength and type of existing relationship.

Which Solutions are Best for You?

Start with measuring the right data.



Happy Home Health Data

	Agency		State		National	
	Current	Previous	Current	Previous	Current	Previous
Acute Care Hospitalization	33%	32%	26%	29%	24%	25%
Oral Medication Improvement	40%	31%	55%	50%	67%	65%
Unplanned ED Visits	88%		97%		97%	

Decline

Improvement

Defining Specific Goals for Reduction in Readmissions and ED

- 5-day readmissions
- 15-day readmissions
- 30-day readmissions
- Readmissions by diagnosis by X%
- HH patient readmissions by X%
- Readmissions for patients discharged to SNF by X%
- ED admissions for indigent patients for CHF by X%
- ED visits for HO patients by X%
- Readmissions due to falls, functional deficits by X%

Defining Additional Specific Goals

- 95% of patients seen by PCP within 5 days of discharge.
- 95% of home health patients on telehealth managed in home (no ED or hospital admission while monitored).
- Increase hospice length of stay by X% to match industry best practice benchmarks by terminal condition.



Tracking Data Elements

- PCP.
- Hospitalist/s.
- Discharge principal diagnosis.
- Cost of care.
- Reimbursement.
- Comorbidities at DC.
- LOS in acute care.
- CNS/PC/GNP.
- Functional deficits and ED visits.
- Readmission to ER.
- Readmissions to acute.
- Medication discrepancies.
- Education provided.
- PCP visit within 7 days post-discharge.
- Standing orders/protocols initiated .
- Were the right labs ordered?

Data Turned Into Wisdom

Facts

What it is all about

Start with good data



Information

How facts fit together

Unearth hidden patterns



Knowledge

Why do patterns occur

Grasp meaning, causes



Wisdom

What prudent action to take

Knowledge:
no guarantee of prudent action

System Issues Identified

- Workflow process change: redesign and eliminate waste and duplication.
- Integration of care and practices across settings.
- Patient care goals in place:
 - Implications for skilled and non-skilled interventions

Methodologies and Processes to Reduce Rehospitalizations: Home Health

- Integrated patient care/clinical paths:
 - Evidence based.
 - Part of EMR and documentation systems.
- Well-defined transitional care elements.
- “Front loading” patient contact at SOC.
- Telehealth: remote monitoring for complex patient populations.

Methodologies and Processes to Reduce Rehospitalizations: Palliative Care/Hospice

- Earlier identification of chronic disease decline within each care setting; evidence-based criteria.
- Palliative care “bridge” program to follow and intervene between home health and hospice levels of care:
 - Integrated/shared team between palliative care and hospice.
 - Determine causes of ED visits and increased rehospitalizations.

How Can Private Duty/Non-Medical Agencies Benefit an ACO?

- Define your core services:
 - Companion care.
 - Housekeeping.
 - Household management.
 - Personal care.
 - Functional/mobility assistance.
 - Client safety.
 - Transportation.



Defining More Types of PD Services

- Geriatric care management.
- Wellness navigator.
- “Lifestyle for Independence” coach.

**ANALYZE WHAT THESE SERVICES
CAN MEAN TO AN ACO!**

**IMPLEMENT ENHANCED DATA-GATHERING
CAPABILITIES TO QUANTIFY VALUE.**

What is Your Non-medical Value Proposition?

- Reducing ED visits.
- Reducing hospital readmissions.
- Safety factors.
- Sense of well-being versus depression or substance abuse.
- Staying motivated and compliant with medications, diet, and mobility.

Planning is Key ...

- Identify and develop plans for communication and inclusion for each X-system key departments and individuals to collaborate with home health/hospice.
- Identify current related processes impacted by each change.
- Determine level of integration of current staff and staffing needs and current functions and workflow processes to be considered.
- Identify key political potential partner issues.
- Know your data and present to your future partner and fine-tune to meet their goals.

Whether you are a
freestanding agency or
part of a health system

Lessons Learned: Critical Elements

- Developing patient/client and caregiver “ownership”:
 - Behavioral modification based on their goals.
 - Motivational interviewing techniques.
 - Coaching versus directing.



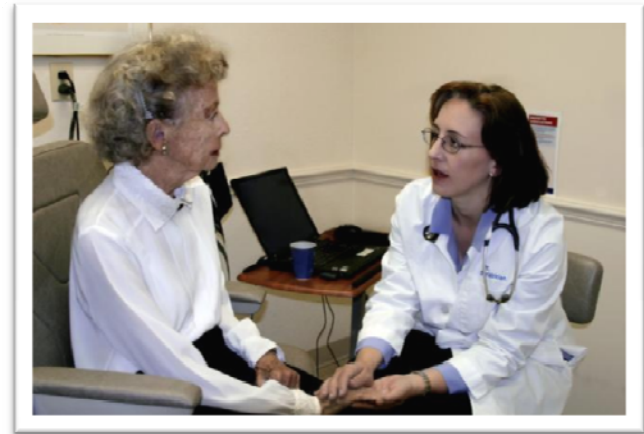
Medication Reconciliation



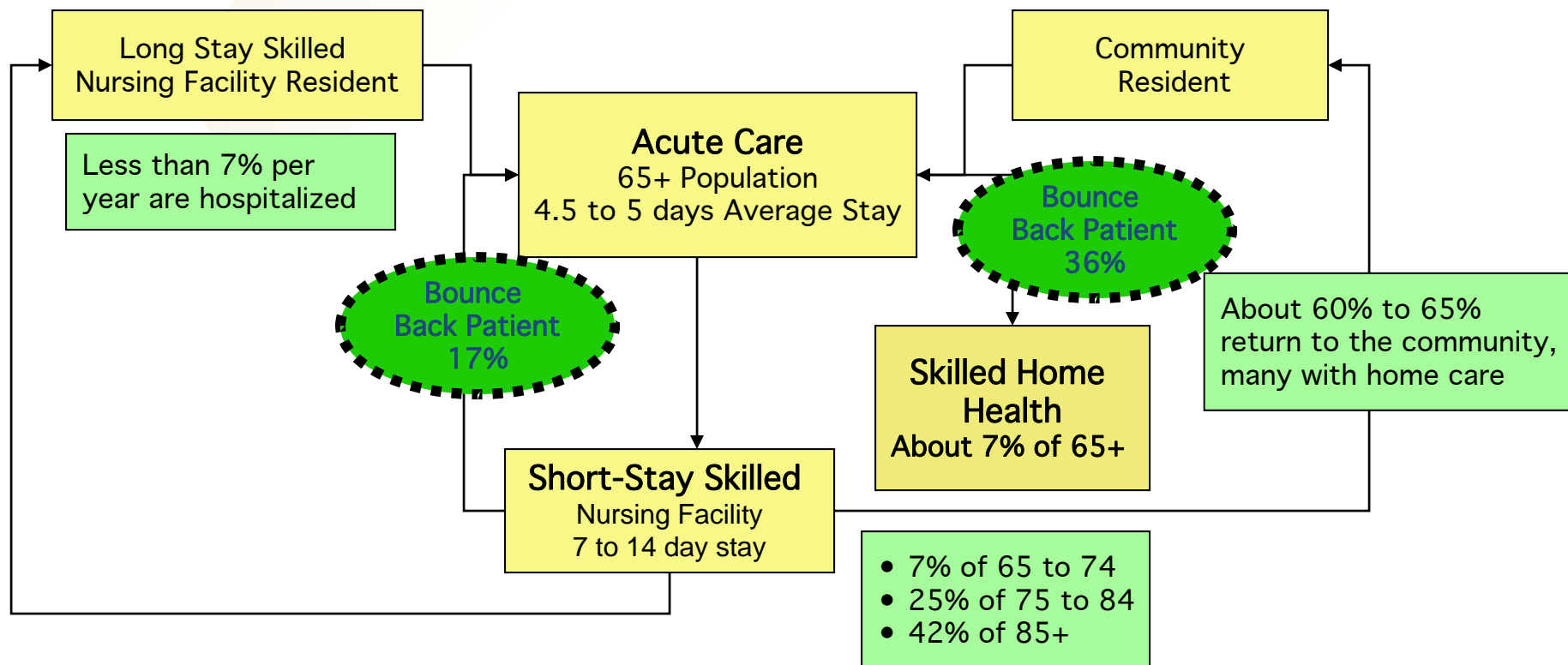
- Thorough.
- Consistent—never ends.
- Track discrepancy rates.
- Use data to analyze “failed” system.
- Make system changes.
- Use data to analyze patient errors.
- Identify and implement systems to decrease patient errors.

Addressing Psychosocial Issues: Medical and Non-medical

- Palliative care discussions and planning.
- Assessing and treating depression.
- Transportation issues.
- Financial issues related to care.
- Legal issues.
- Caregiver competence.



Regional Emerging Post-Acute Care Model



- Short-stay skilled care program has evolved to become specialized step-down program for those older adults recovering from surgery, with new chronic diseases, and/or debilitated by their illness who require greater recovery time.
- The “bounce back” patient is a focus for quality improvement; best performing state has about 13% of short-stay residents return to acute care within 30 days.

A Final Thought...

“The real voyage of discovery consists not of finding new lands but of seeing the territory with new eyes.”

Marcel Proust



THANK YOU.

QUESTIONS, THOUGHTS, MORE IDEAS?

Faculty Contact Information

Jane Gorwin, RN, BSN, MA
Senior Home Care Consultant
Health Dimensions Group

4400 Baker Road, Suite 100
Minneapolis, MN 55343

760.250.4558

763.537.9200 fax

janeg@hdgi1.com

www.healthdimensionsgroup.com





HOSPITALITY

STEWARDSHIP

INTEGRITY

RESPECT

HUMOR