The Role of Home Health in Preventing Hospital Readmissions

The Value of Home Care in Accountable Care

MaineHealth's Home Health Partners

Key Topics

- Home Care. Who are we?
- The Multidisciplinary Team Case Conference Approach to Managing Patients with Chronic Disease
- Integrated Chronic Care Management Certification
- Q&A

Who We Are

- Medicare Certified & State Licensed (Medicaid) Home Health Providers
- Medicare Certified & State Licensed (Medicaid) Hospice Providers

Centers of Excellence

- WOCN/WON
- Diabetes Specialists
- Lymphedema Certified Therapists
- Hospice/Palliative Care Certified Nurses
- Pediatric Specialists
- RN, PT, OT, SLP, MSW
- Integrated Chronic Care Certified Staff

When patients can remain in familiar surroundings, the benefits are many: the person retains greater control over their daily lives, families and caregivers report greater satisfaction with the care and unnecessary hospitalizations are avoided.”

-- CMS Acting Administrator Marilyn Tavenner

Key Characteristics of Providing Health Care in the Home

- Continuation of **teaching/learning** that began in the hospital, SNF, LTC, physician's office
- **In-home** assessments provide a holistic view of the patient, caregivers
- Evaluate true **functional** mobility
- **Medication** reconciliation and management
- Reinforcing **Red Flags** to avoid readmissions
- **Telemonitoring**

Key Characteristics of Health Care in the Home

- Use Clinical **Pathways** or Care Plans based on evidenced-based practices
- **Electronic medical record** (for over a decade)
- **24/7** on-call nursing
- Palliative Care/end-of-life care
- Community **Integration**
- **Low cost** provider: for a 60-day home care episode … $2,400
- **Quality:** Outcome Assessment and Information Set (OASIS) provides quality and process outcomes

The past is like a foreign country, they do things differently there.

The Foundation: Value-Based Payment

- *" a reform initiative whereby health care providers will receive payment for service based on their performance or the potential outcomes of the services"*
- The de facto definition of value as it relates to health care is the intersection of lower cost with outcomes
- Providers who have low costs and can deliver quality will be measured as value-based providers.

Make it a Science or…Meaningful Metrics

- Every organization will tell their story and define their value proposition.
- All need to demonstrate impact on health care utilization across the continuum

How Home Care Readmissions are Calculated

- If a patient is admitted to a hospital at any time while they are on a Home Care active census, it is considered a readmission.
- *A patient can be on service for months or years.*
- *If a patient is readmitted for elective surgery, it is considered a readmission.*
- *Getting below 20% is our collective goal.*

The Delta Study to Reduce Hospitalizations

- A National Study to Reduce Avoidable Hospitalizations through Home Care by Identifying Best Practices.
- Sponsored by Delta Health Technology, National Association of Home Care, The Joint Commission, American Physical Therapy Association and Fazzi Associates, Inc.

Key Characteristics of Agencies with Lower Readmission Rates

- Fall Reduction Program
- Medication Management/Reconciliation
- Patient / Caregiver Education
- Disease Management
- Telehealth
- Telephone Practices
- Front Loading of Visits

Key Characteristics of Agencies with Lower Readmission Rates

- 24/7 Availability
- Strong Staff Education: ICCC etc.
- Interdisciplinary Team Approach
- Formal Hospitalization Avoidance Program

Health Systemwide Strategies

- Non-medical Community Agency Support Services
- Physician – Home Care Hospitalization Avoidance Protocol
- Hospital to Home Care Hospitalization Avoidance Protocol
- ED to Home Care Hospitalization Avoidance Protocol
- Care Transition Strategy (CTC)

Kno-Wal-Lin Home Care and the Fazzi SafeSide Project

- Two-day workshop to review Delta Study
- Data sent to Fazzi and Associates on patients who have been readmitted via a specific chart review tool
- Monthly conference calls to look at trends and at strategies moving forward
- Goal is to reduce home care readmissions toward 20%
- At start of study, KWL was at 26% in January 2012
- Currently at 22% (low was 14%, high was 29%)
- National average 27%

New Vocabulary

- ACO's
- Triple Aim
- Medical Home
- Coleman Model: 4 Pillars
- Value-Based Purchasing
- Predictive Modeling
- Fee for Volume (current) Versus Fee for Quality (future)
- Core Values
- Boost and the 8 P's
- Shared Decision Making

New Vocabulary

- 4 Pillars of Chronic Care Management
- The Eighth Scope of Work
- The Pennsyltucky Protocol

“The fox knows many little things but the hedgehog….he knows one big thing.”

Managing Patients with Chronic Disease

- > 75% of health care spending is attributed to patients with chronic illness
- This represents 5% of Medicare beneficiaries and accounts for nearly one-half of Medicare expenditures
- This has prompted an expansion of Dr. Edward Wagner's Chronic Care Model into The Home Based Chronic Care Model which supports MaineHealth's goal to reduce readmissions

The Four Pillars of The Home Care Chronic Care Model

- High Touch Delivery
- Theory-Based Self-Management Support
- Technology
- Specialist Oversight

The Multidisciplinary Team Approach to Chronic Disease Management

- Weekly and mandatory for all disciplines
- Starts on time, ends on time
- Led by Director
- Clear consistent format
- Clinical Information is projected
- Patients due for recertification are reviewed
- New admissions are reviewed and screened (for telehealth…)
- Visit schedules are critiqued
- Barriers for solid discharge plans are reviewed

Multidisciplinary Team Meeting

- Focus on those patients with chronic illness and those known to us as high risk
- Ad hoc complex case conferences
- Documented in the clinical record
- Difficult cases are rolled forward

Integrated Chronic Care Management Certification

- 8-hour Classroom education
- 4 online modules on HF, Diabetes, COPD and Depression
- On-Line course exam, approximately 2 hours to complete, minimum score 80%

ICCM Course Content

- Self-Management Support Concepts: Systematic provision of education and supportive interventions to increase patients skills and confidence in managing their health.
- Evidence-based Guidelines for chronic disease management
- Use of telehealth and technology
- Transitions of care
- Assessing Health Literacy: a stronger predictor of health than age, employment status, educational level, and race
- Principles of adult learning
- Teach-back method

ICCM

- Motivational interviewing
- Listening as a core competency
- SMART goal setting: Specific, Measureable, Attainable, Relevant, Time defined
- Community-Based Care Transitions Model (Avoidance protocols)

Can First World Countries Learn Something from Third World Countries?

Questions/Discussion

Thank You

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  Kno-Wal-Lin Home Care and Hospice

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