The Home Health Challenge

**PLAN, POSITION, PARTNER**

*Presented by:*
Tim Ashe MSN, MBA
Partner
Fazzi Associates, Inc.
tashe@fazzi.com

---

**WHEN THINGS ARE CHANGING FAST**

Not Paying Attention to the Changes and Not Responding to the Changes Can Lead to Your... *Demise*
A SHARED APPROACH TO THIS SESSION STRATEGIC MANAGEMENT MODEL

What's Going To Happen?

What Should We Do About It?

What Are The Implications?
KEY CONTEXT

- Our Health Care system is strained and constrained
  - Quality is a problem; a very expensive problem
  - Reactive rather than preventative
  - Silo impact:
    - Gaps in transitional care and disease state management
    - Lack of system inter-operability limits communication or creates more labor/more cost to navigate
    - Duplicative work—overall reduction in productivity

- Seniors/demography and associated chronic disease are major, growing cost drivers

- Is Healthcare is Moving Home?

INDUSTRY CHALLENGE

DO MORE WITH LESS

- 2011: Standard 60-day episode rate was reduced by 2.5%.

- 2012 and 2013: Market basket update was reduced by 1%.

- 2014 to 2016: Sequestration and a phased rebasing was implemented to lower payments to a level to reflect changes in average visits per episode and other factors that may have changed since rate was originally set.

- 2015 and following years: Market basket was reduced by multifactor productivity for each year.
IMPACT OF REVENUE PRESSURE
AGENCIES WILL HAVE TO DECIDE

• Reduce margin
• Sustain operations
• Reduce employment
• Reduce benefits
• Mergers or acquisition
• Close
• Innovate...

MEDICARE-CERTIFIED HOME HEALTH AGENCIES

Source: CMS/CSP, Table VI.3, Other Medicare Providers and Suppliers Selected Years, December 2011 and MedPAC, Report to the Congress: Medicare Payment Policy, March 2012 and March 2013
**Medicare Home Health Patients**

*In Millions*

<table>
<thead>
<tr>
<th>Year</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Value</td>
<td>2.47</td>
<td>2.42</td>
<td>2.55</td>
<td>2.68</td>
<td>2.83</td>
<td>2.97</td>
<td>3.03</td>
<td>3.09</td>
<td>3.16</td>
<td>3.30</td>
<td>3.43</td>
</tr>
</tbody>
</table>


**Medicare-Certified Hospices**

<table>
<thead>
<tr>
<th>Year</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Value</td>
<td>2,323</td>
<td>2,434</td>
<td>2,645</td>
<td>2,872</td>
<td>3,071</td>
<td>3,255</td>
<td>3,346</td>
<td>3,405</td>
<td>3,509</td>
<td>3,630</td>
</tr>
</tbody>
</table>

Source: Medicare & Medicaid Research Review, 2012 Statistical Supplement and CMS/OIS/HCIS, Data from the Standard Analytical Files. Table 8.1
**MEDICARE HOSPICE PATIENTS**

<table>
<thead>
<tr>
<th>Year</th>
<th>Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>1,223,551</td>
</tr>
<tr>
<td>2010</td>
<td>1,163,037</td>
</tr>
<tr>
<td>2009</td>
<td>1,094,005</td>
</tr>
<tr>
<td>2008</td>
<td>1,054,722</td>
</tr>
<tr>
<td>2007</td>
<td>999,803</td>
</tr>
<tr>
<td>2006</td>
<td>942,375</td>
</tr>
<tr>
<td>2005</td>
<td>873,909</td>
</tr>
<tr>
<td>2004</td>
<td>799,715</td>
</tr>
<tr>
<td>2003</td>
<td>731,021</td>
</tr>
<tr>
<td>2002</td>
<td>662,333</td>
</tr>
<tr>
<td>2001</td>
<td>594,665</td>
</tr>
<tr>
<td>2000</td>
<td>534,408</td>
</tr>
</tbody>
</table>

Source: Medicare & Medicaid Research Review, 2012 Statistical Supplement and CMS/OIS/HCIS, Data from the Standard Analytical Files. Table 8.1

**PERCENT OF SENIORS WITH CHRONIC DISEASE**

<table>
<thead>
<tr>
<th>Conditions</th>
<th>Age 55 to 64 Years</th>
<th>Age 65 Years and Over</th>
</tr>
</thead>
<tbody>
<tr>
<td>1+ chronic conditions</td>
<td>69.5%</td>
<td>85.6%</td>
</tr>
<tr>
<td>2+ chronic conditions</td>
<td>37.1%</td>
<td>56.0%</td>
</tr>
<tr>
<td>3+ chronic conditions</td>
<td>14.4%</td>
<td>23.1%</td>
</tr>
</tbody>
</table>

Source: CDC/National Center for Health Statistics: National Health Survey, Percentage of Adults age 55 and over (Total, Male & Female), with one or more, two or more, or three or more of a possible six chronic conditions: United States, 2008.
2056

The year in which, for the first time, the population 65 and older would outnumber people younger than 18 in the U.S.

Source: U.S. Census Bureau, Population Projections, 2012

GROWTH IN MEDICARE ENROLLMENT

HISTORIC & PROJECTED

(In Millions)

Note: Enrollment numbers are based on Part A enrollment only. Beneficiaries enrolled only in Part B are not included.
THE TRIPLE AIM

- Improving the patient experience of care (including quality and satisfaction)
- Improving the health of the populations
- Reducing the per capital cost of health care

Source: Institute for Healthcare Improvement

CMS INNOVATION MODELS

41 MODELS; 7 CATEGORIES

<table>
<thead>
<tr>
<th>Accountable Care</th>
<th>Bundled Payments for Care Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care Transformation</td>
<td></td>
</tr>
<tr>
<td>Initiatives Focused on the Medicaid and CHIP Population</td>
<td>Initiatives Focused on the Medicare-Medicaid Enrollees</td>
</tr>
<tr>
<td>Initiatives to Accelerate the Development and Testing of New Payment and Service Delivery Models</td>
<td>Initiatives to Speed the Adoption of Best Practices</td>
</tr>
</tbody>
</table>
ACCOUNTABLE FOR WHAT?

Health IT & HER Utilization  Interoperability  Care Coordination

Best Practices  Quality and Outcomes Improvement  Patient Education

Patient Satisfaction  Cost Containment  Cost Reduction (to increase shared savings)


HOME CARE MUST EVOLVE

Move from an acute intermittent episodic-based service to a Value Added provider of transitions and population-based Care Management across the continuum.
Whether you are involved in an ACO, Medical Home model or Value Based contract, the common denominator is to move the patient to the highest level of self care at the lowest cost setting at the right time.

Home care knows care management, how to identify patient needs and provide the best possible plan of care to achieve patient self care and independence...we need to move this to the Continuum level and manage patient transitions.
THE NEW HEALTH CARE REFORM

VALUE-BASED HOME CARE MODEL

Value-Based Partnering

Value Based Care Mgmt. Model
Lean, Accountable, Clear, and Measurable Value-Based Outcomes

Value Based Supervisory Management
Skills, Accountability, Competence and Ability to Manage New Health Care Models

Value Based Home Care Model: Population Management/Care Transitions/Triple Aim Ready

Value Based Targets
1. Top 1/3 Profit Margin
2. Top 1/3 Patient Sat.
3. Top 1/3 HHC
4. Lowest 1/3 Hosp.
5. Lowest 1/3 Cost

CONTINUUM-BASED CARE MANAGEMENT

BY FAZZI

Information Management

Positive Outcomes: Clinical Financial

Care Management

Operations Management

Marketing Accounting Leadership
Billing Functional Management Technology
CONTINUUM-BASED CARE MANAGEMENT

BY Fazzi

Patient / Community

Plan of Care / Level of Care

Risk/Care Needs Assessment

Monitor and Measure

Care Transitions

The FirstHealth Model
FirstHealth of the Carolinas

4 Hospitals
Reid Heart Center
Hospitalist Services
Specialty Practices
Primary Care Practices
Hospice Services
Inpatient Rehab
Outpatient Services
Care Transitions

The Road to Transitions
Strategic Partnerships

Hospital to Home Pilot

Post Acute Care Workgroup

Skilled Nursing Facility Team

Reid Heart Center Project

Hospital to Home Pilot

Partnership with Hospital, Hospitalists, Outcomes Management, Corporate Quality, Pharmacy, Education, Community Care Network

100 HF and COPD patients x 1 year

Transition processes defined, gaps identified
Lessons Learned

Significant reduction in ED utilization at 30, 60 and 90 days

20% Improvement in PAM scores

30% improvement quality of life

Impact on 60/90 day readmits- but not 30

Back to the Drawing Board

100% record reviews for hospitalized patients

Identified key areas to address:
  - Critical thinking skills of frontline staff
  - Clinical skills of the multi-d team
  - High risk days to hospitalization
  - Treating the whole patient
Post-Hospital Syndrome
An Acquired, Transient Condition of Generalized Risk

"During hospitalization, patients are commonly deprived of sleep, experience disruption of normal circadian rhythms, are nourished poorly, have pain and discomfort, confront a baffling array of mentally challenging situations, receive medications that can alter cognitions and physical function, and become deconditioned by bed rest or inactivity."1

1. NEJM 368;2 January 10, 2013, Harlan M. Krumholz, M.D.

Cardiothoracic Surgery Pathway

Partnership between the Reid Heart Center and FirstHealth Home Care

Standardized clinical pathway
- Telehealth/Heart Center trained
- 8 structured home nursing visits
- Standardized patient education
- ECG capabilities
- Transitions the patient to cardiac rehab and cardiology follow up

New pathway developed for Transmyocardial Revascularization and Transcatheter Aortic Valve Replacement
Cardiothoracic Surgery
Home Health Hospitalizations

Cardiothoracic Surgery
Clinical Outcomes
Patient Activation Measure

The Universal Language of Care Transitions

The Patient Activation Measure

Measures the patient’s knowledge, skills and confidence essential to self management

Stratifies patients into one of four activation levels

Predicts healthcare outcomes including medication adherence, ER utilization and hospitalization

Creates a universal language across care settings
**Level 1**
Starting to take a role
Individuals do not feel confident enough to play an active role in their own health. They are predisposed to be passive recipients of care.

**Level 2**
Building knowledge and confidence
Individuals lack confidence and an understanding of their health or recommended health regimen.

**Level 3**
Taking action
Individuals have the key facts and are beginning to take action but may lack confidence and the skill to support their behaviors.

**Level 4**
Maintaining behaviors
Individuals have adopted new behaviors but may not be able to maintain them in the face of stress or health crises.

---

**The MORE ACTIVATED you are in your own health care, the BETTER HEALTH CARE you get...**

<table>
<thead>
<tr>
<th>MORE ACTIVATED Patient</th>
<th>LESS ACTIVATED Patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Readmitted to the hospital within 30 days of discharge</td>
<td>12.8%</td>
</tr>
<tr>
<td>Experienced a medical error</td>
<td>10.2%</td>
</tr>
<tr>
<td>Have poor care coordination between health care providers</td>
<td>12.6%</td>
</tr>
<tr>
<td>Suffer a health consequence because of poor communication among providers</td>
<td>13.2%</td>
</tr>
<tr>
<td>Lose confidence in the health care system</td>
<td>13.1%</td>
</tr>
</tbody>
</table>

Source: Adapted from AARP You "Beyond 50" Patient Survey. Published in AARP Magazine. Study population age 50+ with at least one chronic condition. More Involved: Levels 3 & 4. Less Involved: Levels 1 & 2.
Care Transition Services

*Managing Chronic Disease Across the Continuum*

---

**Lessons Learned**

**Transitional Care**

- Patient-centered: patient goal driven
- Excellent communication across settings
- Coordinated hand-offs: transitions
- Standardized education: consistent message

*Highly skilled nurse* to address patient’s complex needs and help navigate the care system

High risk patients identified: the PAM
The FirstHealth Center for Telehealth

$1 million HRSA Telehomecare Network Grant

Provide remote monitoring for high risk patients:
- SNF
- Community Care Network
- PACE Program
- HUD residents

Achieve economies of scale

Standardize practices and interventions

Develop cross setting communication strategies

Create sustainable payment model
Complex Care Management

High risk, lowly activated, not homebound

3 activity specific home visits

Structured weekly follow up phone calls

Telehealth monitoring

Standardized education

Build knowledge, skills and confidence

FirstHealth Medicare Advantage
Complex Care Management Pilot

30 high risk patients

Patient Satisfaction

Total cost of care

Quality of Life

Hospitalizations

Patient Activation

ED utilization
Transitions Clinic

ANP led, multidisciplinary clinic follows high risk HF patients for 30 days post hospital discharge

3 clinic visits then transitioned to PCP

Available resources include:
- RD
- Health Coach
- Palliative Care
- Pharm D
- Complex Care Management

60 day Complex Care Management Program bridges the gap

Care Transitions Nurses

Specially trained nurses embedded in different care settings

Report under one organizational structure

Consistent approach across care settings

Community not hospital focused

Goal is to improve activation and change behavior
Chronic Disease Transitions Nurse  
Emergency Department

Coordinates care

Provides education

Initiates referrals

Focus on heart failure, COPD, diabetes and HTN

Referrals  
2013

38% new PCP

31% medication assistance

4% home health
Transitions and the ED Revolving Door

Heart Failure Transitions Nurse
Acute Care

Inpatient education

Follow up telephone calls for 30 days

PAM; PHQ2

Sets meaningful, patient centered goals

Principles of Coaching for Activation

Recommends appropriate post acute referrals and transitions to the next level of care
Country Ham and Fried Bologna

“I think what you have done for me with the teaching and the phone calls has done more for me than any pill I am taking.”
Home Health Transitions Nurse
Acute Care

Visits patients once referred to home health
Identifies goal and concerns
Administers depression screening and PAM
Ensures appropriate post discharge referrals are made
Calls patient evening of discharge
Hands-off to home health staff

Home Health

Pathway Driven Care
Why Pathways?

Chronic Disease Pathways provide a road map for the clinician and ensure that patients and their caregivers receive consistent, standardized and evidence based care.

Home Health Clinical Pathway

8 Visits/3 TC's/42 days  Teach Back Method
Coaching for Activation  Telehealth
Knowledge, skills, confidence  Therapy Pathways
Focus on patient’s goals and concerns  Nutrition interventions
Teaching of Red Flags using Standardized video
Zone Tools  education
The Home Health Hand Off

Are goals met
Repeat PAM Score
Any med changes
Any Hospitalization/ED

Next level of care identified
Referrals coordinated
PCP follow-up scheduled

FirstHealth Transitional Care Model
Care Delivery Redesign

Character, Competency, Coordination and Accountability

Character

Flexible → Resourceful
Team Player → Enthusiastic
Work Ethic → Committed
Organized → Critical Thinker
Critical Thinking Skills

Critical thinking is a set of skills used to identify a problem and make sound judgments that lead to *good decisions*.

It is the most essential skill for clinicians.

These skills can be taught.
Characteristics of Critical Thinking Skills

Anticipatory thinking
  What could happen?

Questioning assumptions
  Do I really know what is happening?

Critical listening
  What is the patient really saying?

Critical communicating
  Who needs to know?

Retrospective thinking
  What could have been done differently?

Competency

ICM Certificate  AIM
Physical assessment skills  OASIS COS-C
Breath sounds lab  Critical thinking skills
Pathway competency  Patient Activation
Pharmacology education  Telehealth
Respiratory device training  Targeted nutrition
Advanced Illness Management (AIM)

Patient-centered approach to life-limiting or progressive chronic illness

Focus on what troubles the patient most

Active management of symptoms
- Pain
- Dyspnea
- Fatigue
- Poor Appetite

AIM

Begin discussion about advanced care planning

What are the patient’s goals- how do they want to live their life

Bridge to Palliative Care and Hospice
Therapy and Chronic Disease

Borg Dyspnea Scale
Standardized assessment tool

Improve posture
  Thoracic Kyphosis
  Reduce air trapping
  Improve lung capacity

Improve strength
  Address steroid induced muscle wasting

Improve exercise tolerance
  Pursed lip breathing during exercise
  Monitor heart rate- target <20 BPM baseline

Nutritional Challenges

30% to 50% malnourished upon hospital admission

37% of patients hospitalized for 1-2 days have lean body mass loss

Many patients continue to lose weight after discharge
Targeted Nutrition

Disease-specific nutritional protocols developed

Patient’s receive specific nutritional supplements based on nutritional risk assessment

Coordination

The POD is a small, cohesive interdisciplinary team that shares the complex and demanding responsibility of managing patient care.

This team approach encourages better care coordination and continuity as the team works together to manage the case load and the day to day challenges.
Components of the POD

Multidisciplinary team manages 60-70 patients
The patient is introduced to the POD concept
The patient may only be assigned to a POD clinician
The POD self schedules and handles all routine and PRN visits
The Clinical Manager ensures that the number of patients per POD remains consistent
Leads to greater patient and clinician satisfaction

Accountability

Quarterly Clinician Scorecard
  2 Outcomes Measures
  1 Process Measure
  Hospitalization Rate
  1 HHCHAPS Measures

Bonus based on individual and team performance
Managers in the field weekly
Documentation due by 6 PM
Care Delivery Redesign

Results

Home Health 30 Day Rehospitalization
(not risk adjusted)
Home Health All Hospitalization
(not risk adjusted)

Heart Failure Hospitalization
(not risk adjusted)
COPD Hospitalization
(not risk adjusted)

Diabetes Hospitalization
(not risk adjusted)
Home Health  
The Transitional Care Partner

Highly functioning, multidisciplinary, patient centered team

Clinical expertise in chronic disease management

Sees the patient in the most challenging environment- their home

Where Vision and Value Merge

*FirstHealth Care Transitions offers a patient centered, evidence based and technology infused approach to chronic disease management that works in partnership across the continuum of care for the benefit of the health care system, the community, our patients and their families.*
Care Across the Continuum

Coming together is a beginning.

Keeping together is progress.

Working together is success.

-Henry Ford