Trends in Home Care: Everybody Wants to Be There

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Trend 1: The Medicare Home Health Benefit: Limiting Positive Innovation and Comfort

- It is an acute illness benefit - not wellness, not palliation or comfort-caught in a world of chronic disease.
- Defined by its regulatory quirks (e.g. F2F and homebound, intermittent, maintenance) and when it ends.
- Millions of people learn this shortly before or after discharge from hospital, SNF or IRF.
- Our worry, who are we handing off to at the end of the episode?
  - Often disease does not end, nor aging, nor disability, nor multiple medications but our contact does.
Despite the Benefit’s Limitations, Home Care is being Reinvented in the Continuum of Chronic Care

Aging: chronic Disease

Physician

Crisis: ER or Urgent Care

Skilled Home Health

SNF/IRF

Physician

Hospital

Skilled Home Health

Palliation/ Hospice

Personal care, chronic care support

Skilled home health

Personal care, chronic care support
Trend 2: Home Care Manages Continuous Transitions

- It's not just post facility—its post MD office, lab, CT scan...what to do next after they leave

- Can’t remember what medications to continue to take, which ones to stop; what side effects to watch for

- Can’t remember what symptoms to watch for, what are signs of worsening – then who to call and when

- Can’t remember when to see and which doctor to see

And they all go home alone, sit at the kitchen table, often confused and try to make decisions
The Family Caregiver Responds: A Combination of Family/Private Pay

- Medication Reminders
- Chronic disease symptom monitoring reminders
- Family notification of worsening symptoms
- Making appointments
- Arranging Transportation
- Meal prep, shopping
- Supporting safe ADLs
- Socialization/LifeEnrichment

It all happens in the home
Trend 3: Machine or Person - Who, When, How Long

Pharmacist

PCP

EMTs

Navigator

Home Care

30, 60, 90 days

weeks, months, years
Trend 4: Drowning in Data or NO Data; Can’t Communicate

Big data, little information:
- 2000 OASIS begins for skilled Medicare FFS, MA, Medicaid, Medicaid MCO patients; no information on what works and does not work
- What could the data tells us that may support best practices?

NO data on personal care, support services; commercial insurance coverage – what works, what does not

Need unique common measures across settings, standardized so we can talk to each other

Pain          Fall Risk          Able, willing caregiver
Function      Frailty

Need outcomes for patients/consumers, families and providers to aid decisions
Trend 5: Enter ‘Health’ and ‘Habilitation’

The promise of the “duals” demonstrations and ACOs, etc:

• Coordinated care across the continuum
• Not solely illness management—but wellness, prevention, ‘habilitation’, coaching to self-management
• Health includes mental, psychosocial, family, meals, socialization, cognitive, developmental
• Argument over “maintenance” stops
The Promise of Home Care

Home ‘health’ care is over time, not ‘episodes’ and not limited to acute illness management - when are eyes in the home needed, who decides that?

Transitions are more than post acute, rather at each touchpoint of the health system

Home care doesn’t always mean a person in the home: there is a time for apps, e-mail, phone calls, a call-center, PERs and a live person – we need to know which, when and for how long

Home health needs information: what works, what doesn’t -- across the spectrum of care at home
The Promise of Home Care-Today

Home care
- has more face time, 6-15 hrs, with the patient and family
- ‘at the kitchen table’ where health decisions are made every day

Who needs that time, when, and how often is a question being asked daily

Can you manage a population without it?
The Reality of Home Health Care: The ‘Present’ for Millions Daily