



Future of Home Health Care **The Value of Team Based** **Care**

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Workshop Objectives

What will it take to get to the ideal state?
WORKFORCE

- **Current state of home health care:** VA Home Based Primary Care - Overview; team; outcomes VA+MC
- **Home health agency role in achieving triple aim:** Complementary and crucial integration
- **How to integrate home health care into the future marketplace:** Integration, beyond coordination
- **How to facilitate future role of home health care:** Focus on 5%; Consumer voice; Policy and payment to support teams, transitions, technology, caregivers, alternative settings
- **Research priorities:** Alternative methodology



Case: VA Home Based Primary Care (HBPC)

- 74yo male Veteran, end stage Parkinson's Disease (PD), depression, falls, 40 pound weight loss, mild dementia; hallucinations
- PD failed deep brain stimulation; scissor gait, muscle spasms, tremors, aspiration
- After several hospitalizations, medical team planned discharge to nursing home, hospice
- Veteran stated he "would die if admitted to a nursing home"
- Option: discharged home with HBPC, HHA



What is VA Home-Based Primary Care (HBPC) ?

- Comprehensive, longitudinal primary care
- Delivered in the home
- By an Interdisciplinary team: **Nurse, Physician, Social Worker, Rehabilitation Therapist, Dietitian, Pharmacist, Psychologist**
- For patients with complex, chronic disabling disease
- When routine clinic-based care is not effective

For those “too sick to go to clinic”



Characteristics of HBPC Population

“Too sick to go to clinic” -

Mean age 78.4 years; 96% male; 24% annual mortality

More than 8 chronic conditions; among 5% highest cost
Heart disease, diabetes, depression, dementia, cancer,
lung disease, schizophrenia, PTSD, stroke, neurologic

48% dependent in 2 or more Activities of Daily Living (ADL)

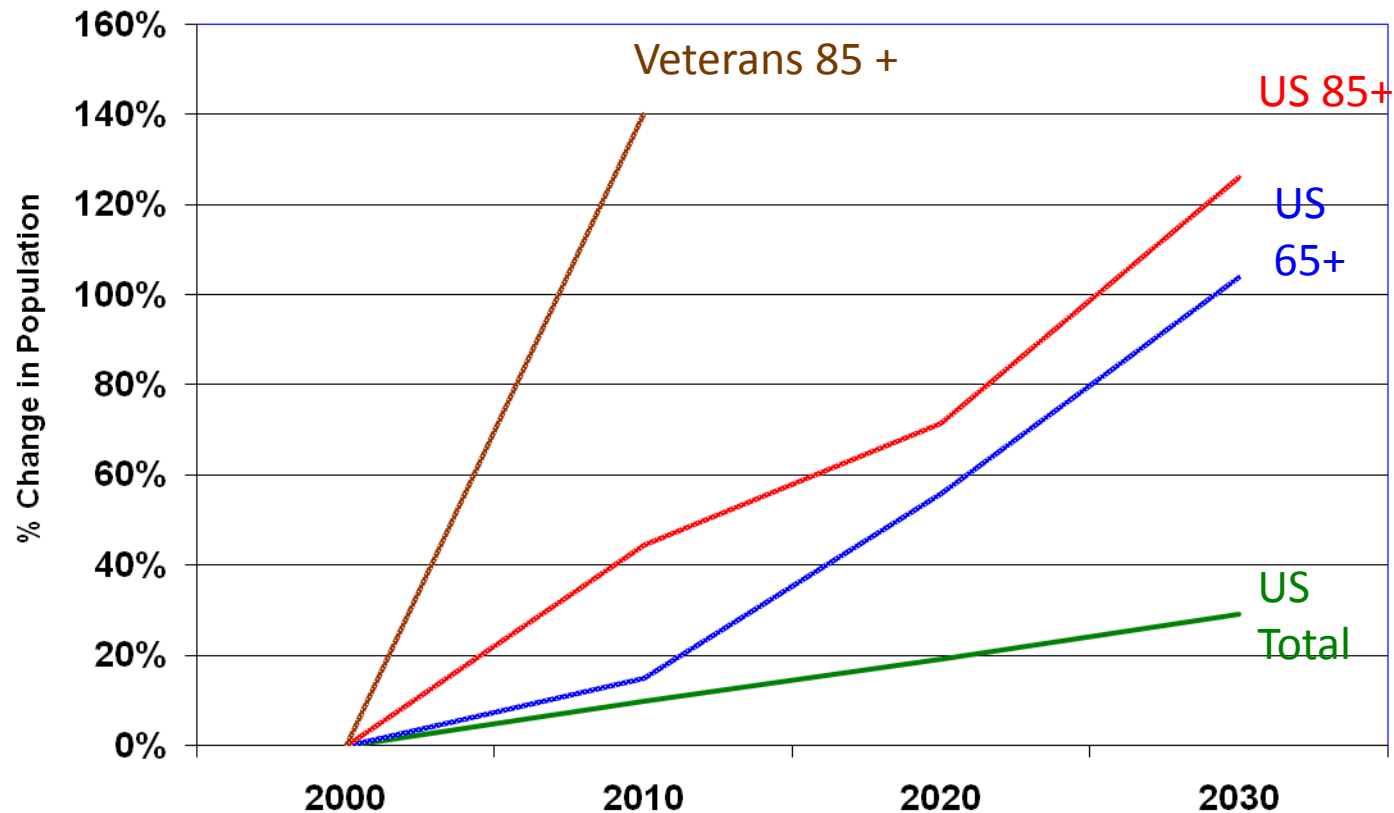
47% married; 30% live alone; Caregivers: 30% limited ADL

Mean duration in HBPC 315 days; 3.1 visits/mo; 28 visits/yr



% Change in Population from 2000

United States





CHALLENGE: Increase access, improve quality, lower cost?

GOAL: Support Veterans to remain at home as long as feasible, with optimal health, safety, independence and purpose. (And at lower cost)

**Focus: 5% of Veterans who account for 50% of cost
NOT the 50% of Veterans who account for 4% of cost**

S H I F T care from institution to home

- Increase Veterans' access to home services
- Minimize avoidable hospital days
- Prevent or optimize nursing home care
- Reduce total cost of care



HBPC is NOT like Medicare (MC) Home Care

- Different target population
- Different processes
- Different outcomes
- HBPC provides **longitudinal comprehensive, interdisciplinary care** to veterans with **complex chronic disease**

Different and Complementary

VA Home Based Primary Care

Targets **complex chronic disease**

Comprehensive Primary Care

Skilled care not required

Strict homebound not required

Accepts declining status

Interdisciplinary team

Longitudinal care

Reduces hospital days

Limited geography & intensity

Medicare Home Care

Remediable conditions

Specific problem-focused

Requires skilled care

Must be homebound

Requires improvement

One or Multidisciplinary

Episodic, **post-acute care**

No definitive impact

Anywhere; anytime



Case: HBPC

End Stage Parkinson's Disease

- **HBPC interdisciplinary team** worked with Veteran's caregivers, educated on daily care and support
- **HBPC Social Worker** worked with Veteran to identify caregiver for support & socialization through Veteran Directed Care, connections with community; support for daily care needs
- **Rehabilitation Therapist** education to support exercise: walking, adaptive aquatic equipment, wheelchair safety, fall prevention



Role for HBPC in Medicare?

Impact of HBPC in VA

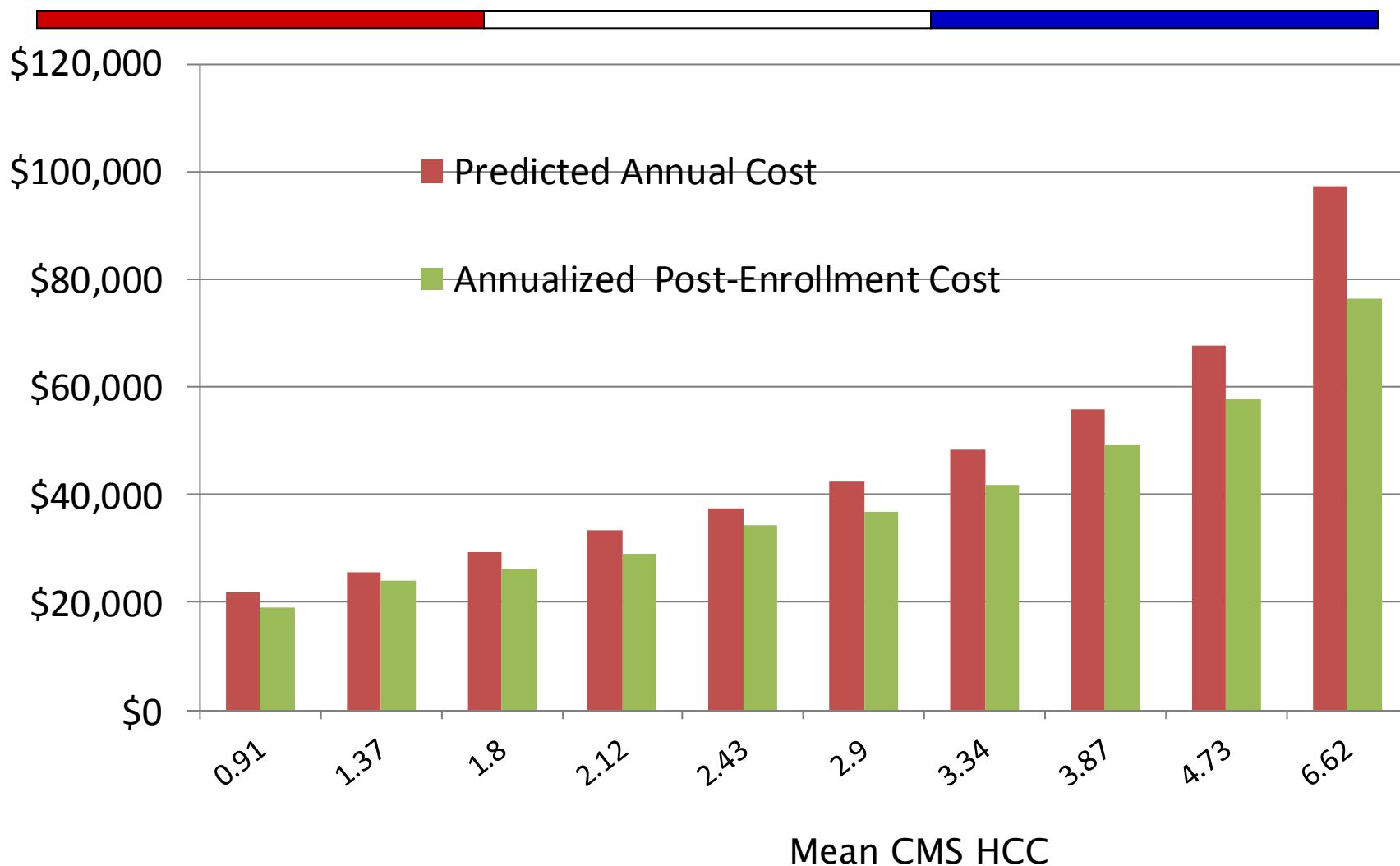
- 2002 pre-post analysis: n = 11,334
- 62% fewer hospital days; 29% fewer admissions
- 88% fewer nursing home days
- 21% lower 30 day readmission rate
- **24% lower net VA cost** – accounting for cost of HBPC
 - Clinics in Geriatric Medicine, Beales and Edes, Feb 2009
- Growth 7312 in 2000 to over 34,000 in 2014.
- 38% of Veterans in HBPC live in rural area
- Pilots with Indian Health Service
- Might costs be shifted to Medicare? Impact on VA+MC



> Average Predicted & Post HBPC Enrollment Annualized Costs by Risk Adjustment Decile: HBPC (942 participants per decile); n = 9,425 for total

> Annualization Adjusted for 1-yr Mortality of 24%

> Mean Predicted \$45,980 $\pm$ 3,692





Impact of HBPC on VA + Medicare (MC) Costs

- VA data strong, are we sure we're not shifting cost to MC?
- 2006: 9625 Veterans in HBPC, 6951 used MC.
- Analysis same Veterans, same time: While in HBPC, MC inpatient days dropped 9.5%, MC costs dropped 10.2%

Enrollment into VA HBPC associated with:

1. 25% reduction in combined VA+MC hospital admissions
2. 36% reduction in combined VA+MC hospital days
3. 13.4% reduction in combined VA+MC costs
 - a drop from \$45,980 to \$39,796 in total cost (after adding in the costs of HBPC \$9113 per pt/yr)
 - Analysis of Hierarchical Condition Category (HCC) score



Case: HBPC

End Stage Parkinson's Disease

- **HBPC provider and nurse** - education for complicated medication management; training on Heimlich for aspirations.
- **HBPC Dietitian** - training on thickening foods with non-commercial products due to taste, warming foods to avoid esophageal spasms, nutrition education to support weight goals
- **HBPC Psychologist** – depression; isolation
- **Full HBPC team** continuously works to find solutions to new problems



Case: HBPC

End Stage Parkinson's Disease

- Results from **1 year in HBPC** –
- Remarkable **improvement in health status**
- **Fewer falls**: 16 documented falls in year before HBPC vs 9 falls during HBPC despite continued decline from Parkinson's, scissor gait, tremor, and spasm.
- **Stabilized weight**: despite refusing PEG placement and commercial thickening additives, aspirations, esophageal spasms



Case: HBPC

End Stage Parkinson's Disease

- **More results** from 1 year in HBPC –
- **Improved Quality of life**: decreased isolation; increased community involvement
- **Reduced hospitalizations**: 5 hospitalizations in year prior to HBPC vs 1 during HBPC
- **Patient goals met**: no nursing home, no feeding tube, less hospitalizations, more active
- **Recovered control** that PD tried to take away. From debilitated to new beginning, mitigated decline, new relationships; engaged community



Independence at Home Act

Section 3024, Patient Protection and Affordable Care Act

- Model in Medicare like VA HBPC, with economic structure in CMS to support it
- Targets complex chronic disabling disease
- Interdisciplinary, longitudinal care in home
- Geriatric skills, EHR, quality, satisfaction
- Outcomes: Fewer inpatient days; minimum annual 5% savings to MC, added savings shared by team
- 16 sites plus 3 coalitions; 3rd year of demonstration
- Training: American Academy of Home Care Medicine www.aahcm.org



Impact of HBPC on Medicare (MC) Costs

- HBPC of frail high-risk, high-cost Washington DC
- Team: Physician, nurse, social worker +
- 5 yr case-control study, propensity matched
- 722 in HBPC, matched with 2161 controls.
- **2yr study: HBPC 17% lower total MC cost** (\$8477/patient/2 yrs) $p=0.003$
- 20% lower hospital and skilled nursing facility costs
- 58% **higher** home health costs (incl HBPC)
- 104% **higher** hospice costs
 - Effects of Home-Based Primary Care on Medicare Costs in High-Risk Elders. E De Jonge, N Jamshed, D Gilden et al, JAGS Aug 2014



Impact of HBPC on Medicare Costs

CONCLUSIONS

- HBPC for selected frail elders reduces cost
 - Primary care visits in home are integral
 - Savings only in highest frailty score group
 - Savings begins after 6 months
 - Supports Independence at Home expansion
-
- Potential CMS savings from IAH: 3% of 50M MC recipients = $1.5\text{M} \times \$4200/\text{yr} = \$6.3 \text{ B } / \text{yr}$



Alternative Methodology?

“We need robust methods of analysis in addition to randomized controlled trials to meet the challenges of –
evaluating complex interventions
involving diverse populations
with variable comorbidities
receiving individualized care
in a rapidly evolving healthcare system”

Edes T, Kinosian B, Vuckovic N, et al; Improved Access, Quality and Cost for Clinically Complex Veterans with Home Based Primary Care; in press, JAGS



www.tinyurl.com/vamfhnbc



What is VA Medical Foster Home (MFH)?

For persons with medical complexity & disabling conditions meeting nursing home level of care, ***an alternative to nursing home, in a personal home, at half the cost***

- Merges adult foster home with VA Home Based Primary Care
- Person takes dependent Veteran into their personal home, role of family caregiver - daily supervision and personal assistance
- VA HBPC provides caregiver education, comprehensive medical care in home

Happier Vets, Lower Costs

For veterans who don't want to live in institutions, foster homes offer a promising alternative

By STEPHANIE SIMON

MABEL VALE, Ark.—The federal government's ambitious new drive to cut costs and improve care for disabled military veterans begins not in a big-city hospital, but here in small-town Arkansas, in a tidy brick bungalow set back from a country road.

Daffodils bloom outside the bungalow, and a ginger-and-white cat snoozes on the stoop. Inside, Roy Strange, a 90-year-old Army vet, stretches out in a recliner to watch a video about model trains.

Mr. Strange suffers several combat-related ailments from his service in World War II and is thus eligible for subsidized nursing-home care, paid for entirely by the Department of Veterans Affairs. Instead, he chooses to spend his own money to stay in this "medical foster home," run by private caretakers, Cristina and Cornell Onecic.

The home is one of hundreds across the country that take in veterans who can't care for themselves, but don't want to live in an institution. The vets pay the foster family's expenses, while the VA covers the costs of regular visits from health-care providers, such as nurses, therapists and dietitians. The result is dramatically lower costs—the VA pays just about \$52 a day for patients in foster homes, compared with an average of \$469 for those in nursing homes. And many vets like Mr. Strange say



Homeowner and caregiver Cristina Onecic and her dog, Jake, with World War II veteran Roy Strange

program began in Arkansas a decade ago but remained a pilot project until its director, Thomas Edes, began aggressively promoting it as a way to cut costs and boost the quality of life for severely disabled vets. In 2008, Congress set aside \$9 million to expand the program. Last year, that expansion began, with the VA bringing programs to 19 states and Puerto Rico, and Dr.

leave them vulnerable to abuse or neglect. He worried that they would be isolated. He wondered whether private homeowners, some of them untrained in health care, could really handle such complex patients—many with dementia, some incontinent, others bedridden.

In 2002, he flew to Little Rock to see the pilot project in action. He

books to them. In one home, Dr. Edes spotted a photo of the caregiver's grandchildren helping the vet around Disney World. "We take Joe everywhere," the caregiver explained.

Covering Costs

Veterans pay their caregivers \$1,500 to \$4,000 a month, depending on the level of assistance. For most vets,

cover nursing-home fees for all veterans, just those whose ailments are tightly tied to their military service. But so far, about a quarter of the 600 veterans who have gone into medical foster homes are in that category. As long as they're happy in foster homes, the VA is off the hook for nursing-home care.

Sometimes, of course, the vets aren't happy in the private

are really remarkable people," says Dr. Edes, who has given the program the tagline "Where angels meet heroes."

'Open Your Heart'

Cristina Onecic, a 53-year-old Romanian immigrant, signed up as a caregiver after years of doing similar work on an itinerant basis, traveling from home to home to provide services to the elderly. Like all caregivers, she underwent a background check and opened her home to fire and safety inspections. Every month, she conducts an evacuation drill to prove she can get all three veterans in her care safely outside within three minutes. She gets only two weeks of vacation a year—during which she must move the vets to a VA hospital or pay a substitute caregiver to tend to them in her home.

It's not an easy job. But Ms. Onecic's face lights up when she talks about the veterans—"my guys," as she calls them. "If you open your heart, there is nothing difficult about it," she says.

Another caregiver, Judy Ryan, who lives outside Denver, has taken great pleasure in weaning her veteran off soda and cookies and onto an organic, nutrient-rich diet. She also insists that he do his physical therapy. Wheelchair-bound when he arrived and barely able to speak because of a neurological disorder, he can now get around with a walker and recently had a phone conversation with his sister.

Ms. Ryan, who used to work in an Alzheimer's unit, was already at home full time caring for her 95-year-old father, also a veteran, so she says it made sense for her to take on a buddy for her dad. At first, Ms. Ryan says, her father was jealous, but he and the new arrival have since bonded. Now they watch sports together on TV, and on nice days they sit outside, tracking the planes landing at the nearby airport.

For Mr. Strange, the vet-

Jeff Bower/Department of Veterans Affairs







Growth in VA Services for Serious Chronic Disease

From 2000 to 2005, while VA costs per patient increased less than 2% -

- VA-Paid Home Hospice increased over 400% 54%/yr
- Inpatient Hospice and Palliative Care increased 25x
- Palliative Care Team Consults: increased 21%/yr
FY12 68% of all inpatient deaths have palliative care
- Home Based Primary Care increased 55% (7312 to 11,994 per day)
- Medical Foster Home nearly tripled
- H&CBC: Increased 87% or 12%/yr; Avg Daily Census 11,706 (1998) to 21,838 (2005)

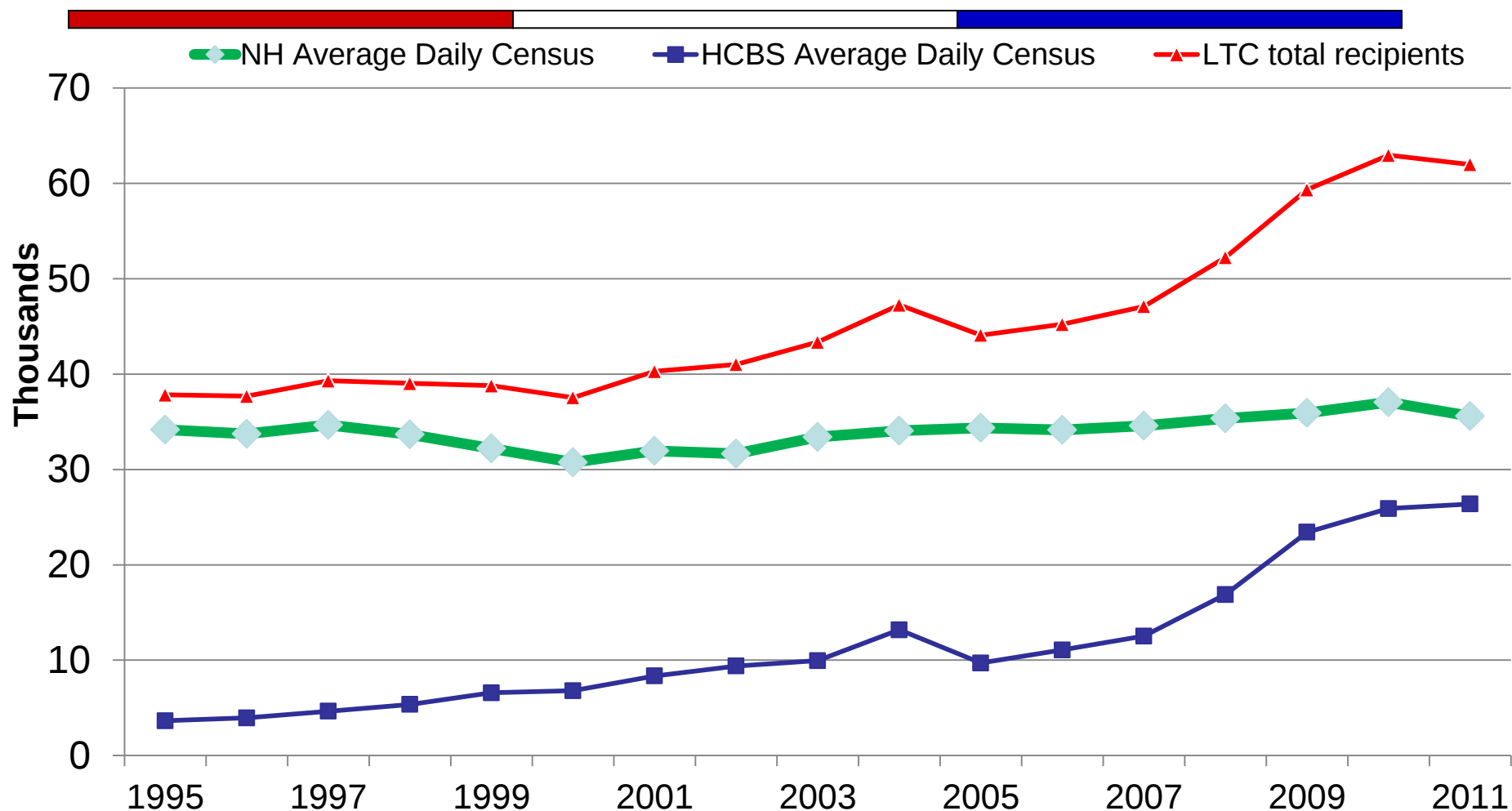


Hospice & Palliative Care

- **2013 Landmark year** – more Veterans died in VA inpatient hospice beds than in acute care hospital and ICU combined
- Highest Bereaved Family Satisfaction when loved one died in VA hospice bed
- HBPC – 22% of Veterans get palliative care
- **Veteran goals of care** – two-thirds of Veterans in HBPC and MFH die at home (25% of US decedents die at home)



Veterans Receiving VA-Financed LTC 1995-2011



Source: H. Stephen Kaye, Center for Personal Assistance Services, University of California San Francisco. PAS
Center Funded by National Institute on Disability & Rehabilitation Research



Where do we need to establish, strengthen & INTEGRATE teams?

For the 5% who account for 50% of health care costs -

- Personal support services
- Caregiver support
- Comprehensive interdisciplinary longitudinal CLINIC care
- Comprehensive interdisciplinary longitudinal HOME care
- Palliative care spanning all settings
- Optimal use of and alternatives to hospital and nursing home
- Assistive technology spanning all settings
- Transitional care **INTEGRATED** into clinic; hospital; community agencies for skilled care, personal support, hospice, and caregiver support; nursing home; palliative care in all settings; hospital at home; telehealth; home based primary care
- Not just coordinate, but **INTEGRATE** = presence



Can we increase access, improve quality and lower total cost of care?

- **We are:** Home Based Primary Care, Medical Foster Home, Palliative Care
- **We can do better:** Through Teams, Technology, Transitions & Integration
 - Home Telehealth to support serious chronic disease management
 - Home Telehealth to expand reach of VA Home Based Primary
 - VA Computerized Patient Record System – immediate EHR access for any Veteran at any VA facility across country.
 - Mobile Electronic Documentation – all clinic notes, labs, tests, discharge summaries stored in laptop
 - Hospital at Home; Point of Care Diagnostics
 - Transitional care integrate with teams & services in all care settings
 - Policy and Payment supporting teams, technology, transitions, caregivers
- **Unsustainable rise in health care costs**, geriatrics and long term care team services integral to **THE SOLUTION**
- **Focus on the 5%** that accounts for 50% of health care costs, NOT the 50% that accounts for 4% of health care costs. **Who is this 5%?**