Linking Home Health to the Larger Health Ecosystem

Presented to the Institute of Medicine Workshop on The Future of Home Health Care

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Today's Evolving HealthCare Environment

- Affordable Care Act established the Triple Aim:
  - Improve quality of care
  - Improve population health
  - Reduce cost of care
- New focus on *patient-centered episodes* of care, not silos of service-centered care
- Congressional mandate for *quality reporting* programs for all Medicare services
- Innovative *payment methods focus on episodes of care and incorporate outcomes* in the payment methodology
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Payment Innovations in Public and Private Insurance Sectors

- Quality adjustments for hospital readmissions in FFS
- Value-Based Payment systems for Hospitals, SNF, HH, ESRD
- Shared savings payments in ACOs, Gainsharing, Medical Homes, and Bundled Payments
- Coordinated Care Programs for Dual-Eligible populations
- Rebalancing grants for state LTSS programs (BIP, SIM, TEFT)
- Carve-out and other innovations proposed in both private and public insurance sectors

What Role Can/Should Home Health Play in the Changing Marketplace?

- Links between inpatient and community-based services
- Coordination across caregivers (both medical and social support)
- Communication/education of patient on options and available resources

Role of Home Health in the Medicare Program

Characteristics of Medicare Beneficiaries using Home Health Services, 2010

	Community-Admitted Users	Post-Acute Care Users
Percent of all home health episodes	64%	36%
Service Use		
Average number of episodes	2.6	1.4
Episodes provided to dual-eligible beneficiaries	42%	24%
Episodes where home health aides provided the majority of services	11%	4%
Beneficiary Characteristics		
White	74%	86%
Average number of chronic conditions	3.8	4.2
Beneficiaries with Alzheimer's or dementia	29%	21%

Source: Medicare Payment Advisory Commission. March 2013, Report to the Congress: Medicare Payment Policy.

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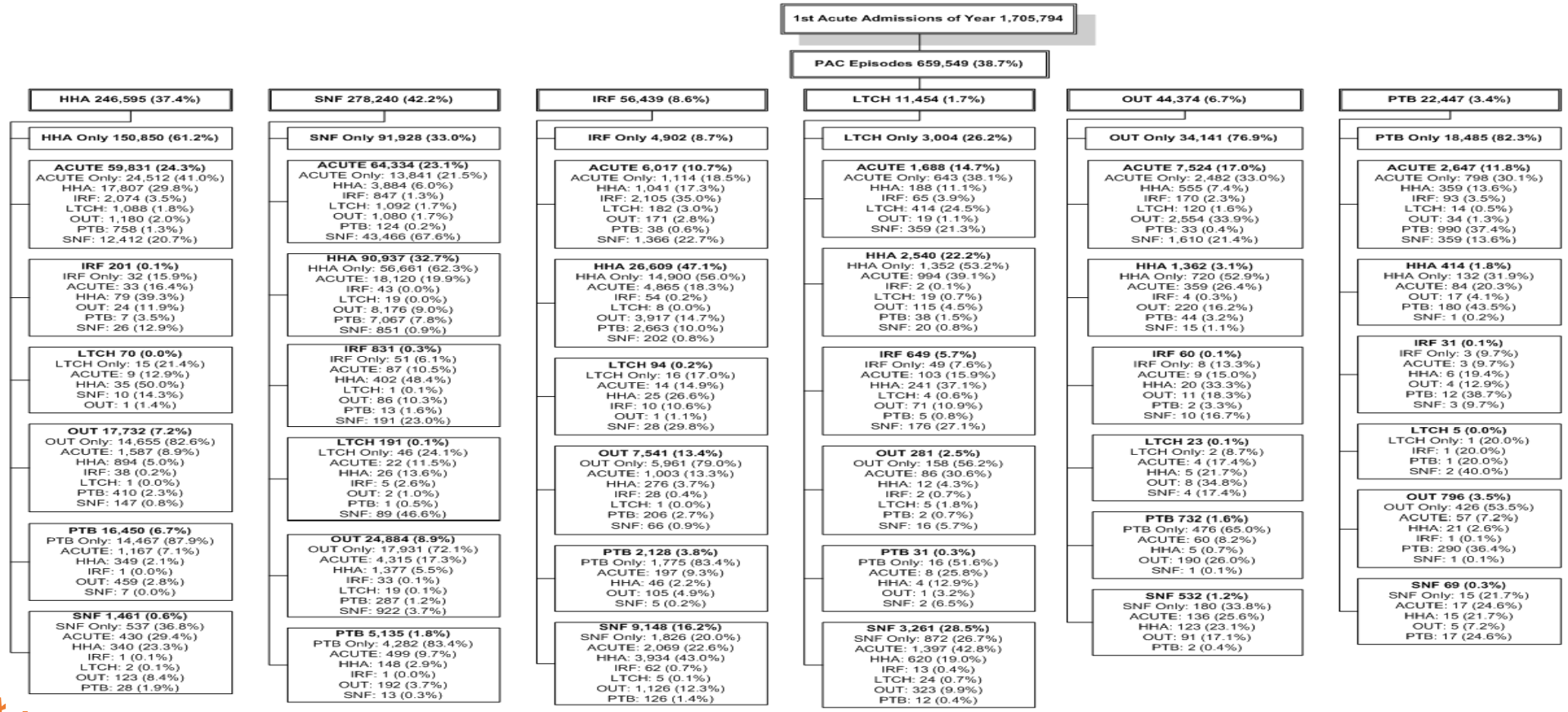
Home Health Use following acute hospital discharge, 2008



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Types of Services Following Hospital Discharge in the Medicare Program:

About 35% of the hospital cases will be discharged to PAC, of them:

41.1% → SNF

37.4% → Home Health

10.3% → IRF

9.1% → Outpatient/ambulatory therapy

2.0% → LTCH

Source: Gage et al. (2009). *Examining post-acute care relationships in an integrated hospital system*, ASPE.

Most Use More Than One PAC Provider During their Episode of Care

- **HHA: of 37.4%→ 38.2% use more**
- SNF: of 41.1% → 59% use additional services
- IRF: of 10.3% → 87.7% use more
- Outpatient Therapy: of 9.1%→ 34.4% use more
- LTCH: of 2.0% → 74.9% use more

Source: Gage et al. (2009). *Examining post-acute care relationships in an integrated hospital system*, ASPE.

Utilization Patterns Following Hospital Discharge

Episode Pattern[1]	Count (5% Sample)	Percent of PAC Users (N=109,236)	Cumulative Percent	Mean Episode Payment	Mean Episode Length of Stay
AH	25,238	23.1	23.1	$12,696	48.9
AS	18,714	17.1	40.2	17,930	44.2
ASH	8,474	7.8	48.0	22,208	76.4
AO	6,533	6.0	54.0	8,165	40.0
AHA	4,909	4.5	58.5	25,035	57.2
AIH	3,066	2.8	61.3	30,915	69.3
AHO	2,941	2.7	64.0	14,250	88.0
ASAS	2,934	2.7	66.7	33,346	81.7
ASA	2,092	1.9	68.6	28,106	47.2
ASO	1,993	1.8	70.4	18,805	87.1
AHAH	1,635	1.5	71.9	26,956	171.5
AIO	1,467	1.3	73.2	27,270	79.1
AI	1,382	1.3	74.5	25,330	17.4

NOTES:

1. A=Acute Hospital; H=HHA; I=IRF; L=LTCH; O=Outpatient Therapy; S=SNF/

Source: Gage et al. (2009). *Examining post-acute care relationships in an integrated hospital system*, ASPE

What Role does HH Play in the Medical System?

- Routine Intensity: Mean Unadjusted Routine Resource Intensity Index Shows HH Provides Much Less Nursing Than Inpatient Options

Setting	RRII/DAY	RRII/Stay
LTCH =	5.5	193.0
IRF =	4.2	70.1
SNF =	2.0	60.9
HHA =	0.4	6.3

Source: PAC PRD Report To Congress, Gage, et al, 2012

What is the Relative Intensity of HH Therapy?

- Therapy Intensity: Mean Unadjusted Therapy Resource Intensity Index shows relative level of therapy services

Setting	TRII/DAY	TRII/Stay
LTCH =	0.7	22.4
IRF =	2.0	32.2
SNF =	1.0	29.7
HHA =	0.5	6.8

Source: PAC PRD Report To Congress, Gage, et al, 2012

How Do HH Admissions Compare to Other PAC Patients on ADL/Self Care?

- Mean Unadjusted Self Care Scores by Setting

Setting	Admission	Change
LTCH =	33.9	9.9
IRF =	43.6	15.5
SNF =	45.4	12.4
HHA =	*59.6*	*10.0*

Source: PAC PRD Report To Congress, Gage, et al, 2012

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What is the Relative Value of Home Health Care in Improving Self Care Function (after Adjusting for Case-Mix*)

	Estimate for All Patients (n = 12,065)	Estimate for Musculoskeletal Patients (n = 3,492)	Estimate for Nervous System Patients (n = 1,756)
CHANGE IN SELF CARE			
HHA	4.02** (n = 3,190)	4.35** (n = 810)	2.80 (n = 361)
IRF	3.75** (n = 4,158)	3.10 (n = 1,463)	3.93** (n = 1,096)
LTCH	0.74 (n = 1,968)	-1.91 (n = 122)	0.67 (n = 86)
SNF (referent)	-- (n = 2,749)	-- (n = 1,097)	-- (n = 213)

Source: PAC PRD Report To Congress, Gage, et al, 2012

*Case-mix variables included demographic factors, primary and comorbid diagnoses, impairments, and other variables..

** $p < .05$

New and Emerging Programs

- Home health case management
  - Bundled payment groups, like naviHealth, use nursing case management to reduce likelihood of hospital readmissions
  - Geriatric Transitions programs, like Rush Hospital, Commonwealth Care Alliance use case managers to facilitate/coordinate/communicate/manage the person's community transition

  - More examples available from LTQA.org conference proceedings on Building Bridges Across the Continuum

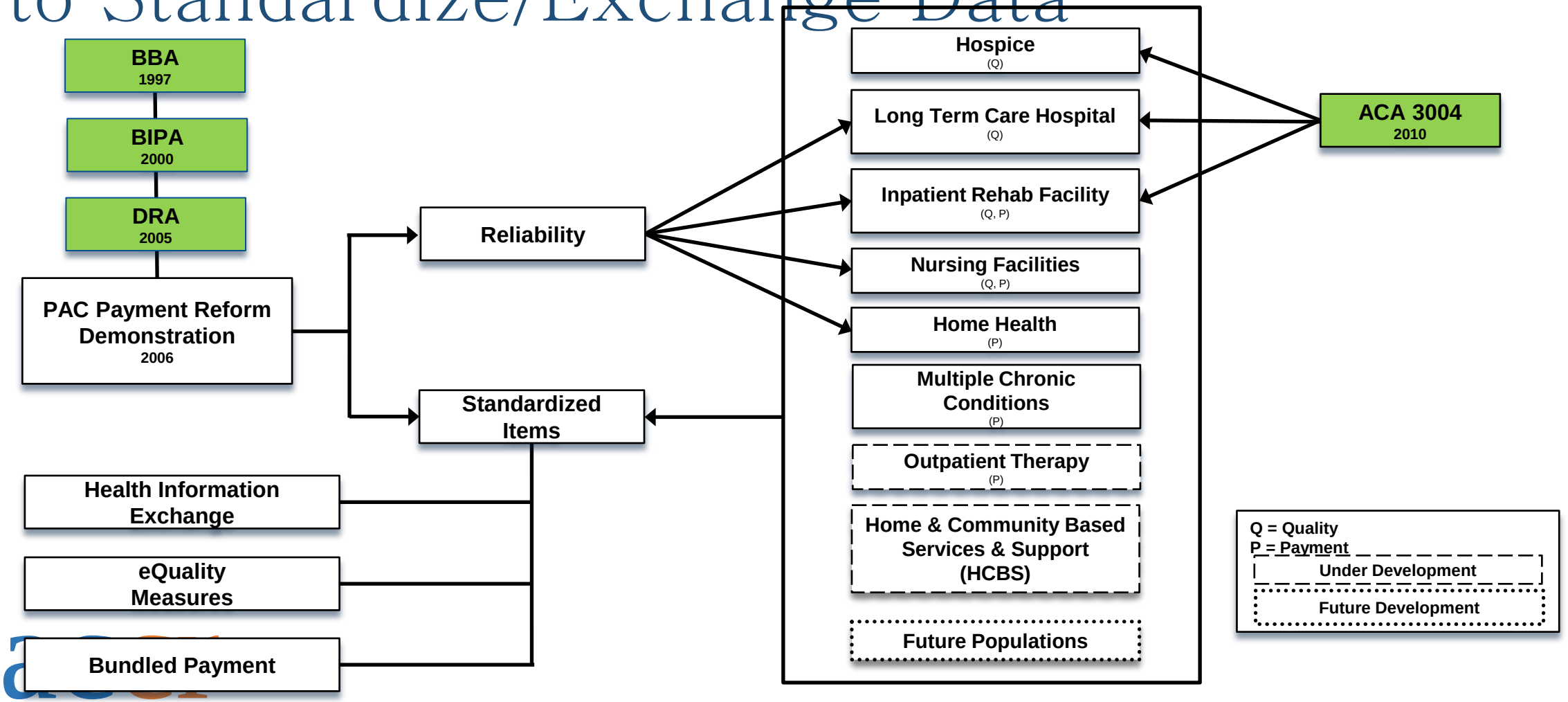
Potential Role of HH in New, Evolving Health Care Systems

- Person-centered movement focuses on care coordination, outcomes and cost-effectiveness
- New accountability efforts are forcing clinicians to follow patients past their front door into the community to minimize readmission risk
- HHAs serve both Medicare and LTSS populations and provide existing resources and often knowledge of local community populations

New Systems All Require Coordination

- National Quality Strategy/CMS' quality reporting programs
- New Federal pilot initiatives in CMMI, ACL, QIO Transitions programs
- CMS' payment policy initiatives
- CMS' data standardization initiatives
- ONC Federal Exchangeability Initiatives

IMPACT ACT: Building on CARE Initiatives to Standardize/Exchange Data



Future of Home Health

- Home health agencies often provide both medical and LTSS
- HHAs are in the communities, know the local providers, and often the more medically complex residents
- HH provides nursing, therapy, social work, and aide services already bridging across the continuum
- HH staff are trained in coordination (e.g., medication reconciliation, social support)
- Its role as an existing resource is often underutilized

Thank You

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