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



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-	Post-Acute Care	
	Admitted Users	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.



Home Health Use following acute hospital discharge, 2008

HHA 246,595 (37.4%) SNF 278,240 (42.2%) HHA Only 150,850 (61.2%) SNF Only 91.928 (33.0%) ACUTE 64,334 (23,1%) ACUTE 59.831 (24.3%) ACUTE Only: 13.841 (21.5%) ACUTE Only: 24,512 (41.0%) HHA: 3,884 (6.0%) HHA: 17.807 (29.8%) IRF: 847 (1.3%) IRF: 2.074 (3.5%) LTCH: 1.088 (1.8%) OUT: 1.080 (1.7%) OUT: 1.180 (2.0%) PTB: 124 (0.2%) SNF: 12,412 (20.7%) HHA 90,937 (32,7%) IRF 201 (0.1%) IRF Only: 32 (15.9%) ACUTE: 33 (16.4%) ACUTE: 18,120 (19.9%) IRF: 43 (0.0%) HHA: 79 (39.3%) LTCH: 19 (0.0%) OUT: 24 (11.9%) OUT: 8.176 (9.0%) PTB: 7 (3.5%) SNF: 26 (12.9%) SNF: 851 (0.9%) IRF 831 (0.3%) LTCH 70 (0.0%) IRF Only: 51 (6.1%) LTCH Only: 15 (21 4%) ACUTE: 87 (10.5%) HHA: 402 (48.4%) HHA: 35 (50.0%) OUT: 86 (10.3%) OUT: 1 (1.4%) PTB: 13 (1.6%) SNF: 191 (23.0% OUT 17 732 (7.2%) OUT Only: 14,655 (82.6%) LTCH 191 (0.1%) ACUTE: 1,587 (8.9%) LTCH Only: 46 (24.1%) HHA: 894 (5.0%) ACUTE: 22 (11.5%) HHA: 26 (13.6%) LTCH: 1 (0.0%) PTB: 410 (2.3%) OUT: 2 (1.0%) SNF: 89 (46.6%) PTB 16,450 (6.7%) OUT 24,884 (8.9%) PTB Only: 14.467 (87.9%) ACUTE: 1,167 (7.1%) OUT Only: 17,931 (72.1%) ACUTE: 4,315 (17.3%) HHA: 349 (2.1%) HHA: 1,377 (5.5%) IRF: 1 (0.0%) IRF: 33 (0.1%) LTCH: 19 (0.1%) SNF: 7 (0.0%) PTB: 287 (1.2%) SNF: 922 (3.7%) SNE 1 461 (0.6%) SNF Only: 537 (36.8%) PTB 5,135 (1.8%) ACUTE: 430 (29.4%) PTB Only: 4.282 (83.4%) HHA: 340 (23.3%) ACUTE: 499 (9.7%) IRF: 1 (0.1%) LTCH: 2 (0.1%) IRE: 1 (0.0%) OUT: 123 (8.4%) OUT: 192 (3.7%)

IRF 56,439 (8.6%) IRF Only 4,902 (8,7%) ACUTE 6.017 (10.7%) ACUTE Only: 1,114 (18.5%) HHA: 1.041 (17.3%) IRF: 2,105 (35.0%) LTCH: 182 (3.0%) OUT: 171 (2.8%) SNF: 1 366 (22 7%) HHA 26,609 (47,1%) HHA Only: 14,900 (56.0%) ACUTE: 4,865 (18.3%) IRF: 54 (0.2%) LTCH: 8 (0.0%) OUT: 3.917 (14.7%) PTB: 2,663 (10.0%) SNF: 202 (0.8%) LTCH 94 (0.2%) LTCH Only: 16 (17.0%) ACUTE: 14 (14.9%) HHA: 25 (26.6%) IRF: 10 (10.6%) OUT: 1 (1.1%) SNF: 28 (29.8%) OUT 7,541 (13.4%) OUT Only: 5,961 (79.0%) ACUTE: 1,003 (13.3%) IRF: 28 (0.4%) LTCH: 1 (0.0%) PTB: 206 (2.7%) SNF: 66 (0.9%) PTB 2.128 (3.8%) PTB Only: 1,775 (83.4%) ACUTE: 197 (9.3%) HHA: 46 (2.2%) OUT: 105 (4.9%) SNF: 5 (0.2%) SNF 9,148 (16.2%) SNF Only: 1,826 (20.0%) ACUTE: 2,069 (22.6%) HHA: 3,934 (43.0%) LTCH: 5 (0.1%) PTB: 126 (1.4%)

1st Acute Admissions of Year 1,705,794 PAC Episodes 659,549 (38.7%) LTCH 11,454 (1.7%) LTCH Only 3.004 (26.2%) ACUTE 1,688 (14.7%) ACUTE Only: 643 (38.1%) HHA: 188 (11.1%) LTCH: 414 (24.5%) OUT: 19 (1.1%) SNF: 359 (21.3%) HHA 2,540 (22.2%) HHA Only: 1,352 (53.2%) ACUTE: 994 (39.1%) IRE: 2 (0.1%) LTCH: 19 (0.7%) OUT: 115 (4.5%) PTB: 38 (1.5%) SNF: 20 (0.8%) IRF 649 (5.7%) IRF Only: 49 (7.6%) ACUTE: 103 (15.9%) HHA: 241 (37.1%) LTCH: 4 (0.6%) OUT: 71 (10.9%) PTB: 5 (0.8%) SNF: 176 (27.1%) OUT 281 (2.5%) OUT Only: 158 (56.2%) ACUTE: 86 (30.6%) IRF: 2 (0.7%) LTCH: 5 (1.8%) PTB: 2 (0.7%) SNF: 16 (5.7%) PTB 31 (0.3%) PTB Only: 16 (51.6%) ACUTE: 8 (25.8%) HHA: 4 (12.9%) OUT: 1 (3.2%) SNF: 2 (6.5%) SNF 3,261 (28.5%) SNF Only: 872 (26.7%) ACUTE: 1,397 (42.8%) HHA: 620 (19.0%) IRF: 13 (0.4%) LTCH: 24 (0.7%) OUT: 323 (9.9%) PTB: 12 (0.4%)

OUT 44,374 (6.7%) OUT Only 34,141 (76,9%) ACUTE 7,524 (17.0%) ACUTE Only: 2,482 (33.0%) HHA: 555 (7.4%) IRF: 170 (2.3%) LTCH: 120 (1.6%) OUT: 2.554 (33.9%) PTB: 33 (0.4%) SNF: 1,610 (21.4%) HHA 1,362 (3.1%) HHA Only: 720 (52.9%) ACUTE: 359 (26.4%) IRF: 4 (0.3%) OUT: 220 (16.2%) PTB: 44 (3.2%) IRF 60 (0.1%) IRF Only: 8 (13.3%) HHA: 20 (33.3%) OUT: 11 (18.3%) SNF: 10 (16.7%) LTCH 23 (0.1%) LTCH Only: 2 (8.7%) ACUTE: 4 (17.4%) OUT: 8 (34.8%) SNF: 4 (17.4%) PTB 732 (1.6%) PTB Only: 476 (65.0%) ACUTE: 60 (8.2%) OUT: 190 (26.0%) SNF 532 (1.2%) SNF Only: 180 (33.8%) ACUTE: 136 (25.6%) HHA: 123 (23.1%) PTB: 2 (0.4%)

PTB 22,447 (3.4%) PTB Only 18,485 (82,3%) ACUTE 2,647 (11.8%) HHA: 359 (13.6%) IRF: 93 (3.5%) LTCH: 14 (0.5%) OUT: 34 (1.3%) SNF: 359 (13.6%) HHA 414 (1.8%) HHA Only: 132 (31.9%) ACUTE: 84 (20.3%) OUT: 17 (4.1%) PTB: 180 (43.5%) SNF: 1 (0.2%) IRF Only: 3 (9.7%) ACUTE: 3 (9.7%) OUT: 4 (12.9%) SNF: 3 (9.7%) LTCH 5 (0.0%) IRF: 1 (20.0%) SNF: 2 (40.0%) OUT 796 (3.5%) ACUTE: 57 (7.2%) HHA: 21 (2.6%) PTB: 290 (36.4%) SNF: 1 (0.1%) SNF 69 (0.3%) SNF Only: 15 (21.7%) HHA: 15 (21.7%) PTB: 17 (24.6%)



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

te Care Center for Research

9.1% → Outpatient/ambulatory therapy

2.0% → LTCH

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

- HHA: of $37.4\% \rightarrow 38.2\%$ use more
- SNF: of $41.1\% \rightarrow 59\%$ use additional services
- IRF: of $10.3\% \rightarrow 87.7\%$ use more
- Outpatient Therapy: of 9.1%→ 34.4% use more
- LTCH: of $2.0\% \rightarrow 74.9\%$ 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
Al	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 =	<i>59.6</i>	10.0

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



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**	4.35**	2.80
	(n = 3,190)	(n = 810)	(n = 361)
IRF	3.75**	3.10	3.93**
	(n = 4,158)	(n = 1,463)	(n = 1,096)
LTCH	0.74	-1.91	0.67
	(n = 1,968)	(n = 122)	(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...

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

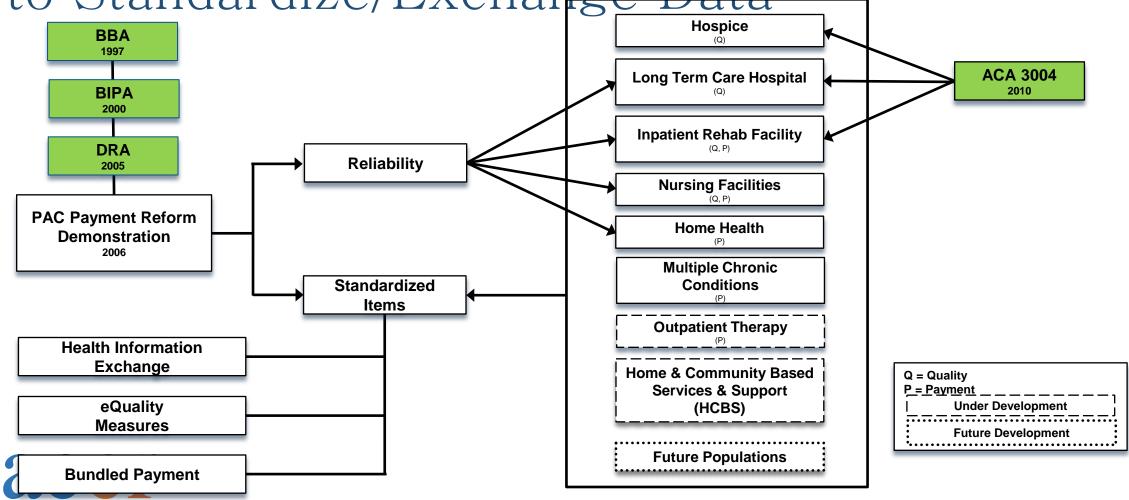


New Systems All Require Coordination

- 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



Post-Acute Care Center for Research

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

For more information:

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