



**The Future of Home Health Care: An Institute of Medicine Workshop
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Thank you to the Institute of Medicine, the sponsors, and planning committee for this opportunity. I must be one of the luckiest physicians in the country—I've been warmly welcomed into my patients' homes thousands of times and have been fortunate to experience some of the richness of their lives. I've been able to work with incredibly bright colleagues to develop post-acute care programs and strategies for the world class Cleveland Clinic. I now get to lead Visiting Nurse Association (VNA) Health Group of New Jersey, one of the country's larger non-profit home health, hospice, and community health organizations; started over 100 years ago by Geraldine Thompson with the support of her lifelong friend Eleanor Roosevelt. And today, the chance to address you all on a topic I care so much about, at such a distinguished venue is an incredible privilege! Thank you.

We're here today to discuss the future of home health care. Before I get too far 'over my skis,' I'm reminded of the great physicist Niels Bohr's advice that *"prediction is difficult, especially about the future."* But, for this workshop let's assume the future state is up to us. In my office hangs the picture of Mrs. Roosevelt and Mrs. Thompson with her famous quote that *"the future belongs to those who believe in the beauty of their dreams,"* and today I'm also reminded of the atrium of Cleveland Clinic where Dr. Toby Cosgrove's words are painted on the wall *"the future belongs to those who seize the opportunities created by innovation."* This workshop should be about dreaming a better and more beautiful future for home health care and about seizing innovation opportunities. With over 70 million aging baby boomers and already too many older Americans and people living with disabilities experiencing unnecessary suffering and unnecessary spending we are at a Sputnik-like moment for home health care. We have a very important task ahead of us.

In building the future let's not forget some of the basic, common sense, advantages of home care that are as true today as they were when Lillian Wald and her colleagues from the house on Henry street ventured out into the squalor of the lower east side of NYC at the end of the 19th Century. When we take care of patients at home there's an enhanced view of patients and caregivers that leads to a better understanding of important issues like how they manage medications and nutrition. Home visits are an access intervention that is most

relevant to patients with physical and socioeconomic barriers to care. During home visits a more intimate clinician-patient relationship can be established. Home care clinicians sit beside their patients in their bedrooms and at their kitchen tables, the home visit is an act of humility that demonstrates to the patient the clinician has left their comfort zone to be on their turf, that they are worth being truly known and visited. Home care can cost less while being desired more by many patients, and care at home is sometimes safer for frail elders. I'm reminded of today's program co-chair, Dr. Bruce Leff's, remarkable contributions and his research findings that common complications of hospitalization such as delirium are less frequent when hospital care is moved home.

I believe the future of home health care is vibrant and impactful. In the coming years the home and community emerge as the main setting for a myriad of health services, the home setting and health services and supports will become so synonymous, it may not be called home care, rather just modern *health care*. "Home-centered care" is health care that embraces the person centric notion that people with serious and disabling conditions should have access to holistic, sophisticated, and individualized care at home. Home-centered care will continue its emergence as a major national health strategy for addressing undue suffering and unnecessary expenses because the common sense benefits and win-win propositions for payer and patient are so powerful. A decade from now home-centered will look somewhat different in Wichita than in Washington, and different in Asbury Park than in Albuquerque or Akron, but in all of these places and everywhere else the purchasers or organizers of care will have adopted home-centered care as a core strategy for addressing the high costs and need to improve the care experience and outcomes for older and disabled Americans. These purchasers and organizers may be families, communities, businesses, health systems, physician networks, accountable care organizations, patient centered medical homes, independence at home programs, bundle conveners, managed care organizations, and informal networks of fee for service providers incentivized by value-based payments. In true American fashion, the exact mix of organizations, local resources, financing models that drive the growth of home-centered care will be a bit different in different places, and the timelines

will be different. One of our opportunities today is to clarify some goals and mile markers in this journey in order to accelerate the needed changes.

The current and future job of home care services in the Medicare program, the responsibility of the breadth of home care services in the Medicare program is clear—the role is to improve patient experience, clinical outcomes and value in two core (though sometimes overlapping) populations: post-acute, and for the high risk chronically ill. Said differently the mission of home health care is to:

- 1) Help beneficiaries , especially lower mobility patients, safely transition home from hospitals and facilities, and continue their recovery and rehabilitation at home, and
- 2) Help the highest risk chronically-ill individuals age in place in home and community settings by both meeting certain primary medical care needs, and by intermittently escalating care at home to avoid the need for hospitalizations in the first place. Helping these beneficiaries with very advanced chronic disease remain comfortable at home in the last 6-12 months of life is part of this role.

The emergence of home centered care strategies will greatly impact post-acute care outcomes in the next decade:

- Many more patients go home from hospital as their initial post-acute destination, and the length of stay in post-acute facilities is halved by substitutive home health care.
- The patient and family experience of coming home from the hospital is greatly improved by electronic information exchange between providers, more urgent and intensive initiation of home care after hospitalization, and mobile and digital resources that keep transiting patients and caregivers as up to date and empowered about their health services as the United airline app does for air travel.
- Transitional care models or bridging interventions that include post-hospital home visits become commonplace even for patients that aren't homebound or typical post-acute users in the current configurations. These care transition services contribute to much lower readmission rates for many diagnoses.

For the high-risk chronically ill independence at home practices, patient centered medical homes, and advanced illness care models will partner with home health agency and community resources and:

- Drive dramatic reductions in the number of hospital days and nursing facility days per 1,000 Medicare beneficiaries (especially those 85 years of age and older).
- Improve key indicators of well-being for this group such as the amount of unmet basic needs and caregiver burden.
- Elevate the overall home care experience for these vulnerable individuals using enhanced care coordination and enhanced access and information made available by mobile and digital resources, videoconferencing, and remote monitoring.
- Lead a doubling of the proportion of beneficiaries 85+ dying at home and with hospice care, these home deaths will far outpace facility and intensive care unit deaths

I believe the unstoppable home centered care movement will drive these outcomes. Again, the mix of stakeholders and entities and financing models that achieve these will and should be somewhat different across our widely different communities and health care markets.

What I mean is the 'cooks in the kitchen' may be different, but the four main clinical ingredients will largely be the same. Main ingredient #1 is physician and advanced practice nurse developed and overseen interdisciplinary home health care plans; plans informed by the well proven concepts of holistic geriatric medicine, palliative medicine, and rehabilitation medicine assessment. Ingredient #2 is enhanced support around care transitions; support that addresses self-management, care coordination, information transfer, and clinical stabilization. Main ingredient #3 is advanced capability for escalating intensity of medical care and palliative care at home in times of decline or exacerbation (including escalation to hospital-like services at home). Main ingredient #4 will be the thoughtful use of advanced information technology to fill the white space between encounters, to aid in the management of unscheduled home care patient problems, and to improve triage and the overall efficiency of care.

These ingredients will be adopted and used by successful independence at home practices, patient centered medical homes, accountable care organizations, federally qualified

community health centers, rural health centers, bundle conveners, advanced illness management programs, managed care and even by informal networks of fee for service providers more sensitive to value-based adjustments in their payments.

Now, this is important. I'd like to address what I believe to be the single most important issue in whether or not we fully realize the potential of home-centered care and whether we realize it in a decade versus two or three. It's the situation with our country's most-substantial investment and most substantial infrastructure for home health care, our Medicare certified home health agencies. Nothing would accelerate this transformation more and across more geographies than a robust Medicare home health agency sector. These groups of nurses, therapists and other clinicians already exist in virtually every community in the country, have hundreds of thousands of multi-disciplinary staff and already make more than 100 million home visits annually. They collectively have enormous resources in regards to practical community knowledge and acceptance, often deep and longstanding clinical and business relationships with other providers and stakeholders, a capacity for information collection for quality and financial monitoring, a mature (but flawed) licensure and accreditation framework, and a viable (though imperfect) payment model that finances the existence and availability of these clinicians. I view many of these agencies as local and national treasures that should be improved not torn down.

In most communities in America, the function of the home health agency will be at the core of how and when we get to this home-centered care future. In most communities in 2024 the home health agency will be to the medical home, to the independence at home program, and to other physician led care models what the hospital was to the practice of medicine in a past era. In 2024 the home health agency is the professional and paraprofessional team that will rally around these different models of financing and physician leadership and implement much of that holistic physician and advanced practice nurse led care. The future home health agency team, under the direction of these physician and advanced practice nurse led care models, provides the current skilled services as well as care coordination and transitional care supports needed for the success. Just like hospital care plans, where nurses and therapists and social

workers, and paraprofessionals are essential to carrying out the care; in the future at times of transition, decline, exacerbation at home, the certified home health agency is that responsive team.

I have seen with my own eyes how home health agency clinicians can be this resource, this hub, and I believe this is the right path to advance home-centered care in most communities. This productive role of home health is accelerated because of policy steps we take right now **to improve** and not diminish, not dis-integrate the basket of services, and not indiscriminately cut our home health infrastructure.

- Future Medicare home health agency payments become tied to outcomes and experience and are tied to participation in a diverse range of alternative payment models. These policies help intensify the culture of quality and value in the home health sector.
- Medicare home health agencies have official medical directors and interdisciplinary team case review similar to hospice care, these medical directors help rationally link and liaison home health agency services to the other key entities. They also play a key role in addressing patient eligibility and certification.
- Medicare home health agencies widely scale the use of evidence-based care transitions interventions for all appropriate patients. Informed by the Affordable Care Act Sec 3026 Community-Based Care Transitions Program, brief care transitions services (including an early post-hospital home visit) become a covered home health service irrespective of homebound status.
- Technology upgrades and interfaces improve information flow between home health and other providers, and multi-channel patient touch-points to the home health agency improve the efficiency and experience of home health agency services.
- A decade of training and career development of HHA staff in state of the art geriatric, palliative, and rehabilitation medicine care and care coordination concepts greatly improves the sector's ability to play this essential role

The central role of the home health agency will also be catalyzed by making major fraud and abuse concerns a thing of the past. The home health agency of the future is accredited

not just at the time of licensure, but on an ongoing basis. It has public reporting of certain utilization measures at the agency level that could be indicators of manipulation or misuse (like episodes per beneficiary, proportion of community admissions, and low utilization episodes.) And, value-based purchasing and oversight models lead to substantial reductions in variability of these patterns across agencies. In markets where currently the number of home health agencies and the amount of home health services far exceed the national norms, moratoria and even capability-based competitive RFPs reduce the number of agencies. The lowest performing Medicare certified home health agency of 2024 is a serious and skilled clinical organization with the talent, culture, and technology to be a core part of helping physicians and advanced practice nurses address Medicare cost and quality challenges. Even beyond eliminating truly nefarious schemes, there will also no longer be room for unserious entrepreneurs who clumsily decide if they should open a dry cleaner, or home health agency without the clinical resources or internal controls needed for success. Though I work in the non-profit sector, I believe sophisticated for-profit home health companies will be an important part of the landscape. Their investors and leaders will have an unambiguous understanding that their profitability depends 1st on clear value creation for post-acute and high risk Medicare beneficiaries. These companies will reach new heights because of superior talent, technology, and clinical resources---resources necessarily focused on targeted clinical success.

Today, together, we have a special opportunity. An exceptional responsibility to catalyze the improvement of our nation's home health system, to accelerate the emergence of a home-centered health system to help more older Americans with serious chronic illness, hospitalized older Americans, and people with disabilities and their families to get home and succeed at home. We meet at a most pressing time in our nation's history for addressing these issues, the early years of a major demographic shift.

We know many of the ingredients that can ensure success, physician and advanced practice nurse leadership, alternative payment models, better technology, and the essential base ingredient (like flour in bread or water in soup) will be a high functioning,

high integrity, and well supported home health agency sector that provides much of the multi-disciplinary team and resources to make this happen. Over the next day, and in the weeks and months ahead we will continue to discuss and explore the best models and approaches and the resources and policies needed for success. As we explore these different models let's try to minimize the importance of the names and labels; where there are common home-centered themes and resources that can help, we should elevate those ideas irrespective of the packaging. We should avoid the temptation of trying to pick winners and losers between marginally different concepts whose success is more dependent on local execution ---instead let's focus on how we can ensure that all of these well-intended and reasonably conceived efforts at advancing home-centered care are as successful as possible. To make home centered care a reality across America there will need to be a diversity of approaches and arrangements, a dynamic toolkit. I believe that a bright home centered health system is clearly and tangibly before us if we continue to nurture the seeds of change that are starting to grow while taking steps to optimize rather than diminish our home health agencies. Together we have the chance to make an enormous difference! Thank you.