

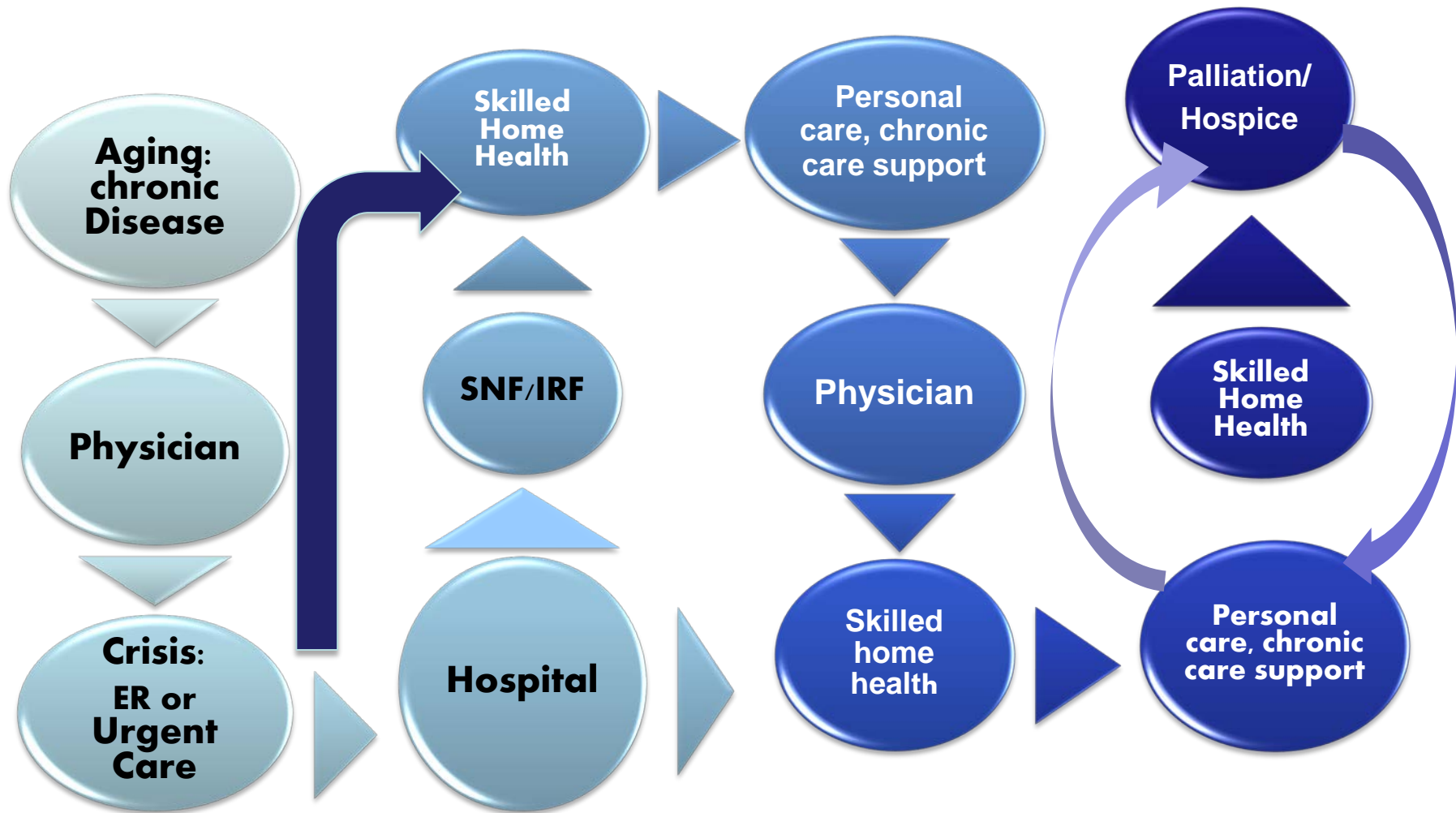
Trends in Home Care: Everybody Wants to Be There

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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

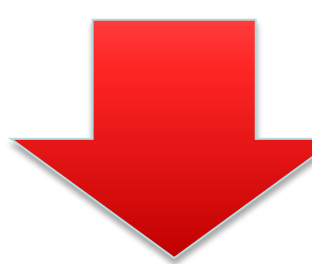


Trend 2: Home Care Manages Continuous Transitions



- Its 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



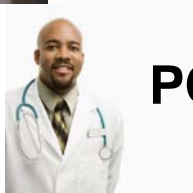
**It all happens
in the home**

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

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 tell 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*
 - Function*
 - Fall Risk*
 - Frailty*
 - Able, willing caregiver*
- 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



Eva Russo / For The Times / August 18, 2009