Alliance for Home Health Quality and Innovation

August 25, 2010

Home Health

- Cost-Effective
- Clinically Sophisticated
- Patient-Centered

An Integral Part of the Solution for America's Health Care

We are an alliance of leading home health care providers that are driving solutions to America's healthcare challenges, using emerging technology and clinical advances to improve the nation's healthcare system.

Challenges Facing U. S. Health Care

- Providing Better Care Transitions and Care Coordination
- Managing Chronic Diseases and the Impact on Medicare
- Reducing Hospital Readmissions

Home Health Care – Leading-edge Models That Address These Challenges

In recent years, home health has pioneered innovative and cost-effective uses of technology and therapeutics, that …

- **Deliver high quality, patient-centered, well-coordinated care**
- **Serve the health care delivery system**
- **Help millions of Americans live independently at home**

Transitions of Care Interventions

A first, important step in addressing many of the challenges we face is better transitions between care.

An integral component of care transitions is the effective transfer of critical patient information from one care setting to another. Obviously, HIT and EHRs must play a vital role in that transfer of information.

This can best be understood by looking at two real world, patient examples …

Case Studies of Two Medicare Patients

Annie P. 75 year old woman

- Chronic knee pain secondary to degenerative osteoarthritis
- Primary caretaker for her husband who has mild-moderate Alzheimer's
- Scheduled for bilateral total knee replacement surgery
- In addition to osteoarthritis, Annie also suffers from the following:
  - hypertension
  - hyperlipidemia
  - depression

Sam G. 82 year old man

- Hospitalized from May 2 through May 6, 2010 with an episode of congestive heart failure
- Discharged home where he lives alone
- In addition to CHF, Sam also suffers from the following:
  - type 2 diabetes
  - chronic obstructive pulmonary disease-stage II
  - hypertension
  - hyperlipidemia
  - coronary artery disease with previous coronary artery bypass
  - osteoarthritis in his knees

Annie P. 75 Year Old Woman

After her hospital discharge, Annie was seen within 2 hours of arriving home by the home health care nurse and therapist:

- She was increasingly distraught about care for her husband and about the potential for her not being able to participate in activities such as golf

Implemented care plan with her primary care physician:

- OASIS-C evaluation
- Reconciled medications
- Rehabilitation therapy to begin with ambulation
- Social worker evaluation for her depression and continuing care of her husband
- Contact initiated with local Alzheimer's Association for visit and assistance.
- Coordination of nurse and therapist visits for Annie and Mr. P.
- Set her care goals, including her ability to walk unaided and to provide previous level of care for her husband

Critical Information Transfers:

- Clinical information/orders from orthopedic surgeon and primary care physician
- Clinical/social information from visiting nurse and therapist
- Home safety assessment to confirm resolution of previously noted problems
- Need for social evaluation for her depression
- Confirmation of primary care physician's plan for home visit
- Recommendation to discontinue tramadol
- Report of therapy goals achievement

Quality Measurement Opportunities:

- Completion of information transfers
- Timeliness of information transfers
- Agency level hospital readmission rates
- Effectiveness of interventions
  - home safety interventions
  - social worker referral
  - medication changes
- Patient achievement of therapy goals

Sam G. 82 Year Old Man

After his hospital discharge home. Sam was seen the day after arriving home by the home health care nurse :

- On the first visit, the nurse reconciled the 8 different medications prescribed at hospital discharge with the his medications at home
- In addition, the nurse found another 6 Rx in Sam's apartment and removed these to prevent their use

Implemented care plan with his primary care physician:

- OASIS-C evaluation
- Provided Sam information to monitor his daily weight and a digital scale and weight chart to record daily weights.
- Arranged for Meals on Wheels to be deliver low-sodium meals
- Taught Sam when to contact his nurse and/or physician re: weight gain or alarm symptoms related to congestive heart failure
- Explain the importance of his Rx regimen
- Conducted a safety evaluation of his apartment including a falls risk assessment

Critical Information Transfers:

- Hospital discharge summary
- Medication list
- Findings and observations regarding possible precipitating causes of congestive heart failure
- Plan of treatment for review and approval
- Recommendations re: substitution of OTC drugs
- Request for specific monitoring , e.g . drawing laboratory studies

Quality Measurement Opportunities:

- Completion of information transfers
- Timeliness of information transfers
- Agency level hospital readmission rates
- Effectiveness of interventions
  - home safety interventions
  - social worker referral
  - medication changes
- Patient level condition specific measures, e.g. congestive heart failure and diabetes specific measures

Critical Information Transfers and Use of HIT/EHRs

Care Setting for Information Transfers:

- From the discharging physician to the primary care physician
- From the discharging physician to the visiting nurse
- From the visiting nurse to the primary care physician
- From the primary care physician to the visiting nurse

Quality Measurement Opportunities:

- Completion of information transfers
- Timeliness of information transfers
- Agency level hospital readmission rates
- Effectiveness of interventions
- Patient level condition specific measures, e.g. congestive heart failure and diabetes specific measures

Critical Information Transfers:

- Hospital discharge summaries
- List of problems addressed during the hospitalization
- Unresolved problems identified during the hospitalization
- Medication lists and reconciliation
- Findings and observations regarding possible precipitating causes of chronic disease
- Training re: social, diet, etc.
- Initial interventions such as Rxs, safety
- Plan of treatment for review and approval
- Recommendations re: substitution and/or replacement Rx/OTC drugs
- Request for specific monitoring procedures
- Response to safety assessment /falls risk assessment

Critical Information Transfers and Use of HIT/EHRs

Recommendations …

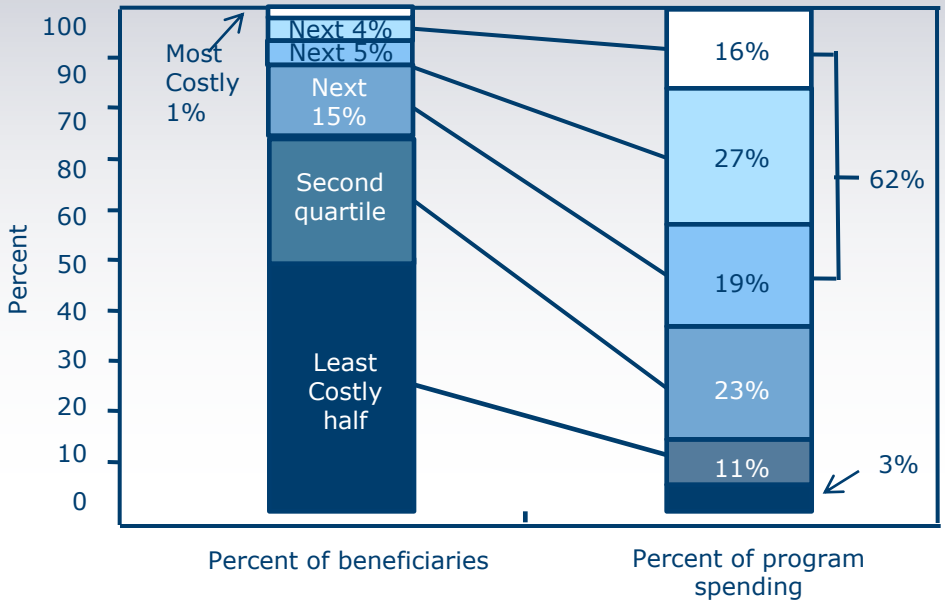
As mentioned before, the effective transfer of critical patient information from one care setting to another is an important element of care transitions and care coordination.

Important data ***not*** being addressed in the standards for electronic transfer :

- 485 Plans of Care
- Nurses' notes from home visit
- Verbal orders
- Admission/Discharge/Transfer records
- Medication information
- Electronic signature capability for all the above records (with checksum/tamper proof capability)

Managing Chronic Diseases

- 96% of Medicare spending is for people with more than one chronic disease
- 66% of Medicare spending is for people with five or more chronic conditions
- With a rapidly growing senior population, costs to treat chronic disease also will continue to rise rapidly



Source: MedPAC analysis of Medicare Current Beneficiary Survey, Cost and Use files.

Managing Chronic Diseases

Home health now provides care for patients that are more complex than the Medicare population

- **More than 74% of Medicare home health users have 3 or more chronic conditions**
  … compared to 53% of all Medicare beneficiaries
- **About 31.3% of Medicare home health users have five or more chronic conditions**
  … compared to less than 15% of the overall Medicare population

2005 Medicare Current Beneficiary Survey

Managing Chronic Diseases

Doctors count on home health to improve outcomes for chronic disease patients because they can rely on home health clinicians to perform the following functions …

- **Monitor patient's symptoms for signs of de-compensation (deterioration) and intervene early**
- **Monitor and manage co-morbid conditions**
- **Educate the patient about diet and lifestyle**
- **Empower patients to self-manage their conditions**

Offering Effective Care Coordination

Home health care combines the following important components of care coordination and moving them to self-care management while meeting people in the most cost-effective setting – their home …

- **Curative Skilled Care**
- **Restorative Care**
- **Compliance – assisting patient to follow plan of care**
- **Transitional Care Interventions**
- **Self Management Education Interventions**
- **Communication – patient and physician**

Reducing Hospital Readmissions

One specific area targeted for savings by HHS is reducing hospital readmissions …

- ***The New England Journal of Medicine*** **recently found that unplanned hospital readmissions may be costing taxpayers as much as $17 billion every year (based on 2005-06 Medicare data)**
- **A 2009 study by Avalere Health sites that early use of home health after a hospital stay is associated with a $1.71 billion savings to Medicare**
- **$216 million of the savings was due to a reduction in hospital readmissions**

Home Health Value in Post-Acute Care

In addition to home health's solutions for chronic disease management and care transitions, home health today offers the best value, in the most favorable setting for post acute care …

Cost Comparison of Health Care Settings:

Health Care Setting	Length of Episode	Cost to Medicare
Home Health	60 days	$2,213
Hospital	One day	$4,603
Skilled Nursing Facility	60 Days	$29,530

Source: 2005 Annual Statistical Supplement to the Social Security Bulletin.