

Themes from the IOM-NRC Workshop on “The Future of Home Health Care”

The Institute of Medicine and National Research Council held a workshop on “The Future of Home Health Care” on September 30 and October 1, 2014 to improve understanding on this topic with a broad range of stakeholders from academia, health care provider and professional communities, and family caregivers. The following are six major themes that the workshop speakers and participants discussed on the key trends and issues for the future of home health care, new models and approaches to home health and home based care, and workforce and technology considerations for the future.

A shift towards community-based care

Several critical factors and trends suggest that the health care system should be shifting towards a greater emphasis on community-based care, with the home as a critical node in the community. Shifting towards the community and the home can facilitate lower cost (because care at home is often less expensive than facility based care), improve quality, and enable patients to remain at home, consistent with their preferences. The workshop surfaced a number of key goals in health care today as noted in the box on the right.

New models achieving the Triple Aim

There is an emerging spectrum of new health care delivery models and payment approaches geared toward making the shift towards home and community based care as a means to achieve the Triple Aim and person-centered care. These models and approaches include care management and care transitions services, accountable care organizations and bundled payment arrangements that are focusing on shifting towards community and home-based care, advanced illness management programs, home-based primary care, and hospital-at-home programs. While these models and approaches are promising harbingers of the future of health care and preliminary evidence was presented at the workshop indicating effectiveness, more consideration is needed to determine how to scale progress towards implementation of these models nationwide.

Key Health Care Goals

- The need to improve quality of care and enhance population health and patient and caregiver experience,
- The need to reduce cost of care to both payers and patients,
- The need to provide optimal care in the face of limited capacity--both in terms of workforce and facility space--to serve the graying U.S. population.

Examples of New Models

- Accountable Care Organizations (ACOs)
- Bundled Payment Arrangements (BPCI)
- Advanced Illness Management
- Home-Based Primary Care/Independence-at-Home Programs
- Care Transitions and Care Management Programs
- Hospital-at-Home Programs
- Community Aging in Place--Advancing Better Living for Elders (CAPABLE)

Policy and payment reforms are needed to propel effective models

Care delivery models discussed at the workshop may be financed in differing ways and a key issue will be how payment and policy will need to be reformed to facilitate adoption of such innovations in care. Today there exists a patchwork of benefits and coverage created by federal and state government programs (e.g., Medicare and Medicaid) that have fostered siloes and poor coordination of care (both within Medicare and between the medical/skilled care covered today and long-term supports and services). To truly achieve the Triple Aim and person-centered care, policy and payment reforms will need to be identified and made.

The home health workforce

Workforce considerations will be paramount to enable appropriate training (especially in geriatrics) for health professionals, including nurses, therapists, medical social workers, and physicians, to practice in interdisciplinary teams, with each able to practice at the top of their license. These health professionals will need to elicit and coordinate the support of aides, the personal care workforce and community health workers in order to meet the considerable and diverse needs of the population. Increasing involvement of physicians, nurse practitioners and physician assistants will be needed to successfully address the multiple chronic conditions predicted for optimal care at home. Moreover, to shift towards community and home-based care, patients and caregivers will need to be appropriately trained in self-care. Family caregivers and patients themselves will need to be treated as integral members of the care team, consistent with person-centered care.

The role of technology as a critical enabler in home health

Technology is rapidly advancing and holds tremendous promise to enable the care models of the future. Mobile, health information, remote monitoring, telemedicine, independent living and point of care technologies will be critical enablers for the health care system's shift towards home and community based care as a means to achieve the Triple Aim and person-centered care.

Quality and outcomes measurement

Quality and outcomes will need to be measured in order to bear out the value of community and home-based care. Identifying appropriate measures for the aging population, focusing both on chronic condition management (preventive maintenance) as well as rehabilitation, will enable us to document and conduct research on progress towards the Triple Aim and achieving person-centered health care.