Mid-Atlantic Health System ➔ Innovation: Physician Visits At Home

A mid-Atlantic hospital group created an innovative house calls program within its department of geriatrics. The program was designed to address the question of how to find patients in need of a geriatrician, rather than those simply in need of a strong internal medicine team.

The house calls program is based on the belief that providers trained in geriatrics are best suited to deliver high-quality care to frail elders. Additionally, unlike most home visit programs that rely exclusively on nurses and aides, the program incorporates physician and nurse practitioner visits. In this way, patients may receive a higher acuity level of care in the home, reducing their dependence on hospital visits. This higher-acuity level of medical care is supplemented by social services; social workers see patients in the home to assess and manage their need for long-term services and supports. Finally, this comprehensive program provides patients with 24/7 access to physicians by phone, ensuring that vulnerable individuals have constant, reliable access to care.

Qualified patients are those that live within a defined geographic distance from the hospital, those that are determined homebound by a hospital-specific assessment that is distinct from traditional home health criteria, and those that have some kind of payer (typically Medicare). Patients are enrolled by word of mouth.

A 2014 study published in the Journal of the American Geriatrics Society found that the program has resulted in a 22 percent reduction in emergency room visits, 9 percent fewer hospitalizations, and 27 percent reduction in days spent in a nursing home. Consistent with these results, the study found that patients used more primary care but less hospital care, less specialty care, and less nursing home care. On average, the 722 patients studied experienced savings to Medicare of roughly $4,200 per person per year.

While the program has been shown to provide significant medical well-being for the patient, it has faced financial challenges. The reimbursement opportunities do not cover the true costs of care, rendering the service financially not viable. Even with philanthropic support, the program’s costs outweigh its funding. All told, this program illustrates the potential of a geriatrics-centered initiative to improve patient quality of life and advance a mission-driven organization’s commitment to care for its beneficiaries.

Visiting Nurse Association Health Systems ➔ Patient experience, lower cost

The VNA Health System utilizes telehealth to deliver care to congestive heart failure (CHF) and chronic obstructive pulmonary disorder (COPD) with limited access to medical care. The telehealth program began in 2012 and covers six home health agencies in nineteen central-Pennsylvania counties, and was first implemented in order to help VNA with the common goal of decreasing hospital readmissions and to be competitive with ongoing advanced technology and therefore have the ability to build relationships with area hospitals. Both patients and caregivers report great satisfaction with the program.

Patients are enrolled in the telehealth program either when they are first diagnosed with CHF, COPD or when they are found to have multiple hospital readmissions. The goal of the program is to help patients become more independent in understanding their chronic disease condition during their time enrolled in home health services. Each patient is then followed according to a series of pathway guidelines based on a six-to-nine week episode. Within each week of the episode, the care team reviews the patient’s health education needs and how to help that individual manage their care transi-
tion. The care team emphasizes potential complications, including how and when to contact their care team for additional support. Finally, the care team reviews the patient’s medications, conducting medication reconciliations as necessary. Care teams consist of registered nurses to do the initial assessment and follow up, licensed practical nurses to perform follow up visits and educate on the telehealth unit, and social workers to assess patients’ psychosocial needs.

Following an initial assessment, a nurse installs the phone-based telehealth program. Metrics such as pulse oximeter, blood pressure, pulse and weight are then reported back to the telehealth software, which the telehealth nurse monitors daily. Like many home health programs, cost is a barrier to expanding this highly-successful program. Telehealth in particular requires purchasing of equipment along with upkeep and staff training. In addition, insurance companies do not reimburse VNA Health System for its in-house telehealth nurse who review patient reports daily and contacts the patient for any needs.

The VNA programs for CHF and COPD have been extremely successful in regard to patient outcomes, and have encouraged expansion to patients with pneumonia and acute myocardial infarction. The telehealth program for CHF, in particular, has resulted in reduced readmission rates. Caregivers have also reported great satisfaction with the CHF program and telehealth, particularly those whose loved ones live in rural areas. All-in-all, the VNA program demonstrates how a patient-oriented remote care and monitoring program may help to reduce readmissions and improve overall patient well-being.

**Southeastern Home Health Provider ➔ Patient experience, population health**

A Southeastern home health care provider implemented a Readmission Reduction program which has been expanded across all the operator's divisions: home health, hospice, and long-term care. -The program focuses on ensuring safe care transitions for high-risk patients transitioning from hospital to home. The provider has a 70-year history of driving innovation and partnership with those in the communities and serves to address the needs of our most vulnerable patients in its region.

The Readmission Reduction Program drives enhanced care quality for home health recipients by emphasizing the importance of physician partnerships. There are six key components designed to reduce hospital readmissions and improve care coordination. First, the program uses phone-based telehealth to increase communication between patients and their care team. This service includes pre-planned, proactive calls to high-risk patients in the weeks following discharge, as well as a Telerisk nurse who serves as a field-based case manager in the event that anything arises in between visits. Second, the Readmission Reduction Program relies on telemonitoring to remotely assess patients’ weight, pulse, and oxygen levels and report back to the care team and the patient’s physician. Third, patients have access to a team of specially trained nurses certified in wound care. These nurses consult with the patient’s nurse case manager to prevent or address common, issues like bedsores and incontinence-related abrasions. Fourth, the provider works with hospitals to address the post-discharge needs of their patient populations. Coordination with the hospital can take several forms; successful efforts have included huddle meetings and appointing a director of high-risk programs to serve as the point person on care coordination efforts, among others. Fifth, the program increased its efforts to incorporate therapy into patient services, acknowledging that working with patients on improving their functional ability and safety in the home, prevents falls and avoids a hospital readmission. Finally, the Readmission Reduction Program includes palliative care counseling for those in need of higher-acuity symptom management as they near the end of life.

Throughout the program’s development and implementation, the agency sought partnerships with physicians in order to build clinical protocols and communication channels, especially for patients at highest risk; those with congestive heart failure.

Physician engagement, they found, not only sets the standard for best practices, but also ensures that those best practices are executed by subsequent providers. The operator has also seen a decrease in readmissions in specific populations where there is physician involvement. Their current 30-day readmission rate is 11.6% as reported by CMS Home Care Compare results.
Despite these successes, however, payment remains a concern. Because there is not reimbursement for many of the program’s components. These unreimbursed services are paid for through fundraising, donations, and grants, most of which are attracted by the program’s quality improvements. The program expects that financing challenges will rise in coming years with the anticipated growth in the indigent population, a group that often experiences higher health costs.

The program faces additional challenges as well. Technology to enable telemonitoring and telehealth aspects of the program are expensive and are not reimbursed. The program is impacted by the nursing shortage and experiences difficulty recruiting qualified nurses, who desire to work in the home health environment.

**Sutter Health ➔ Integrated Care**

Sutter Health, a northern California-based network of hospitals, is home to the Advanced Illness Management (AIM®) program which was designed to provide support to patients with advanced chronic illnesses. Centered on an integrated care model, the program 1) helps patients manage their own care and 2) builds a care plan that accommodates patients’ unique health issues, lifestyle, and personal preferences.

Eligible patients include those who have a high symptom burden, who’ve experienced increasing hospitalizations and ED visits due to clinical, function or nutritional decline and for whom physicians can answer “yes” to the question: Would you be surprised if the patient died in the next 12 to 24 months? This question screens patients who have significant health needs that require careful attention by a multidisciplinary team. Patients who enroll in AIM are not typically discharged from the program until they enter hospice or pass away. However, the program is not meant as a pre-hospice benefit, but an opportunity to monitor patients through transitions of care and ensure that care occurs continuously – not in siloed episodes of illness. Approximately 60% of newly enrolled patients are first served by the AIM home health team. The remaining 40% of newly enrolled patients are first served by a home visit team of care coordinators. After the patient’s home health episode or the initial set of care coordination home visits is complete, patients remain in the program and receive access to a robust tele-support service, which includes telephone check in calls. Access to an after hours nurse triage call center is available to patients throughout their time with the AIM program.

The results of the program are impressive. Sutter has documented that patients have a 58 percent reduction in hospitalizations and a 72 percent reduction in intensive care unit days within 90 days of enrolling in AIM. Patients also show improvement in satisfaction, as well as reduced per-capita costs. Additionally, in 2012, Sutter received a Centers for Medicare and Medicaid Innovation Award totaling $13 million, which when combined with additional health system funding, allowed them to expand the service throughout the entire Sutter Health service area, serving 10,000 patients during the three-year demonstration period.

Despite the benefits to patients, sustainability has been a concern for Sutter. Like many home health providers, they are challenged by Medicare’s lack of reimbursement for non-medical home health services. While many home health programs rely on concepts of patient-centered care, Sutter’s AIM model is different in that it provides services that are not traditionally reimbursed and are filling the gaps complex care patients experience in the traditional care delivery models. Sutter therefore bears the financial burden for these much-needed services, and has provided millions of dollars of uncompensated care. Sutter notes that information technology, data analysis capabilities, regulation, and compliance are key operational hurdles that should be addressed before expansion. All the while, program such as the AIM produce significant savings for Medicare and other insurers. The AIM program conservatively estimates that during the three year award period between 2012-2015, the program produced over $60 million in payer savings, against a target of $29 million in savings for service to approximately 10,000 AIM enrollees.
Private-Pay Home Care ➔ High Quality Home Care: There’s an App for that

Technology, specifically that which is geared toward home care professionals and clients, can improve on-demand homecare delivery. In this world of on-demand services, homeowners can find plumbers and riders can find drivers within minutes. New innovations in private-pay home care are making it easier for patients to initiate care - maybe not in minutes - but in as little as a few hours. Some technology platforms can match patients with care professionals through easy-to-use applications that simplify scheduling and access to private-pay home care.

Private-pay home care companies carefully vet applicants before selecting them and allowing them to be available for scheduling. The companies also assess clients’ specific needs and develop comprehensive care plans that ensure every patient’s unique needs and preferences are noted and met, which improves high quality care and patient satisfaction. Patients or their families can use the technology application to request short-term care based on their needs and care plan. After the service is provided, the care provider inputs notes and provides reports to the patient’s family or care manager. In addition, the patient can easily and directly provide feedback on their experience and even rate their care provider.

Unlike traditional home health agencies, private-pay home care is as it sounds; it requires out-of-pocket payment, and does not accept traditional insurance reimbursement. Under this model, clients and their families only pay for the time that they need, which improves system-wide provider availability. The innovations occurring in this model could create more accessibility to private-pay home care - ultimately filling the need for affordable home care for those who cannot currently afford services but need short-term, occasional coverage and don’t qualify for Medicaid-covered care. Overall, on-demand, private-pay home care provides a compelling vision for how home health services can evolve in an economy accustomed to tailored, on-demand service.