APPENDIX B:

Vignettes

This document provides vignettes to illustrate the three roles that the home health agency of the future will play in the health care system, and the key characteristics and capabilities that are relevant to serving in these roles.

I. Post-Acute Care and Acute Care Partners

In post-hospital care, home health agencies partner closely with hospitals and their staffs (including hospitalists, case managers, specialty physicians, and other professionals), community physicians, and caregivers. Home health agencies provide skilled clinical care (skilled nursing and/or therapy), care coordination (including connecting the patient with community resources), health education (for both the patient and caregivers), and other services to support the patient's safe care transition to the home and community. The vignette below describes home health's role in the context of post-hospital care; please note that home health agencies serve key roles as well in care that is post-emergency department, and care that is provided in the context of hospital-at-home programs.

VIGNETTE

Hospital Y (the "Hospital") is a convener in a bundled payment arrangement. The Hospital is focusing on improving post-acute care transitions as a means to address avoidable readmissions and achieve health care system efficiencies.

Home health agency X (the "HHA") coordinates with the Hospital in a care transitions program.

The HHA is a ***high quality*** agency, as evidenced by the HHA's performance against key measures, such as the Home Health Compare quality of care and patient experience measures. A partnership between the Hospital and the HHA creates a seamless connection between the organizations. A key part of this partnership between the Hospital and the HHA in the context of the bundled payment arrangement is that the Hospital shares savings with the HHA to align incentives.

The Hospital educates its case managers (discharge planners) about home health services. The HHA works with the Hospital's staff to determine whether the patient would meet eligibility requirements for the Medicare home health benefit, to begin assessment in the hospital, and to develop a rapid response approach by the HHA in the home for a seamless hand-off from the Hospital to the HHA. For patients eligible for Medicare home health care, the patient is discharged to the HHA.

The Hospital is able to electronically send the HHA the patient's health information, including the results of any in-hospital assessments and medication lists, via health-information ***technology***, which is key to enabling an effective care transition. The HHA uses evidence-based best practices for care transitions, including medication reconciliation and management, ensuring that the patient has an appointment with (and transportation for) a visit with his or her primary care physician (the "PCP"), with a plan of care that is established by and with the PCP. Technology helps to facilitate use of evidence-based practices through clinical decision support tools, as well as applications and technologies that facilitate interactions with the PCP, community resources (long-term services and supports), and caregivers. Remote monitoring and telehealth technologies facilitate the HHA's efforts to engage the patient in self-management and monitoring, and enables the HHA workforce to stretch its ability to serve many more patients effectively.

The HHA connects the patient with community resources to address caregiving, meals, transportation, and other long-term services and supports. The HHA provides ***patient and person-centered*** health education to both the patient and the caregiver(s) to support the goal of self-management in the home. Where the patient needs caregiving support at home beyond what a family caregiver (i.e., "informal personal care services") can provide, personal care assistance provided by an aide (i.e., "formal personal care services" paid by Medicaid, private long-term care insurance or out of pocket) may be needed to enable the patient to live independently at home.

The HHA is ***seamlessly connected and coordinated*** with the Hospital, the PCP, the caregivers, and various community resources to enable the patient to be (and remain) independent at home, and avoid an unnecessary hospital readmission.

II. Primary Care Partners

Home health agencies partner closely with primary care medical homes (office- based primary care) and home-based primary care programs, with responsive skilled nursing, care coordination, therapy, and related services during time- limited episodes where care recipients need an escalation in home-based care to avoid hospitalization or other undesired outcomes. The vignette below illustrates how home health agencies work with home-based primary care programs; it is important to note, however, that home health agencies also partner closely with office-based patient-centered medical homes to enable patients to stay healthy at home.

VIGNETTE

Home-based Primary Care practice A (the "HBPC Practice") has created a legal entity that operates a site of the Independence at Home demonstration project (the "IAH Entity") that Center for Medicare and Medicaid Innovation (CMMI) is testing. The HBPC Practice has a staff of physicians, nurse practitioners, medical social workers, and administrators. The HBPC Practice serves chronically ill and frail elderly patients with significant functional limitations (activity of daily living limitations). The HBPC Practice seeks to provide longitudinal care to these patients, rather than episodic care, to manage chronically ill and frail elderly well enough to prevent unnecessary exacerbations of their conditions.

To serve its patients, the HBPC Practice is using a model with three critical and interdependent elements of care: caregiving (through a personal care services agency, and/or personal care from a family members); the HBPC Practice (primary care and medical social work services); and Home Health Agency B (the "HHA") and Hospice C (the "Hospice"). Together, this health care team is able to make the patient's home the primary setting of care.

Within the IAH Entity are the HHA and the Hospice, which are agencies that have demonstrated high quality care against key measures. The HHA's ability to deliver ***high quality*** home health care, using well-trained home health professionals that can work in an interdisciplinary team is critical. Likewise, the Hospice is connected and coordinated with the HBPC Practice, caregiving, and the HHA. Having the HHA and the Hospice as components within the IAH Entity supports alignment of incentives and delivery of ***seamlessly connected and coordinated care***.

The HHA provides skilled nursing and therapy to ensure care is brought directly to the patient to support efficiency by avoiding unnecessary and costly hospitalizations. Unnecessary hospitalizations can also lead to further unnecessary services. Moreover, the HHA's services also support ***patient and person-centered care*** by allowing patients to obtain the skilled nursing and therapy care that they want and need, when and where they would like to receive it.

Technology enables the HPBC Practice, the HHA, and the caregivers to provide as much care as possible to the patient at home. For example, mobile and handheld technologies can facilitate home-based care by enabling diagnosis by specialists at the bedside. A visual consultation by a dermatologist at the patient's bedside can take place if a team member

takes and sends the encrypted photo or video to the dermatologist. Some cardiology diagnostics can also be performed via handheld devices, thus enabling the HPBC Practice and the HHA do more for patients at home.

III. Home-Based Long-Term Care Partners

Home health agencies will be partners in home-based long term care and social support models (i.e., formal and informal personal care providers) with responsive skilled nursing, therapy, and related services during episodes where care recipients need a brief escalation of home-based care to avoid hospitalization or institutionalization. Occasionally, home health agencies will provide limited ongoing skilled nursing services to that enable ongoing long- term care in the community (e.g., catheter care, ostomy care, etc.).

VIGNETTE

Home Health Agency E (the "HHA") partners with Managed Long Term Care ("MLTC") Medicaid Plan F in the care of clinically complex patients who are in need of additional services in a managed care long term plan. The MLTC plan care manager helps to coordinate community-based services for patients including, adult day care programs, transportation, , caregiving services, and more.

The Home-Based Long-Term Care model is based on meeting the social needs of the care recipient, but will be unsuccessful in avoiding premature nursing home admission if the medical and chronic illness care needs are not addressed. As the MLTC care manager and MLTC home health aide are intimately involved with their clients, they are often the first to notice signs of medical deterioration or unmet health care needs. To succeed in helping their clients, they must get timely collaboration from a number of different partners, including the Primary Care Physician (the "PCP"). Depending on the urgency and nature of the situation the MLTC providers in concert with the PCP may turn to the HHA as a partner to rapidly assess and escalate health services at home.

The HHA provides ***high quality*** care against key measures. An ability to provide preventive services, the beneficial position of being able to identify potential areas of concern in the home, and a relationship with caregivers allows the HHA to deliver ***patient-and person-centered care***.

Technology enables the MLTC plan, the HHA, the PCP, and additional support services to align a number of different care providers in a ***seamlessly connected and coordinated*** team. For example, the HHA may notice the need for additional equipment to facilitate bathing for a patient. Secure communications platforms within the MLTC give the HHA a compliant means of communicating this need to other members of the patient's managed care team, speeding up the delivery of a necessary, but not clinically-covered, piece of equipment, and helping to reduce possible unnecessary hospitalizations.