

## Connecting Home Health Care to the Care Continuum

Featuring CMMI Innovation Advisor  
**Pamela W. Duncan, Ph.D.**, Professor of Neurology  
Wake Forest Baptist Medical Center



**F**or Pamela Duncan, PhD, reforming the healthcare landscape means reengineering the way providers in the health care system work together to deliver patient care. As a physical therapist and epidemiologist by training, Duncan is a nationally recognized leader in neuroscience and patient behaviors currently serving as a Professor of Neurology at the Sticht Center on Aging, Geriatrics & Gerontology at Wake Forest Baptist Medical Center. Her recent work in transitional care—started with a grant from the Center for Medicare and Medicaid Innovation’s (CMS) Innovation Advisors Program—focuses on reducing avoidable readmissions for patients suffering from chronic diseases like heart failure (HF). Duncan’s project applies academic medical research to the clinical operations that govern a patient’s transition from hospital to the home.

Duncan’s innovation forges new partnerships between acute care providers like hospitals, and long-term and post-acute providers like home health. These partnerships begin with a new conversation about the providers involved in care transitions. “We need to be as diligent with our admission to the community as we are with the admission to the hospital,” Duncan explains. Her view of the care system is holistic, as she characterizes hospital discharge as “an admission to the community,” a statement which reveals her understanding that successful care transitions require acute care providers to work more closely with post-acute care.

### Transitioning Heart Failure Patients to Home Health

Duncan’s current project for the Innovation Advisors Program focuses on transitions for patients with congestive heart failure (HF). The program

involves a partnership with two home health agencies to streamline the transition from hospital to home. Key elements of the program include educating discharge planners about home health services, asking the home health agency to determine whether the patient meets homebound status, and developing rapid response systems for home health care.

The program brings together a multi-disciplinary team including a hospitalist, cardiologists, the nurse manager, the in-patient navigator, the home health team members, and the case management team. The team collaborates weekly, with home health providers participating in bi-weekly meetings. Each week, the team reviews all patients with a primary or secondary diagnosis of HF. The team also reviews all patients who were readmitted and whether the clinicians treating those patients used processes compliant with the program.

Currently, the program caters to a pilot group of approximately 135 patients with primary or secondary diagnoses of HF. Patients are excluded if they have been referred to a skilled nursing facility (SNF) or hospice care or if they are post-surgery patients. Eventually, Duncan plans to expand the program to a larger patient population, including all patients with a primary or secondary diagnosis of HF throughout the hospital, and even patients with other diagnoses.

### Home Health’s Role in the Transition from Hospital to Home

Duncan’s program is significant in that patient transition requires assessment at hospital discharge and a second assessment immediately following the admission to home health. At the hospital,

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clinicians use the BOOST (Better Outcomes for Older adults through Safe Transitions) tool, a CMS-recommended tool for hospital discharge planning from the Society of Hospital Medicine. In addition, the hospital adds a physical therapy assessment that includes functional status and cognitive assessments to its use of the BOOST tool.

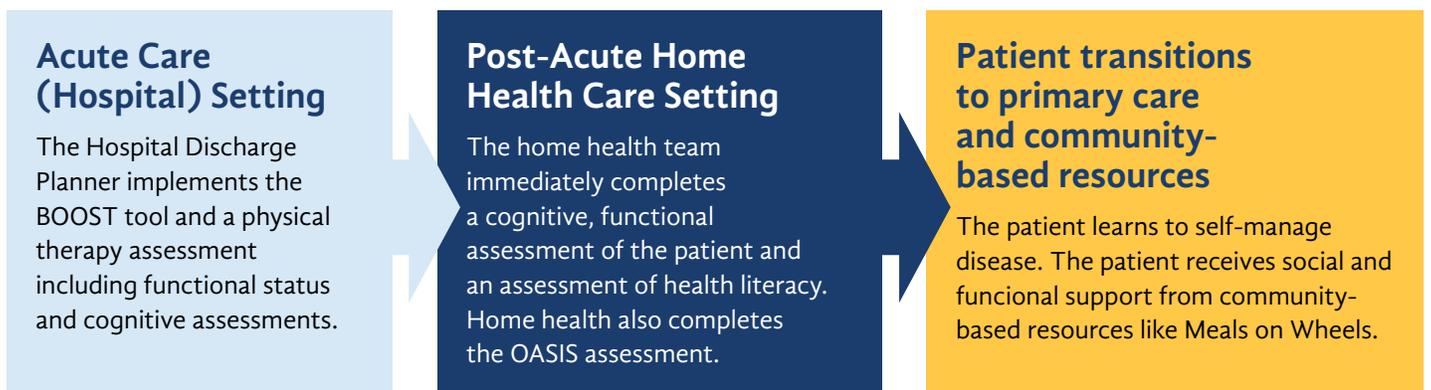
When the patient is discharged to the home health agency, the hospital provides the results of the BOOST tool and the physical therapy assessment to the receiving home health team. The home health agency has immediate access to the patient's medications, the patient's cognitive and functional status, and any additional information the hospital team considers critical, captured in the referral to home health.

The home health provider then completes a cognitive and functional assessment of the patient and an assessment of health literacy. The partnering hospital, working with the home health team, follows the patient for 30 days. Duncan describes caring for the program's patients as a "population management issue" that requires providers to pay

special attention to a patient population facing comorbidities, a high risk for 30-day readmissions after the hospital discharge, and a history of numerous hospital readmissions throughout their health care history. Use of evidence-based practices and strong processes by both the acute and post-acute care providers are critical to managing this population.

Home health agencies also complete a community resource needs assessment. "This encourages agencies to align with community services that can help meet patient needs, such as Meals on Wheels and Aging & Disability Resource Centers (ADRC), which are funded through the Area Agencies on Aging," explains Duncan. Home health plays the combined role of offering clinical care and connecting patients to community resources that can address the patient's barriers to care. For this reason, Duncan's program considers home health agencies to be critical partners in managing HF patients more successfully and aggressively; home health is the care setting focused on improving the patient's functional status and health education. Strong partnerships between acute and post-acute care address Duncan's ultimate goal: keeping patients independent at home.

## Patient Transitions: Acute Care Hospital to Home Health to Independence



## Challenges and Opportunities for Home Health

Though the program has seen a high referral rate to health care services in the home, some patients are reluctant to enter home health care. Part of Duncan's work is communicating how home health will address their recovery. "Patients and their families sometimes don't have knowledge of home health services," Duncan says. "Some may mistakenly think that the

next step is the nursing home." Conversations with patients and their families have revealed ample opportunities for home health to provide more education about how home health services can improve patient outcomes.

"We need to market our partnership with home health as keeping the patient safe and independent at home," suggests Duncan. Better patient and

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family caregiver engagement prior to home health admission may help to alleviate fears about home care. There's also room for home health to improve the quality of its care. Duncan points to two areas in particular, identified through nationally reported data in Home Health Compare that indicate opportunities for improvement: functional status and medication management.

So what about the effect of the program on hospital readmissions? "In my experience, this type of cross-continuum collaboration has reduced readmission rates significantly," Duncan states, although she notes the program is a work in progress and much of the data is still new.

Duncan expects that, like hospitals, home health care will face challenges to adapt to a rapidly changing marketplace that incentivizes providers to develop new models of care. "In order to remain sustainable, home health will need providers to engage in building innovative models and invest their resources now to make new models that will be more sustainable in the long run," she explains. New models will be increasingly more important as health care moves from volume-driven reimbursement to value-based or quality-based payment models focused on CMS's triple aim to provide better quality and outcomes to patients at lower costs.

Home health can be encouraged, however, that CMS has considered care at home as part of the solution. Duncan mentions the Community-Based Care Transitions sites as an example where CMS has singled out the role of home health in new delivery models. "These sites use home health agencies and can be highly effective in managing patients. The challenge is that most physicians and most health care systems really don't have a true knowledge of home health services; they don't communicate effectively across the transition; and sometimes home health agencies don't communicate effectively in return." Additionally, many hospital-based transitions models have increased utilization of nurse practitioners and physician assistants which requires home health agencies to better articulate which services they can provide to complement the work of the hospital's care team.

Communicating what home health can do to improve patient transitions involves not only a better working relationship with acute care providers but also training and education for the home health workforce across the care continuum. Duncan suggests stronger partnerships with acute care, primary care physicians, skilled nursing facilities, and community-based resources. "The success of managing the ever-growing elderly and complex patient population is that we function as full systems, and home health is an integral part of that leadership," says Duncan. There are opportunities for home health to engage and Duncan is quick to offer her academic, medical center facility as an example of an acute care partner that wants to engage home health for better care. She is hopeful that home health will capitalize on its full potential, as she concludes, "Home health care can be a great partner but there is still work to be done to make home health the best partner in the system it can be."

*The Alliance would like to thank Dr. Duncan for her time and insight. Do you know of a home health innovator that is making a difference in patient lives and outcomes? To suggest an agency or company for our innovator series, please email your suggestion to the Alliance's Director of Strategic Initiatives & Communications, C. Grace Whiting at [gwhiting@ahhqi.org](mailto:gwhiting@ahhqi.org).*

### **Patient transitions to primary care and community-based resources**

#### Partnerships focused on:

- Managing acutely ill patients with evidence-based care processes
- Palliative and hospice care
- Rehabilitation to achieve independence