Accountable Care for Patients and Population Health: Home Health's Role in Integrated Care Delivery Models

Featuring **Monique Reese, DNP, ARNP, FNP-C, ACHPN**
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Challenged to improve coordination of care across the health system and the patient experience, Monique Reese, DNP, ARNP, FNP-C, ACHPN, is looking for long-term solutions. As Vice President and Chief Clinical Officer for UnityPoint at Home, Dr. Reese's goal is to provide holistic patient care from birth to death, in authentic care settings that are the most comfortable and appropriate for the patient and their family.

As a nurse practitioner with board certification in family practice, hospice and palliative care, Reese's background includes experience in community health, school nursing, post-secondary education, medical-surgical, orthopedics and palliative care. She has an associate degree in nursing from Des Moines Area Community College, Master of Nursing and a Doctorate of Nursing Practice both from the University of Iowa.

About UnityPoint at Home's Integrated Home-Based Care Models

UnityPoint at Home is a part of the larger UnityPoint Health, operating across eight different regions in the states of Iowa and Illinois. Reese's work includes creating a cross setting strategy for UnityPoint's home health care services and communicating best practices between offices within the overall system. As a participant in the Trinity Pioneer ACO, one of the sites for the CMS Innovation Center's Pioneer ACO program, UnityPoint at Home has focused its efforts on transforming care from disconnected models of siloed care to coordinated, system-wide care that capitalizes on the unique advantages of the acute and post-acute care settings. UnityPoint at Home is particularly focused on using home health to enhance, improve and deliver interventional care in partnership with the patient and their physician, outpatient clinics, community resources and new models of care like the Patient Centered Medical Home ("PCMH").

While traditional health systems include home health under the auspices of the hospital, UnityPoint at Home's programs are part of a separate, single organization with its own leadership and expertise. There are many home health care providers within UnityPoint at Home, and the advantage to this organizational structure is that it facilitates their ability to identify and quickly disseminate best practices among all of the home health providers and integrate those practices with other parts of the health system.

The scope of services at UnityPoint at Home includes both a pediatric and an adult skilled home health program, which are offered both in metropolitan and rural areas. In her words, Reese defines home health as "care delivered in the home setting." This broad, home-based care model offers a comprehensive solution for managing patients at all stages of life. An interdisciplinary team provides home health services and includes physicians, nurse practitioners registered nurses, physical therapists, occupational therapists, social workers and specialists who have expertise in diet, wound and ostomy care, and infusion (among others).

Using Home Health in New Delivery Models

The UnityPoint at Home program uses home health as a trusted health care partner in several new models of care delivery:

- Pioneer Accountable Care Organizations (ACOs): Home health care is a full participant in the Trinity Pioneer ACO, which also includes UnityPoint Clinic and Trinity Regional Medical

Center. The Trinity Pioneer ACO the only ACO operating in the region and is focused on improving the quality of care and patient experience, and decreasing the cost of care.

- Integration with the Patient-Centered Medical Home: One of UnityPoint at Home's goals is to achieve better collaboration with physicians, nurse practitioners and physician assistants through integration and alignment of home health services into Patient-Centered Medical Home Models.
- Community-Based Home Care: UnityPoint Clinic has 280 clinics within its health system, and UnityPoint at Home has community-based home health care with a team of clinicians (including a nurse practitioner, registered nurse, physical therapist, and an occupational therapist). These programs work synergistically to help patients to improve health literacy and increase confidence and used evidence-based practices (such as the teach-back technique and motivational interviewing) to empower patients to better manage their health.
- Other Accountable Care and Shared Savings Programs: In addition to the Pioneer ACO program, UnityPoint at Home clinicians partner in the Medicare shared savings program and private payer ACO's. In total, the organization serves nine different markets and approximately 267,000 patients in value-based payer contracts.

As Reese explains, the move towards new models of care coupled with meaningful payment reform allows providers to put the focus on the value of the services being provided. The existing fee-for-service reimbursement system does not promote value. Although UnityPoint Health programs are team-based models, Reese's team treats each patient with a unifying approach to care. UnityPoint at Home begins by identifying the relationship between the patient and the patient's primary care provider, and wraps appropriate interdisciplinary team members around the patient based on a holistic assessment.

Fostering System-Wide, Meaningful Change in Quality

So how does UnityPoint Health leverage the expertise in home-based care that an individual agency may gain through experience? Reese explains that the key to system-wide innovation is a platform that allows for innovative leadership and empowerment of the workforce. UnityPoint at Home works closely to align its goals with the strategy of UnityPoint Clinic and UnityPoint Health hospitals, and the close relationship allows the organization to build cross-continuum training teams. These training teams combine clinicians with expertise in acute care, clinics, and care in the home in an effort to ensure an interdisciplinary approach to educating team members in how to work across the spectrum of care. Clinical programming focuses on utilizing data to identify sub-populations, which allows UnityPoint to identify and risk stratify programs specific to each sub-population in the system.

Another element of disseminating best practices is the ability to share information and data electronically. "Because we're moving toward accountable care strategies or value-based models, data and analytics are imperative," explains Reese. Real-time data can be used to proactively identify patients that are at risk, and to track the impact of interventions that are working. This allows UnityPoint at Home to identify successful interventions and then replicate that success at other care sites."

Encouraging System-Wide Innovation

Build a Culture of Change

- Invest in the right people for your organization
- Develop a leadership structure open to new ideas and emerging best practices
- Approach quality improvement as a partnership

Develop Data to Tell Your Story

- Identify existing data capabilities that can be leveraged to track improvement
- Establish data collection that will allow for risk stratification and measure improvements

Disseminate & Share Best Practices

- Actively engage providers that have great outcomes
- Analyze how successful interventions can be scaled and shared with other providers
- Learn from cross-continuum best practices

Opportunities for Authentic Patient Care in the Home Setting

Reese says that the greatest value offered by home-based health care is the ability "to provide patient-centered care in a place that's most authentic for the patient and their family." At times, some patients present themselves to their clinical team and doctors as healthier than they actually are, but the home is a setting that belongs to the patient and their family. "Being in the home setting provides the patient with a sense of comfort," explains Reese. "That often means a more, open conversation can transpire in regard to the patient's needs and goals."

Additionally, the home setting allows the care team to understand how the patient functions in their everyday life. This includes seeing what a patient eats, how they move throughout their house, what obstacles to care may be present, and what difficulties a patient may have in self-managing a disease. Home-based programs on the cutting edge of medical technology, such as hospital-at-home, even offer the potential to care for acutely ill patients in the home setting. Reese says that there is a responsibility on the part of the health care community to provide patients and families care in a "home-like setting" as they age.

Even so, there are still challenges to using traditional home health services in new models of care. One of the biggest challenges is the lack of awareness on the part of primary care providers of the interventional care that home health can offer. Likewise, many patients also have little knowledge about home care or community-based services that may improve their current conditions. In general, hospital stays are growing shorter, which means that patients are being discharged to home while still in an acute condition, says Reese. "There is a need to elevate understanding across the health system about the interventional care that home health can deliver so that patients continue to receive the level of care they need, whatever their condition," says Reese.

Challenges for Future Reform

Innovation in home health care, as in any industry, requires innovators to be open to learning. "Part of innovation is the ability to be adaptable," says Reese. Reese notes that several trends have forced health care providers to reevaluate how to best use home-based care. One trend is an increase, over the last five years, in the acuity of patients discharged to the home settings. The influx of higher-acuity patients was one of the starting points for UnityPoint at Home to increase interventional training for their home health

care clinicians. Cross continuum education on how to treat acute conditions has given the home care teams an improved clinical skill set and increased confidence.

The work with the Patient-Centered Medical Homes and care coordination has also resulted in UnityPoint at Home's focus on developing liaisons between the acute and post-acute care settings. "Care coordinators function to improve care coordination within the clinic," explains Reese. "We wanted to add a community-based expert to the team to assist with coordinating care in the community." To facilitate better care coordination, the UnityPoint team offers training to members of their care team on care transitions and patient coaching.

The increased use of technology in the home has played a part in a changing health care landscape as well. UnityPoint at Home has incorporated telehealth, which encompasses telemonitirng and video capabilities, into its models of care and is looking toward technology as a possible solution to an increasing shortage of resources (especially caregivers). Virtual visits, in particular, offer a means for patients and families to stay on track with managing a disease in a manner that encourages more efficient use of the care team.

True change will require better communication with policymakers and improved health care delivery and payment reform. Reese points to two areas that would facilitate a move towards value-based care from the current fee-for-service system. First, providers should focus on increasing policymaker's awareness of home-based care programs and their successes. Second, Reese points to nurse practitioners and physician's assistants as members of a clinical team that could function to sign orders to start home care and approve plans of care for home-based patients. This type of change would require modifications to existing law. For future reform, it is critical for policymakers to understand how home based-care, including home health, palliative care, and hospice, offer a viable, cost-effective alternative to other models of care. "The tough changes in reimbursement indicate that we need to help policymakers understand how home health can achieve the triple aim," explains Reese. "Home health can improve outcomes, lower costs, and improve patient care but will struggle to do so as long as current policies challenge the ability to delivery home-based services. The patients and families we serve deserve an opportunity to age in their home environment."

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