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Home Care Gets a New Place in the Medical Neighborhood

Collaboration with home care providers allows family physicians to extend their influence over patient outcomes and health care costs.



Family physicians treating older patients with chronic and disabling comorbidities who cannot leave home without considerable effort have the opportunity to establish collaborative partnerships with an increasingly diverse array of home care providers. By forming working relationships with these providers, physicians can help their patients achieve positive health outcomes in ways that will also reduce overall health care costs.

As Medicare and other payers shift to value-based payment models, the need for collaboration along the care continuum will be greater than ever. Increasingly, payments to physicians will be linked to their ability to influence positive health outcomes through the resources of multidisciplinary, collaborative teams that have aligned financial incentives through shared savings and bundled payment programs. (See “Reducing the cost of health care,” page 21.)

New home care models now being regularly introduced by health care systems, payers, and managed care organizations are designed to provide continuous, coordinated medical care that

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taps into value-based revenue streams. These new models expand on traditional models that provide home care – sometimes uncoordinated – for only a limited period of time while relying heavily on transporting patients to care facilities. The new models have several elements in common, namely effective care transitions, multidisciplinary teams, an identifiable care coordinator, the use of home based technology, patient and family engagement, palliative and hospice care, and quality reporting. And, very importantly, these models align the financial incentives of the professionals working on behalf of the patient, giving them good reason to collaborate frequently and effectively. Family physicians will increasingly find themselves with new and growing reasons to collaborate with the home care providers in their medical neighborhoods.

What collaborative partnerships look like

When a well-trained home health nurse calls a busy physician about a patient at home with heart failure who has increased weight and swelling and is complaining of shortness of breath, what does the physician do?

“That nurse might feel comfortable giving IV-pushed Lasix, maybe giving at least some water pills at home, but right now, unless the physician is in a shared savings program, he or she is probably not willing to spend 15 or 20 minutes working with the nurse to keep the patient at home,” said Thomas Cornwell, MD, a family physician with Northwestern HomeCare Physicians in suburban Chicago. He adds that many physicians have liability concerns and understand the patient’s heart failure is worsening. “Why risk trying to keep him at home? Let’s just see what the emergency room says,” would be the common approach, he explained.

Cornwell says his practice’s model, which features house calls by physicians and nurse practitioners, is different. “When a home health nurse calls me, the first thing I start thinking about is ‘Can we safely, as a team, manage this at home?’ More often than not, we can.” He says there are enormous cost savings – and even more potential savings – to this kind of home-based approach, which keeps patients in their preferred home environment while sparing them the risks of going to an emergency department or hospital.

Other models maintain physicians as leaders of inter-professional care teams while using nurse practitioners or social workers to coordinate services ranging from home health nursing to hospice care. These models also provide additional support and resources, particularly in relation to care transitions and coordination. For example, The Bridge Model, pioneered at Chicago’s Rush University Medical Center and now replicated at nearly 60 sites across the country, features a master’s degree-level social worker serving as the central care coordinator and convener of an interdisciplinary team of physicians, nurse practitioners, and other hospital and community providers. In addition to including medical elements, the model stresses the importance of social determinants of health and patient engagement in health outcomes. This model has dramatically reduced readmission and mortality rates.¹

The Community Care Alliance of Illinois specializes in the care of seniors and people with disabilities, supporting primary care physicians with disability-trained nurse practitioners who coordinate team members providing care at the home.¹

Home care models used by Sutter Health, Atrius Health, Humana, Optum, and other organizations have achieved success on many performance metrics, such as improving patient satisfaction, lowering patient mortality, and reducing the use and costs of hospitalization, emergency departments, intensive care, and rehabilitation. These models build multidisciplinary support hubs around physicians, who benefit financially by achieving better outcomes and using their time more efficiently.²

Getting the best results from home health agencies and support services

Physicians and home health agencies sometimes have relationships that are more transactional than collaborative, with minimal communication before, during, and after the care transition. The physician may make the referral and sign the paperwork, but he or she does not personally introduce the patient to the agency to make an effective transition, and there is little follow up or discussion initiated by the physician or the agency.

The roles of home health agencies are changing,

Several health care organizations using home care models are scoring well on performance metrics.

Home health agencies are moving from episodic care to continual chronic disease management.

moving from providing purely episodic care, such as after hospitalization, to providing continual chronic disease management. Physicians who collaborate with these partners and emphasize two-way communication can gain better results for their patients.

For physicians participating in shared savings or bundled payment arrangements, the extra time spent working with home health agencies can have a financial return. For example, shared savings programs value treating patients in the most appropriate location with the most cost-effective medication and treatment. Also, the new value-based and bundled arrangements reward physicians for better outcomes of care with premium payments. Physicians in a fee-for-service arrangement can be reimbursed for care plan oversight by meeting the requirements of Form CMS-485, “Home Health Certification and Plan of Care” (<http://1.usa.gov/1OSNtuH>).

Teresa Lee, executive director of the Alliance for Home Health Quality and Innova-

tion, said home health care providers can provide “boots on the ground” for physicians, seeing patients in their homes and observing the patterns and behaviors that can affect their health, such as medication compliance or diet.

“Physicians can view home health providers as an extended arm reaching into the home and supporting patients where they live,” Lee said.

The number of home health resources has grown rapidly to meet demand. Physicians must carefully evaluate home health agencies and services and help patients and caregivers do the same. Medicare’s Home Health Compare website (<http://www.medicare.gov/homehealthcompare>) is a good resource. (See “Partnering with home health agencies” below for additional tips.)

When patients need a doctor in the house

Frail, homebound patients who have two or more chronic conditions may need a referral

PARTNERING WITH HOME HEALTH AGENCIES

1. Thoroughly evaluate the agency. Ensuring a home health agency has the right skills and a proven track record will increase your confidence that the agency will meet your patient’s needs. For starters, look up a prospective agency’s Outcome and Assessment Information Set (OASIS) data through Medicare’s Home Health Compare website (<http://www.medicare.gov/homehealthcompare>). This provides the agency’s one- to five-star rating on such things as managing pain or preventing unplanned hospital care, as well as patient satisfaction scores. Once the agency is working with your patients, evaluate its work by asking tough questions, such as whether it is properly carrying out the care plan you signed off on and for which you are accountable, and whether the agency is providing enough information for you to make correct decisions.

2. Set clear expectations. At the start, make sure the agency understands what you expect in terms of care and responsiveness, and verify that its staff can handle a patient’s specific needs, such as specialty care, telehealth, infusion services, low literacy, or differences in language or culture.

3. Collaborate. Determine “rules of engagement” between yourself and the agency so that you understand what kinds of services the agency will provide and what is covered by Medicare and other payers. Establish a mutual understanding of the patient’s needs and goals and what you together as a health care team will do to help the patient achieve those goals. Focus on what makes a good team – shared

goals, respectful two-way communication, and patient-centeredness – and how these elements can help you achieve outstanding quality and cost outcomes.

4. Develop protocols. In many cases, outlining how to deal with a potentially urgent situation before it happens may avoid unnecessary trips to the emergency department, increase patient satisfaction, and decrease the need for you to be contacted for advice or instructions. Anthony Clarizio, executive director of the University of Florida Health Shands HomeCare, said his organization has designed more than 15 care pathways for heart failure, chronic obstructive pulmonary disease, and other diagnoses, as well as for specific patient needs, such as anticoagulant management or oxygen. These pathways provide a template of goals and interventions based on the experience of patients with these diagnoses or needs. The physician or home health nurse can supplement these interventions by ordering other services based on an assessment of the patient’s needs. The pathways and care plan can also incorporate the preferences or protocols of the referring physician, Clarizio said.

5. Expand your network. Look to meet the needs of patients beyond what home health agencies can provide by establishing working relationships with home medical equipment companies, area agencies on aging, social service agencies, and even other health professionals, such as optometrists or dentists. Give new patients a handout that lists other services beyond your own.

Home care medical practices have demonstrated that homebound patients have better health outcomes when they receive primary care in their homes.

to a home care physician or nurse practitioner. The success of house call programs like the Independence at Home (IAH) Medicare demonstration program, which began in April 2012, is expected to encourage more of these practices to form to meet a burgeoning need.³ A study published in May 2015 estimated that 5.6 percent of the elderly, community-dwelling Medicare population – about 2 million people – are completely or mostly homebound.⁴ This population, which is expected to dramatically increase, drives costly hospital and nursing home services.^{5,6}

The IAH program demonstrated that home care of chronically ill Medicare beneficiaries by a physician or nurse practitioner can significantly reduce costs while improving quality performance. According to the Centers for Medicare & Medicaid Services (CMS), the program saved \$25 million in year one, averaging \$3,070 in savings per beneficiary and reducing hospital readmissions and emergency department use.³

CMS awarded \$11.7 million in incentive payments to nine participating practices for reducing Medicare expenditures while meeting designated quality goals during the IAH program's first year. According to CMS analysis, the physicians' Medicare beneficiaries had fewer hospital readmissions within 30 days and used inpatient hospital and emergency department services less frequently for conditions such as diabetes, high blood pressure, asthma, pneumonia, or urinary tract infection.

Northwestern HomeCare Physicians has made more than 95,000 house calls to 7,000 homebound patients. The program gets 19 percent of its referrals from home health agencies compared with 17 percent directly from physicians. Because the agencies generally talk to the primary care physician before they refer a patient, physicians are the main referral source, Cornwell says.

Physicians acknowledge that they are referring their most difficult, complex patients,

Cornwell says. But he points out that his and other home care medical practices have demonstrated that homebound patients have better health outcomes when they receive primary care in their homes.

Home care physicians can engage with patients and their families to help manage patients' conditions, living environment, and diet. Cornwell provides instruction sheets on topics ranging from itching to leg swelling to constipation. He also instructs patients and families to call him about any issues and not worry that they are "bugging the doctor." The practice's physicians and nurse practitioners also look for challenges visible in the home, such as throw rugs, clutter, or broken stairs that can lead to falls, and they make recommendations, such as adding a grab bar next to the toilet. They also do "refrigerator biopsies," educating patients on the need to lower dietary salt intake.

Although his practice helps to extend patients' lives and improve their quality, it also seeks to prepare patients for the end of life through advance directives. As a result, 75 percent of the program's patient deaths have occurred at home, where most patients prefer

Reducing care costs can lead to financial benefits for physicians in shared savings or bundled payment arrangements.

The number of home health agencies is growing because of high demand.

House call programs can save money by helping homebound patients avoid the hospital or nursing home.

REDUCING THE COST OF HEALTH CARE

Health care economists are relying heavily on new delivery models that align financial incentives across the care continuum to rein in national health care costs, which are particularly high at the end of life:

- About a quarter of the \$500 billion-plus Medicare spends goes to care in the last year of life.¹
- 1 percent of the U.S. population accounts for about 23 percent of overall health care spending.²
- 5 percent of the population accounts for 50 percent of overall health care spending.²

1. Riley GF, Lubitz JD. Long-term trends in Medicare payments in the last year of life. *Health Serv Res.* 2010;45(2):565-576.

2. National Institute for Health Care Management Foundation. Health care's 1%: the extreme concentration of U.S. health spending. November 2014. <http://bit.ly/293z143>. Accessed May 24, 2016.

New approaches to home care can show how the entire health system can function more efficiently and effectively.

to die, compared with the national average of 33.5 percent, Cornwell says.

Palliative care for chronic, painful conditions

Many home health agencies and hospices provide general, short-term palliative services for patients who are near death. For patients with chronic and painful conditions who are not necessarily terminally ill, physicians may consider long-term, specialty palliative care to reduce illness burden, suffering, and health care costs, if this type of care is available locally and is covered by the insurer.

Russell Portenoy, MD, chief medical officer of Metropolitan Jewish Health System (MJHS) Hospice and Palliative Care in New York, said health care entities' experience with population health management, as well as evidence demonstrating the value of inpatient palliative care consultation, is beginning to show the value of at-home palliative care. Interdisciplinary home-based teams give patients and their families more choices about care, especially for chronically ill patients who need help managing severe symptoms, complex care, and other sources of distress.

Portenoy's team provides "high-touch," specialty-level palliative care through contracts with several managed care companies. He said he is trying to expand the program to include enough patients to demonstrate empirically that treating very ill people at home improves both the quality of care and clinical outcomes. He said that keeping those patients out of a hospital reduces costs as well. The high-touch model receives patients referred by health plans, not the hospital, and includes home visits by a physician or nurse practitioner, a social worker, and a chaplain if needed. In addition, nurses follow-up with patients by telephone, and physicians and nurse practitioners are always on call. All program staff have received specialty training in palliative care. Portenoy added that such a service-intensive

program can be paid for only through capitation or enhanced fee-for-service.

MJHS also offers a short-term consultation palliative care program that provides patients with a limited number of home visits for care.

It's time to bring health care to the home

As health care is spurred to improve outcomes while limiting end-of-life costs, new approaches to home care can show how the entire health system can function more efficiently and effectively. It is essential for physicians to commit to establishing partnerships and improving communication with a diverse mix of home care providers. By leading the way to bring health care to the home, family physicians can ensure that patients receive patient-centered care through a multidisciplinary team in a safe, timely, and equitable fashion. **FPM**

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2. Institute of Medicine and National Research Council. *The Future of Home Health Care: Workshop Summary*. Washington, DC: The National Academies Press. 2015.

3. Centers for Medicare & Medicaid Services. Affordable Care Act payment model saves more than \$25 million in first performance year. June 18, 2015. <http://go.cms.gov/1XnXAdM>. Accessed May 24, 2016.

4. Ornstein KA, Leff B, Covinsky KE, et al. Epidemiology of the homebound population in the United States [published correction appears in *JAMA Intern Med*. 2015;175(8):1426.] *JAMA Intern Med*. 2015;175(7):1180-1186.

5. Riley GF, Lubitz JD. Long-term trends in Medicare payments in the last year of life. *Health Serv Res*. 2010;45(2):565-576.

6. National Institute for Health Care Management Foundation. Health care's 1%: the extreme concentration of U.S. health spending. November 2014. <http://bit.ly/293z143>. Accessed May 24, 2016.

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■ Home care physicians need to engage with patients and their families to manage patients' conditions.

■ Home health services can also prepare patients for end of life through advance directives.

■ Some home health agencies provide long-term palliative care for patients with chronic, painful conditions who need help managing severe symptoms.