

## **Medical House Call Programs and Home Health: A future full of possibilities**

In today's health care environment, medical house call programs and home health agencies should have mutually beneficial, collaborative relationships. Areas of common benefit include referrals, coordinated clinical efforts and enhanced patient outcomes and satisfaction. As we look ahead to the possibilities of health care reform in a new administration, there are several issues which confront and confound healthcare. The collaborative relationship between home health agencies (HHA) and medical house call programs (MHCP) can and should be at the center of two proposed key solutions: transitional care and the patient-centered medical home.

### **Today: A Springboard for Tomorrow**

Currently, medical house call programs and home health agencies can enjoy a mutually beneficial relationship due to complementary, distinguishing clinical, financial and strategic factors that enable them to effectively and profitably work together. Among these are (1) superior coordination and collaboration of in-home services; (2) enhanced quality and improved outcomes; and (3) competitive differentiation in marketing; (4) mutual referrals; and (5) enhanced capacity management. Together, the result is an improved bottom line for both. Let's look at each factor briefly.

1. *Superior coordination and collaboration of in-home services* - With both intimate knowledgeable of the home environment and resources focused on the home-limited population, HHA and MHCPs can collaborate in a fashion typically not possible with office-based PCPs. Access, staff, resources and knowledge together enable this level of coordinated service, which extends past direct patient care to timely approval of orders and completion of forms and submissions.
2. *Enhanced quality and improved outcomes* – As a result of the first factor, quality of care and level of patient satisfaction are often markedly higher, resulting in improved outcomes, including reduced re-admissions and enhanced OASIS results.
3. *Competitive differentiation in marketing* – The option for a HHA to offer patients a tightly coordinated MHCP (or vice versa) truly enhances your “difference” in an increasing competitive market place. An HHA can work with a private medical practice or a hospital-based MHCP that lacks a captive HHA; similarly, a MHCP can build a relationship with a private HHA or one affiliated with a hospital. Regardless, this “continuum” of home-based care sets you apart.
4. *Mutual referrals* – Pretty straightforward: both organizations can and should refer to one another, as appropriate. Don't forget private duty if the HHA offers it.
5. *Enhanced capacity management* – Complementary skills and a common knowledge of the patient permits the MHCP and the HHA to “check-in” on an issue or concern for the other. This approach leverages staff resources and assists both the MHCP and the HHA to better manage patient capacity.

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### **Looking Forward**

Among the most critical issues facing health care are those involving care coordination, that often ill-fated attempt to ensure smooth coordination among care locations and care providers as the frail elderly patient moves through our disjointed health care system. The goal: maximize quality outcomes and reduce unnecessary costs and utilization.

Leveraging the natural relationship that can exist, MHCPs and HHAs can advance the art and science of care coordination for the frail elderly due to the unique skill sets developed in part through their common benefits, as well as their presence in and familiarity with the home environment. Two areas in particular show promise for this partnership: transitional care programs and the medical home.

### **Transitional Care: The Three Cs of Effective Care Coordination**

Seniors with complex medical conditions and accompanying mental and/or physical frailty are often hospitalized due to acute episodes of the underlying chronic illness. Hospitals and health systems typically provide well-coordinated care to address these acute episodes during the inpatient stay. Many patients are not able to be returned to the homes independently after hospitalization due to the complexity of their illness and the accompanying impact of their frailty. Rather, these individuals are often discharged to their residence with home health services for further treatment and rehabilitation.

Once discharged from the inpatient setting, however, these individuals are returned to a fragmented health care system in which the Three Cs of care transition, Communication, Collaboration and Continuity, are the exception rather than the norm.

Effective care transition should enable and empower the key players in this cycle: patients; caregivers; hospital staff; hospital-based physicians; home health agencies; and office-based PCPs. The goal: to communicate, collaborate and ensure continuity of care in order to provide superior outcomes and to reduce redundant or inappropriate utilization, such as readmissions or ED visits.

Unfortunately, the end result is often fragmented care, the possibility of further decline in functional and/or health status, and inappropriate or redundant utilization of health services, including a readmission rate of about 28 percent for first home care episodes.

The failure of transitional care is a serious problem. Yet, despite the challenges, some home health agencies are able to control readmission rates and other adverse events. Among home health agencies, performance on the risk-adjusted outcome of emergent hospitalization varies three-fold from the best-performing to the worst. This suggests that some transition problems are remediable.

Several studies on post-acute medical management shown that pro-active medical management when crossing the bridge from hospital to residence with some form of

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home services can prevent early readmissions and adverse events, as well as more efficiently manage resource utilization.

Common to efforts in these outcomes is the physician or advance-practice nurse who initiates a pro-active management plan and participates in the post-hospital care process for a period of time after hospital discharge, typically one or two months. When caring for patients with advanced chronic illness and high degrees of medical instability, it is helpful to have timely access to and continuity of medical care. Medical house call providers working closely with home health agencies are a valuable addition to the care model if one is considering management of this ill population in their residences, whether those are private homes, senior apartments or assisted living complexes.

### ***Evolution of a Care Delivery Model***

Most house call programs today evolved based on the needs of the chronically-ill, frail elderly through regular primary medical care home visits enhanced by appropriate home health and psycho-social support services.

Recently, this collaborative model of care delivery has found an additional purpose: effect smooth care transitions for patients with high likelihood of readmission or decline in functional status.

Specifically, transitional care programs have been started to:

- Enhance the efficacy of post-acute care
- Provide in-home or in-facility primary care to bridge the period from discharge to office-based PCP
- Assist office-based PCPs in patient care/management
- Enhance the effectiveness and utilization of post-acute therapies and skilled nursing
- Eliminate unnecessary readmissions

The target population for a transitional care house call program is seniors post-discharge with high likelihood of functional decline and/or readmission, characterized by:



- Deficiency in 1+ Activities of Daily Livings (“ADL”)
- Difficulty getting to/from the PCP office
- Ambulatory sensitive, chronic medical conditions and polypharmacy
- Need “SNF-level” care
- Risk loss of functionality and/or exacerbation of chronic condition(s)
- Most likely to bridge “at-risk” period successfully with effective, coordinated care

Transitional care patients are typically with the program 30 – 60 days until a successful transition back to office-based care by their PCP can be made.

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Like primary care house calls, a physician serves as medical director of the transitional care program. However, unlike primary care house calls, physician home visits are infrequent at best and the involvement of an advanced practice nurse is highly targeted and leveraged. The core of the transitional care team is typically home health staff that serve in a variety of capacities from patient assessment for placement in the program to traditional skilled care services to education/coaching visits.

A patient's risk level for functional decline and/or re-admission is assessed at discharge based on several key factors. The appropriate level of provider is assigned. The table below summarizes one such assessment and categorization.

Risk Level	Provider Category	Patient Volume	Office-based PCP Involvement
Low  High	<b>Care Coach</b> – RN on transitional care team; educates, guides and monitors patient, family and caregivers; if appropriate, can be through telephone or telehealth technology.	High	High  Low
	<b>Home Care Nurse</b> – HHA RN and a member of the transitional care team; works with HHA to provide/coordinate skilled care and monitoring.	Moderate	
	<b>APN/NP</b> – Employed by transitional care team; provides primary care to the patient in residence or facility and coordinates all other aspects of the care plan under the direction of the transitional care physician medical director.	Low	

As the level of provider and the intensity of care required for successful transition increases, the direct involvement in day-to-day patient management by the office-based PCP decreases. This approach leverages the skills of the provider team and best meets the needs of the patient.

The outcomes of a successful transitional care program are (1) significant reduction in post-acute utilization, including re-admissions; (2) improved outcomes; and (3) stronger financial performance.

### Patient-Centered Medical Home

Public and private payers, as well as some professional associations are launching patient-centered medical home (PCMH) pilots as one strategy to improve the quality and coordination of care, reduce resource consumption, lower costs and more closely align the economics of the current primary care physician practice model with these desired outcomes. These experiments in care coordination seek to test a concept that emphasizes the central importance of primary care to an organized and patient-centered health care system.

While varied in form, the PCMH concept suggests that primary care physicians' direct and trusted relationship with patients, coupled with a depth and breadth of clinical training across body systems, position them to assess an individual's health needs and

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to tailor a comprehensive approach to care across conditions, care settings and providers.

Recognizing this untapped potential, the Medicare Payment Advisory Commission (Med-PAC) recently provided a set of recommendations for Medicare payment reforms. A key piece of this reform agenda is pilot testing the PCMH. However, in order for the highest-risk beneficiaries driving much of the high Medicare costs (those with 4 or more chronic conditions and activity limitations) to be materially impacted, the care provided needs to be accessible, personal, holistic, and integrated.

Unfortunately, these highly vulnerable Medicare beneficiaries often cannot access office-based medical practices because of their functional limitations. Even if these patients could, many physician practices are high volume and not well positioned to deliver or coordinate the type of time-intensive cross-disciplinary care that can improve outcomes and reduce resource consumption for these patients. Additionally, home health services, among the most important of the cross-disciplinary care services, is limited in effectiveness working with an office-based PCP, whose interactions with the patient are either non-existent or limited by the very nature of the office-based model.

MHCPs and HHAs should be an integral part of the various PCMH initiatives for high-risk Medicare beneficiaries by making patients' homes the central venue of primary health care. Once again, the uniqueness of the MHCP/HHA relationship, characterized by appropriate skills, knowledge of the home environment and ability to coordinate care through the continuum of locations and providers, places them in a leadership position in the PCMH initiative for chronically-ill Medicare beneficiaries.

In 2007, four leading primary care physician organizations, lead by the American Academy of Family Physicians, released seven joint principles for PCMH. Of the seven, one emphasized the need for a personal relationship with a PCP and another highlighted the need for payment which recognizes the investment required and the value received. The remaining five joint principles each emphasized characteristics of PCMH that the MHCP and HHA are uniquely positioned to address for frail Medicare beneficiaries. Let's briefly consider each of these five joint principals:

1. *Team Approach* – A MHCP and HHA together can form the basis for a team that is uniquely qualified to collectively take responsibility for a patient's care
2. *Comprehensive* – All patient health care needs must be addressed either directly or through appropriate arrangements. Clearly, the HHA and MHCP can provide a broad spectrum of care and arrange for the provision of the remainder through already well-established relationships with other providers and community organizations.
3. *Coordination* – While this characteristic emphasizes technological coordination through information technology, it also suggests strong coordination of care delivery through the continuum of providers and locales. This is obviously a particular strong point for the MHCP/HHA relationship (refer to the Transitional

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Care section of this article for a discussion of the HHA/MHCP relationship and coordination).

4. *Quality and Safety* – Enhanced quality and safety are thought to be by-products of the other joint principles. Not only does the MHCP/HHA relationship support the joint principles in this regard, but ongoing access to the home and knowledge of that environment enables MHCP/HHAs to promote quality and safety in a distinctive manner.
5. *Expanded Access* – Responsive, open scheduling and alternative access options, such as telehealth are mandated for PCMH. The MHCP/HHA partnership offers the ultimate access point – the home - and developments in clinical technology permit them to bring a comprehensive array of clinical, therapeutic and ancillary services along with them. Many MHCPs and HHAs offer flexible appointments, including in some cases, urgent care visits. Their use of telehealth is in many communities pioneering.

Regardless of the PCMH model or models that eventually find acceptance, the common thread among them is that without effectively addressing these joint principles, the desired outcomes will not be achieved. The MHCP/HHA relationship is distinctively positioned to realize the full potential of the PCMH concept for those high-risk Medicare beneficiaries whose utilization and costs drive the largest portion of Medicare's controllable expenditures.

### **Summary**

Improving access, controlling unnecessary costs and reducing redundant utilization are *de rigueur* for Medicare to remain economically viable. Two promising programs, Transitional Care and PCMH together present a unique opportunity to address these concerns for the most vulnerable and most resource intensive Medicare beneficiaries. The MHCP/HHA partnership possesses the features and potential to effectively participate if not lead the development and implementation of these programs. It truly is a future full of possibilities.