Don't Reinvent the Wheel: Home Care is Already Your Hub for Community-Based DSRIP & Value Based Services

What every DSRIP committee and Value Based Payment leader needs to know about partnering with home care.

HCA
HOME CARE ASSOCIATION OF NEW YORK STATE

The BASICS

What you need

You have DSRIP projects with ambitious performance metrics to achieve. You want and need to improve care coordination, reduce potentially avoidable ED visits, hospitalizations, and readmissions, and improve population health. You are embarking on Value Based Payment arrangements with providers and preparing your PPS/ACO/hospital system for the progressing health care reimbursement landscape.

Home care's ability to meet your needs

Home care providers with decades of experience in your community can help you meet your goals while saving you money using their existing infrastructure, community presence, staff expertise and clinical portfolio. Home care providers have the daily contact with the most vulnerable members of your community, and they intimately know your community and region's unique health care needs.

Data demonstrates that home health care is a cost-effective option for post-acute and chronic care management that delivers strong clinical outcomes across an array of the most costly diagnoses.[1] Additionally, home care is an established option for primary medical management, experienced in working with physicians to provide and coordinate care of their patients throughout the community.

Patients in high-quality home health and home-based care have experienced 26% fewer acute care hospitalizations, 59% fewer hospital bed days, and a 19-30% reduction in medical costs than those who receive services in an institutionalized setting.[2]

Home care's regulatory environment

Article 36 of the Public Health Law outlines home care's scope of services. In many cases, Article 36 restricts non-home-care-provider entities from engaging in certain home care provider services, for the protection of patients and the integrity of the Medicaid system.

Federal and state laws and regulations require that such services be provided only by certified or licensed home care providers.

Home care's infrastructure and expertise

New York State has an incredibly comprehensive and diverse home and community based care system. Home care agencies and programs provide a broad array of skilled/professional, aide and support services.

Over 150 Medicare certified home health agencies in New York provide: nursing, physical/occupational therapy, speech-language therapy, social work, audiology, respiratory therapy, nutritional counseling, and more. Further, approximately 1,000 New York State licensed home care service agencies provide home health aide, personal care aide, and other support services in the community. In addition to Certified Home Health Agencies and Licensed Home Care Services Agencies, New York also certifies Long Term Home Health Care Program (LTHHCP) providers who are especially well-suited with care-management expertise, and comprehensive, coordinated service to the long term and chronic-care populations.

With thousands of staff serving approximately 400,000 patients, these agencies are a major presence in your community and have the human resource market share to assist major population heath, preventive and post-acute care needs in the community. Home care agencies also:

- Are experienced with quality outcomes measures and the payment consequences for meeting those measures under payor contracts and government rules;
- Already have contracts with managed care plans you may be working with to serve members' needs;
- Are accustomed to a variety of reimbursement and risk-sharing models, whether it's capitated payments, episodic reimbursement, or other unique configurations to ensure efficiency and appropriate service utilization.

The EVIDENCE

Home care clinical interventions in-depth

Home care agencies are delivering high-quality services every day to keep patients in their homes and out of the hospital and long term care facilities. This includes helping to coordinate major health and social support needs and enabling effective care transitions from hospitals and nursing homes to home, managing chronic diseases, delivering post-acute care, overseeing medication regimens, and much more.

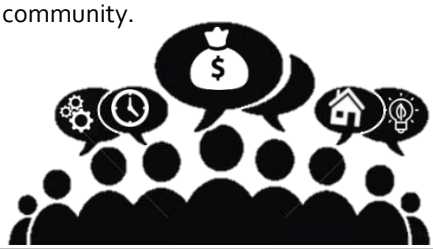
According to Community Needs Assessments conducted throughout all regions of New York as part of the DSRIP PPS Application Process, the following conditions were consistently cited as the leading causes of Emergency Department visits and hospital readmissions:

- Hypertension
- Diabetes
- Asthma
- Depression, Anxiety, Bipolar Disorder and other Chronic Mental Health Diagnoses
- Maternity-related conditions/complications
- Chronic Obstructive Pulmonary Disease (COPD) & other major Chronic Pulmonary Diagnoses
- Congestive Heart Failure (CHF) and related cardiovascular diagnoses
- Septicemia & Disseminated Infections

In addition, VBP has identified priority areas for providers and systems to address. These include many of the items above plus: Acute Stroke (and the post-acute period); the multimorbid, disabled, and frail elderly population; and chronic kidney disease.

These patients are home care's specialty! Agencies across the state have demonstrated success managing patients across all of these categories and helping to keep them out of the hospital. Every area of New York State has a home care agency addressing these conditions and they can each provide you with evidence of their successes in these areas for your specific community or region.

Consider the value these organizations present to your system and community.



Under DSRIP and VBP you are faced with new and emerging priority areas, some with evolving outcome metrics and opportunities for innovative program design and partnership.

Clinically, you are working on improvement of **medication adherence** and management, and **behavioral health** management in the community.

- Home care agencies can provide skilled nursing and social work services to patients in the community, in their homes, including assessment, counseling, medication adherence, and more.

You have identified **asthma** as a priority area and are identifying mechanisms for home-based self- management and evidence-based Medication Adherence Programs.

- Asthma management is a core service of home care agencies. Their staffs are trained and experienced in working with patients to: understand and adhere to medication regimens, make modifications to environments and behaviors that may trigger episodes, and recognize signs and symptoms that warrant further attention or treatment.

Programs to increase support for **maternal and child health**, including higher risk pregnancies, are on your radar – such as the Nurse Family Partnership.

- Many home care agencies provide maternal and child health services in the home to assist expectant and new mothers, and their infants. Whether it's the Nurse Family Partnership program or similar evidence-based models, home care agencies are capable of partnering to supply these services in your community.

As previously noted, Septicemia is a leading cause of hospital readmission.

- Home care providers are becoming uniquely positioned in early sepsis recognition and intervention in concert with physicians through a new and innovative model developed in New York.

The EVIDENCE

You are focusing on **care coordination and transitions** to proactively manage higher risk patients at home and reduce ED visits and 30-day readmissions related to both **post-acute and chronic conditions**, such as orthopedic joint replacement or **cardiovascular disease and diabetes**. Home care providers are already assessed on their ability to meet these needs. One of the benchmark quality measures for a home care provider is its 30-day readmission rate. Home care providers have designed a targeted infrastructure to address this quality measure, and others, and you should be utilizing this long-established expertise if you want to succeed under value-based payments or DSRIP. Here are some more data points:

- Data suggests that patients who have received care transition services through a collaborative partnership between a hospital and home care agency are significantly less likely to be readmitted to the hospital.[3]
- Comprehensive transitional care that focuses on coordinating providers, educating patients, and encouraging self-care management can help reduce rehospitalization rates in CHF patients.[4, 5]
- One case study of an agency in the state found that its CHF patients were significantly less likely to be readmitted to the hospital when hospitals and home care organizations implement collaborative transitional care programs.[6]
- Several studies have found that – when evaluating factors like pain, functional outcomes, and patient satisfaction – home-based rehabilitation after a total hip or knee replacement is equally as effective as hospital or facility based rehabilitation.[7, 8]
- The average cost of a 60-day stay in a skilled nursing facility is $26,940 as compared to a 60-day home health episode which costs on average $2,674.[9]
- When comparing post-acute-care settings, discharges to home health yield consistently lower readmission rates across several common diagnoses/conditions.[10]

As you know, the use of **telemedicine** is improving connectivity and connecting settings by expanding access to care and allowing for more routine and cost-effective interventions. Telemedicine has been pioneered by home care providers.

- Telehealth has been used in home care agencies across the state for many years with great success. Many home care providers have utilized telehealth in their care of patients with COPD, CHF, pneumonia, and other conditions and seen subsequent reductions in readmission rates. A 2012 study highlighted several agencies in New York State that have used telehealth to achieve 10% and lower hospital readmission rates for the above conditions, compared with rates close to and over 20% for all patients on census with the same diagnoses.[11]

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Home health care is here to partner with you, and share decades of industry experience and innovation in these areas.

The RESOURCE for more INFORMATION

Home Care Association of New York State

DSRIP lead entities and value-based payment networks are encouraged to work with home care agencies – where required and where appropriate – to best meet your clinical and cost outcomes needs.

For further information and insights, you are invited to contact the Home Care Association of New York State (HCA), which has a policy team ready to answer any of your questions about how home care can meet your needs. HCA can be reached at (518) 426-8764, www.hcanys.org, or info@hcanys.org.

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