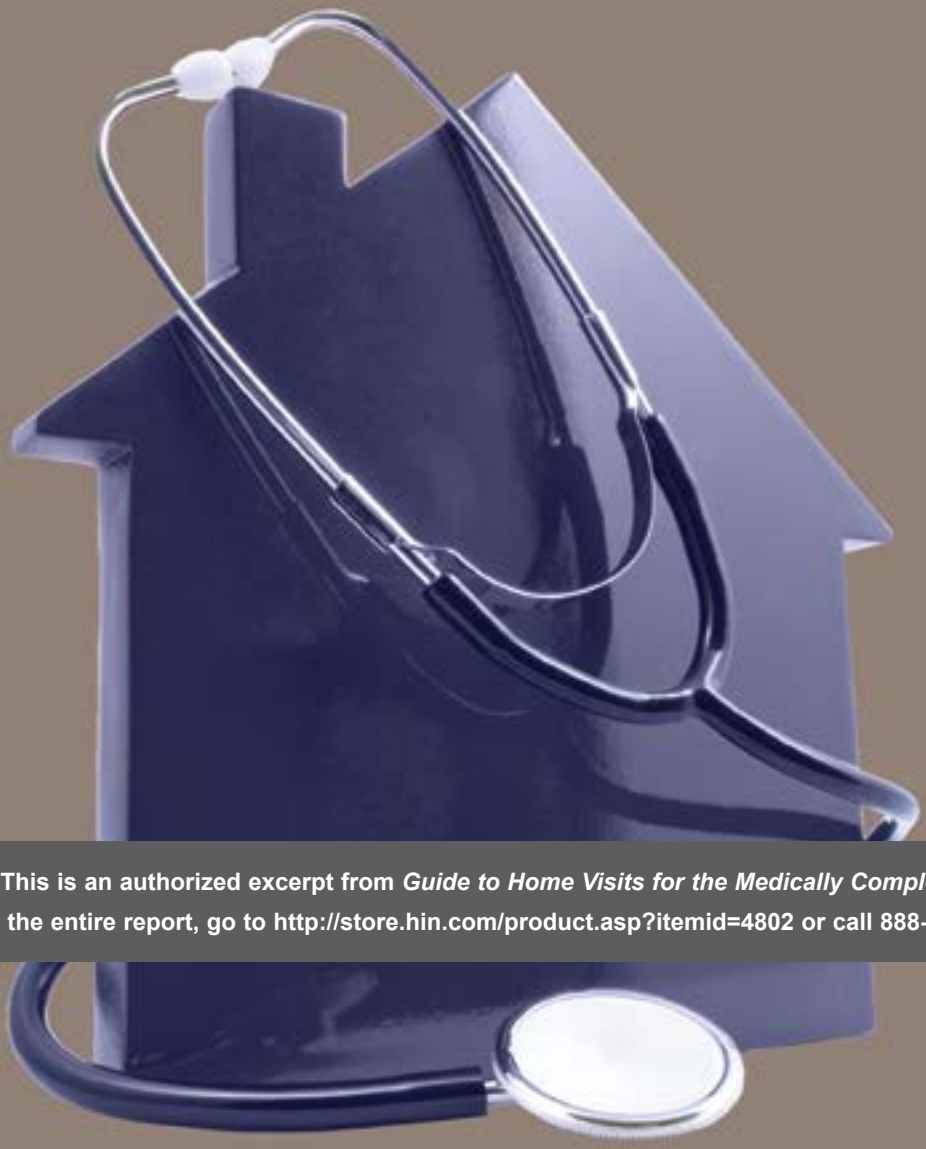
Guide to Home Visits for the Medically Complex



The Healthcare Intelligence Network
800 State Highway 71, Suite 2, Sea Girt, NJ 08750

Guide to Home Visits for the Medically Complex

This special report is based on Healthcare Intelligence Network Home Visit survey data compiled in 2013, as well as case studies and interview on successful home visit programs.

Contributors

Pam Aldridge, manager of care management at Durham Regional Hospital
Lisa Collins, chief clinical officer, Community Health Network, Indiana
Larry Greenblatt, M.D., medical director for the chronic care program at Durham Community Health Network for Duke University Medical Center
Susan Legacy, RN, senior manager of case management at Fallon Community Health Plan
Susan Raye Horton, DNP, APRN, CHFN, vice president of peri-operative services at Central Maine Medical Center and executive director of the Central Maine Heart and Vascular Institute, Lewiston, Maine
Deborah Lyons, MSN, RN, NE-BC, network disease management executive director, Community Health Network, Indiana
Jessica Simo, program manager with Durham Community Health Network for the Duke Division of Community Health
Pat Zinkus, RN, director of case management at Fallon Community Health Plan

Executive Editor

Melanie Matthews
HIN executive vice president and chief operating officer

Project Editors

Patricia Donovan
Jessica Fornarotto

Document Design

Jane Salmon

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Executive Editor's Note

Welcome to the Healthcare Intelligence Network's *Guide to Home Visits for the Medically Complex*. A well-planned home visit to a high-risk patient may offset a potential readmission while posing an opportunity to clarify care plans, reconcile medications, assess the home environment for safety and support, and broach the delicate subject of end-of-life care.

Guide to Home Visits for the Medically Complex examines the industry's growing use of home visits for patients at high risk of readmission, presenting home-based initiatives from eight healthcare innovators that are helping to elevate the level of care and patient satisfaction while reducing 30-day readmissions for the medically complex and recently discharged.

This guide delivers a comprehensive set of 2013 benchmarks in home visit applications from 155 healthcare organizations; insight from two separate home visit interventions for heart failure patients; an outline of an innovative home visit pilot for Medicaid and dually eligible patients; and a look at Fallon Community Health Plan's Home Run program for Medicare Advantage members at risk of high utilization, which keeps patients in their home and improves their functional living status.

- ✓ Chapter 1: 2013 Healthcare Benchmarks in Home Visits
- ✓ Chapter 2: New Horizons in Healthcare Home Visits
- ✓ Chapter 3: Home Visit Handbook
- ✓ Chapter 4: Home Visits for Medicare High Utilizers

There are dozens of tips, tactics and metrics contained in the *Guide to Home Visits for the Medically Complex* that organizations can model to establish a home visit program for vulnerable patients that can impact critical readmission benchmarks closely tracked by payors.

Melanie Matthews, HIN executive vice president and chief operating officer

2013 Healthcare Benchmarks: Home Visits

This special report is based on results from the Healthcare Intelligence Network's industry survey on home visits conducted in August 2013.

Executive Editor

Melanie Matthews

HIN executive vice president and chief operating officer

Project Editors

Patricia Donovan

Jessica Fornarotto

Document Design

Jane Salmon

2013 Healthcare Benchmarks: Home Visits

155 healthcare organizations describe how they employ home visits, including who conducts the home visit, the components of a home visit, how individuals are identified to receive home visits, and more.

"[Our most successful process in use in our home visit program] is having routine proactive phone visits to identify worsening conditions and/or the need for an in-home visit."
> Home health agency and affiliated professional corporation

"We use provider referrals to [identify individuals to receive home visits]."
> Health plan

"[The majority of our home visits fall] under the medication instruction category."
> Pharmacy

"Daily workflow management algorithms with prioritization and mobile access to electronic case management records is our [most successful workflow in our home visits program]."
> Case management/care coordination

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About the Healthcare Intelligence Network

The Healthcare Intelligence Network (HIN) is an electronic publishing company providing high-quality information on the business of healthcare. In one place, healthcare executives can receive exclusive, customized up-to-the-minute information in five key areas: the healthcare and managed care industry, hospital and health system management, health law and regulation, behavioral healthcare and long-term care.

Executive Summary

As a result of home visit programs, patient satisfaction increased for 87 percent of organizations and medication adherence has increased for 81 percent, according to new metrics from the Healthcare Intelligence Network. Today's home visits provide a unique perspective on the patient experience while helping individuals meet everyday needs, avoid rehospitalization or an ER visit, and connect with community resources.

Almost 75 percent of the 155 respondents to HIN's Home Visits e-survey conducted in August 2013 visit some percentage of their patients or health plan members in their homes.

Individuals targeted to receive home visits are often identified by chart reviews, electronic health records (EHRs), hospital census and self-reports. Visiting medically complex patients at home can shed light on health-related issues that might go undetected during an office visit.

The primary staff member who conducts the home visits for these targeted individuals is the case/care manager, say 34 percent.

Survey Highlights

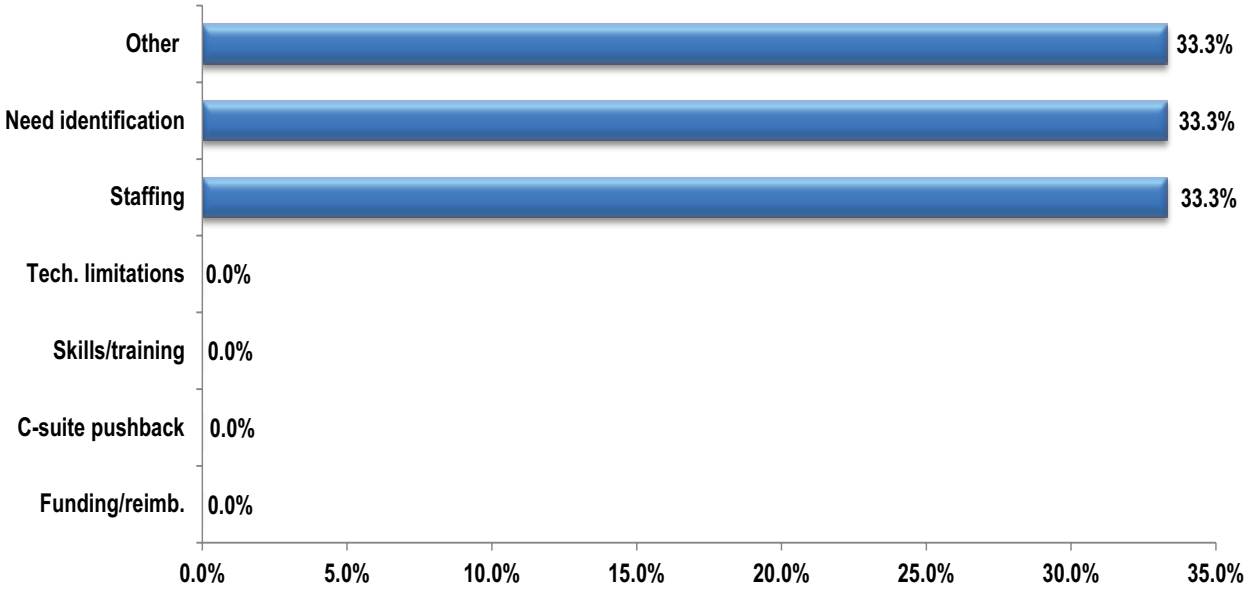
- ✓ Forty-three percent of respondents say the primary purpose of the home visit is post-discharge follow-up. Other reasons include home assessment and illness visits.
- ✓ Less than 10 percent of patients or health plan members receive home visits, according to 37 percent of respondents.
- ✓ Funding and/or reimbursement is the greatest challenge for home visits, say nearly 36 percent of respondents.
- ✓ Beyond the case/care manager, respondents say home health workers and nurse practitioners are responsible for the home visits.

75% of survey respondents conduct home visits for their population.

"Our most successful tool in our home visit program is using teachback to assure comprehension."

Figure 27: Health Plan - Greatest Challenge of Home Visits

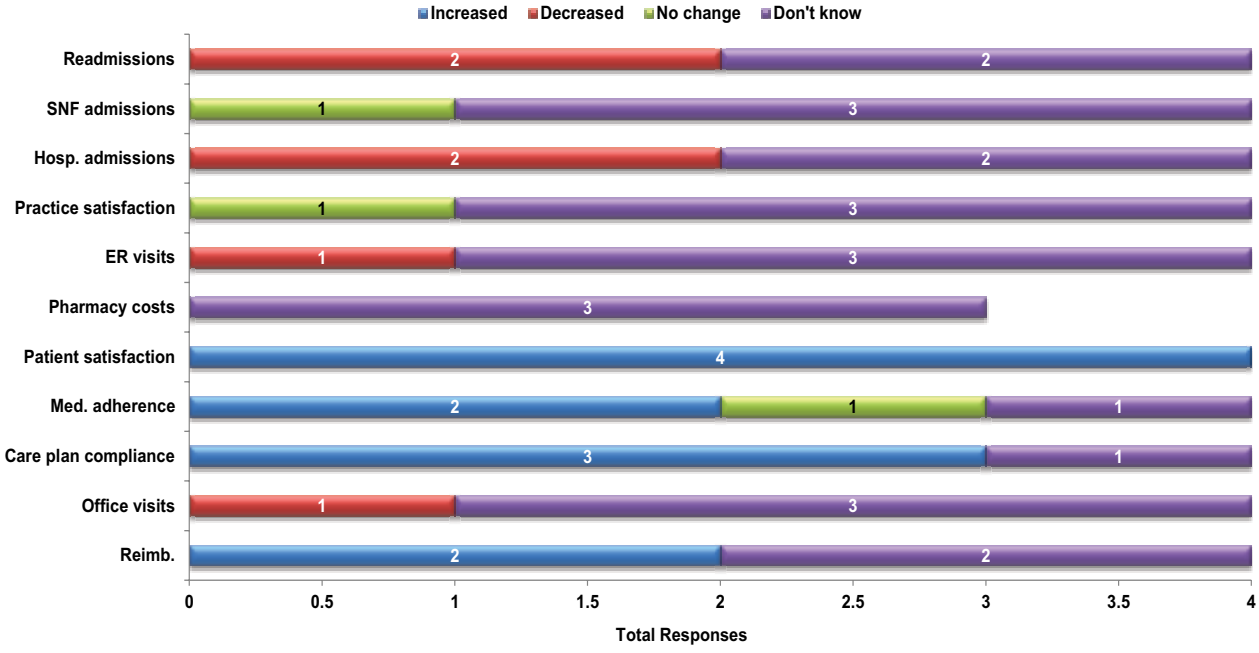
What is the greatest challenge of home visits in your population?



HIN Home Visits Survey
August, 2013

Figure 28: Health Plan - Impact of Home Visits

How have home visits impacted the following metrics?



HIN Home Visits Survey
August, 2013

New Horizons in Healthcare Home Visits

This special report is based on follow-up interviews with select respondents to the Healthcare Intelligence Network (HIN's) 2013 Home Visits survey conducted in August 2013. This report is aimed at CEOs, medical directors, wellness professionals, human resources professionals, disease management directors, managers and coordinators, health plan executives, care management nurses, business development executives and strategic planning directors.

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Lisa Collins, RN, CHPN, chief clinical and operations officer, Community Home Health Services, Indiana

Susan Raye Horton, DNP, APRN, CHFN, vice president of peri-operative services at Central Maine Medical Center and executive director of the Central Maine Heart and Vascular Institute, Lewiston, Maine

Deborah Lyons, MSN, RN, NE-BC, network disease management executive director, Community Health Network, Indiana.

Moderator

Melanie Matthews

HIN executive vice president and chief operating officer

Editor

Patricia Donovan

Cover Design

Jane Salmon

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New Horizons in Healthcare Home Visits

Three-quarters of healthcare organizations responding to HIN's 2013 inaugural survey on Home Visits are delivering care to patients at home. The majority of these visits — 43 percent — are done as post-discharge follow-up to try to keep medically complex patients from being readmitted to the hospital. Community Health Network's discovery that 43 percent of its heart failure readmissions were driven by patients discharged home alone to self-care has led it to risk-stratify all hospitalized patients and visit their high-risk population at home.

Community is one of many healthcare organizations visiting medically complex patients at high risk of readmission in their homes, leveraging existing expertise and in some cases partnering with home health to include the patient's home in the care continuum.

Community Health Network Leverages Home Health Expertise to Reduce Heart Failure Readmissions

HIN spoke with Deborah Lyons, MSN, RN, NE-BC, network disease management executive director of Indiana's Community Health Network, and Lisa Collins, RN, MSN, chief clinical and operations officer of Community Home Health Services, about their responses to HIN's 2013 survey on Home Visits. This is an edited version of that interview.

HIN: Tell us about Community Health Network's traditional home care program.

Lisa Collins: We have an average daily census in home care of about 800 patients. Registered nurses go in and do case management inside of the home along with physical therapy and occupational therapy. They start their assessment by doing a complete head-to-toe assessment, followed by a reconciliation of medication.

On the home care side, this is licensed home care under Medicare. We do see a vast array of patients with multiple diagnoses, most of them chronic, although we see some acute conditions. We take care of post-surgery patients, and usually have our patients on service for about 60 days.

HIN: During that 60-day time frame, how often are they visited at home?

Lisa Collins: That depends on the acuity of their need. The nurse could be there on a daily basis if a wound care patient needs daily care. They could be there on a weekly basis depending on the patient's needs. Each person has an individually prepared care plan tailored specifically to the physician's orders and their acute healthcare needs.

Home Visit Handbook:

Structure, Assessments and Protocols for Medically Complex Patients

This special report is based on a 2010 Healthcare Intelligence Network (HIN) webinar hosted by Melanie Matthews, HIN executive vice president and chief operating officer. This report is aimed at CEOs, medical directors, wellness professionals, human resources professionals, disease management directors, managers and coordinators, health plan executives, care management nurses, business development executives and strategic planning directors.

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Moderator

Melanie Matthews
HIN executive vice president and chief operating officer

Editor

Patricia Donovan

Contributing Editor

Jackie Lyons

Cover Design

Jane Salmon

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Home Visit Handbook:

Structure, Assessments and Protocols for Medically Complex Patients

While costly to conduct, home visits to patients with complex care needs can provide huge returns by identifying patient compliance barriers that are only apparent when seeing a patient in their home. Many patient-centered medical home (PCMH) initiatives are using home visits as part of a care transition program to reduce avoidable hospital readmissions and emergency room utilization.

Home Visits in the Patient-Centered Medical Home

Pam Aldridge is manager of care management at Durham Regional Hospital.

Skyrocketing healthcare costs and new measures to reform healthcare delivery have focused attention on reducing unnecessary care, such as readmission to the hospital for the same medical condition. Centers for Medicare and Medicaid Services (CMS) sponsored 15 clinical trials of care management to reduce utilization among beneficiaries with chronic illness. Fourteen of the trials failed to reduce inpatient utilization and one reduced hospitalization by .168 admissions per year per beneficiary. None of the original programs reduced or saved money.

Over the past decade, leaders of medicine have looked to outpatient care management programs to improve medical outcomes and decrease cost. Individuals with complex care needs often incur higher cost, frequently utilizing inpatient and emergency services. These individuals routinely experience fragmented and uncoordinated care, leading to excessive use of these higher cost services without adequately meeting their healthcare needs.

Previous care management programs used in this population have experienced limited success. There have been many grant-funded studies that have shown success in controlling cost of patients with chronic illness and improving their quality of life.

Most of us are aware of Dr. Eric Coleman from Colorado and his program model, known as the Care Transitions program. (See "For More Information.") This is similar to our Care Partners model.

Home Visits for Medicare High Utilizers

This special report is based on a 2011 Healthcare Intelligence Network (HIN) webinar hosted by Melanie Matthews, HIN executive vice president and chief operating officer. This report is aimed at CEOs, medical directors, wellness professionals, human resources professionals, disease management directors, managers and coordinators, health plan executives, care management nurses, business development executives and strategic planning directors.

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Susan Legacy, RN, senior manager of case management at Fallon Community Health Plan
Pat Zinkus, RN, director of case management at Fallon Community Health Plan.

Moderator

Melanie Matthews
HIN executive vice president and chief operating officer

Editor

Patricia Donovan

Cover Design

Jane Salmon

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Home Visits for Medicare High Utilizers

Key members of the Fallon Community Health Plan (FCHP) case management team describe how they identify Medicare Advantage (MA) members at risk of high utilization, the strategies they've implemented to reduce this utilization and the outcomes and cost savings achieved by FCHP. They provide key identifiers of frail elderly patients at high risk of preventable healthcare utilization; the critical components of the FCHP "Home Run Program" that keeps these patients in their home and improves their functional living status; the collaborative, risk-sharing model for the program that includes the health plan, Fallon Community Health Clinic and a local Visiting Nurse Association (VNA) that creates a multi-disciplinary team to meet the needs of the patient; and the program's impact on patient satisfaction, emergency room (ER) use, hospital and skilled nursing facility (SNF) admissions and readmissions and cost savings.

Identifying Functional Decline in Chronic Care Patients To Reduce Preventable Healthcare Utilization

Pat Zinkus, RN, is director of case management at FCHP, and Susan Legacy, RN, is senior manager of case management at FCHP.

The FCHP Home Run program targets the Medicare population at risk for high utilization of services such as preventable admissions and ER admissions.

Prior to its implementation in 2009, while facing the healthcare challenges of rising medical costs and the increase in the aging population with a targeted joint effort between FCHP and Fallon Clinic — a local multidisciplinary medical group in central Massachusetts — we identified the purpose of the program. The purpose is to provide care for the homebound in high utilizing MA patients at home, and to reduce the preventable hospital-SNF admissions, readmissions and ER visits.

We also identified another goal: to improve the functional status and quality of life of the frail MA members and referrals to appropriate levels of care including hospice, the Program of All-Inclusive Care for the Elderly (PACE) program and the Senior Care Options program. (See Figure 1.) (See "For More Information.")

The current information demonstrates that the frail senior members who do not

The Home Run Program Goals

- ✓ Improve the functional status and quality of life for frail, Medicare Advantage members
- ✓ Referral to appropriate level of care including:
  - Hospice
  - PACE
  - Senior Care Options program

Source: Pat Zinkus and Susan Legacy, Fallon Community Health Plan

Figure 1