

A Bridge to the Future

The Business Case for Homecare's Leading Role
in Chronic Care Management

The Center of Excellence for
Chronic Care Management[®]

A Division of 2020 Health Solutions[™]
Little Rock, Arkansas
www.2020HealthSolutions.com



2020 Health Solutions[™]
Clearly seeing the future of healthcare[™]

© August 2009
All Rights Reserved

TABLE OF CONTENTS

<i>Fred's Story</i>	3
Executive Summary.....	4
Healthcare and Homecare: Humanitarian Businesses.....	5
The Business Aspects of the Home-Based Chronic Care Model®	6
Taking the Plunge: How We Began to Implement The Model.....	7
Solid Business Results Courtesy of a New Model.....	9
Experiencing Model Benefits Today	12
Preparing for Model Benefits Tomorrow	14
Applying the Model Wherever It Is Needed.....	16
Summary.....	19

FRED'S STORY

Fred is a 71-year old patient with a history of heart problems and diabetes. After his most recent rehospitalization, Fred was placed on a telehealth monitor in his home. Three weeks later, the data from the monitor indicated an increasing weight trend. His homecare nurse contacted the primary care physician and Fred's medications were quickly adjusted. As a result, his weight issue was resolved and another rehospitalization was avoided. Imagine the clinical and financial impact across the nation if people like Fred had access to chronic care management services! This paper examines those possibilities....

EXECUTIVE SUMMARY

Providing care to patients with chronic disease is a mainstay in homecare's business model. However, as reimbursement methodologies nudge toward an outcome-based, value-driven modality, it is apparent that homecare agencies must elevate their practice in this key service to remain viable. The eventual inevitability of national healthcare reform will require agencies to reevaluate their business strategies to survive – and hopefully thrive – in the restructured system that ultimately emerges. In addition, the looming threat of reduced Medicare reimbursement for homecare services is a call to action for all homecare leaders.

In the midst of these uncertainties, there is an unprecedented opportunity for homecare to reposition itself for a pivotal role in the national healthcare system. By equipping clinicians with chronic care management skills, and by utilizing homecare's existing infrastructure, the industry can catapult itself into a new era of relevance. While the current system vainly attempts to manage long-term chronic conditions in short-term acute care settings, homecare can offer a quick and viable alternative: home and community-based chronic care management services. If the industry offered these services on a broad scale, it could become the catalyst for a transformed healthcare system.

Set against this opportunity is a sobering reality check. It is becoming increasingly clear that most healthcare services will return to the home in the 21st century; the unanswered question is whether or not the *present* homecare industry is prepared to capitalize on this once-in-a-lifetime convergence of favorable factors. Unfortunately, homecare's outstanding value proposition is not well understood by most healthcare stakeholders – even in some cases by homecare administrators! Much education is needed to inform these stakeholders of our proven ability to improve quality and lower costs while providing care where most patients prefer to receive it: in the comfort of their own homes.

We must acknowledge that the sheer volume of individuals with chronic disease, and the scope of services they will require, presents an unparalleled business opportunity. However, the willingness and ability of homecare agencies to seize this historic moment is not yet clear. Meanwhile, companies with no history of healthcare provision are entering the market to fight for a share of an ever-increasing space.



“If you share the same goals, you’re more likely to find a way – together – to reach them.”

In view of these realities, the time has come to carefully consider two possible outcomes going forward: the emergence of homecare's “golden age” as a central provider in a redefined healthcare system, or homecare's further marginalization and ultimate decline as other entities push forward to meet the increasing demand for home and community-based chronic care management services. We are at a crucial crossroads, and careful attention and thoughtful reflection is advisable by all homecare decision makers.

There are many compelling business reasons to declare an agency's core business is providing high-quality chronic care management services. Additionally, obtaining advanced chronic care management competencies for an agency's staff is a distinct, strategic business advantage. These commitments can be made with confidence that a solid business case rests beneath them. However, until we recognize both the opportunity and the threat we face as an industry, movement in this direction will not occur as quickly as it must for us to succeed in the long term.

While our past accomplishments should position us to provide these services, the industry does not have a comprehensive, standardized approach to chronic care management that collectively defines us as the best choice. As a result, most agencies are not adequately trained or equipped to argue persuasively and compete effectively for market share in their communities. The window of opportunity to address this handicap and situate ourselves for the future is slowly closing. We must act now to prepare for a future that will undoubtedly be very different from our past.



“The ever-changing “rules of the game” in healthcare are about to change as never before, and now is the time to reevaluate and prepare.”

HEALTHCARE AND HOMECARE: HUMANITARIAN BUSINESSES

In our homecare network, we are firmly committed to patient-centered, evidence-based care as the driving force in our clinical practice. In point of fact, *this IS our business!* We direct a multi-million dollar service-based healthcare business. We function daily in a highly competitive, tightly regulated and politically sensitive sector of the national economy. Failure to understand and operate our organization on sound business principles unique to our sector (healthcare) and sub-sector (homecare) would eventually result in the discontinuation of our services, the unemployment of our staff and a great loss to the communities we serve.

As a non-profit healthcare provider, we often encounter the misconception that we are not required to make a profit. *If we do not make a profit, we cannot continue to operate as a business.* This is a difficult reality currently faced by many of our colleagues – both for-profit and non-profit - who have negative margins and question their ability to continue as a homecare provider. In this section we will discuss the financial wisdom of implementing and applying The Home-Based Chronic Care Model™ (HBCCM) as a viable business strategy.

The real issue in regard to profit is what is done with it. Non-profit healthcare providers typically reinvest profits in staff development, equipment purchases, operational efficiencies, etc. This has certainly been the path we have followed in our organization. In contrast, for-profit providers decide how much of their profits to return to their owners/shareholders and how much to reinvest in staff and operations. *We simply maintain that the business aspects of healthcare should be deeply rooted in the humanitarian nature of our business and not the pursuit and generation of excessive profits.* Unfortunately, the entire homecare industry has been placed at risk for decreased reimbursement in the future because of the very high profit margins of a few.

The overall healthcare industry – in which homecare is a very small player - currently represents approximately one-seventh of the American economy as measured by annual expenditures. This fact alone is a clear indicator of failure. We spend more and get less – in terms of clinical outcomes and healthy citizens – than any other industrialized nation. In addition, healthcare has not been exempt from the greed and self-interest which has swept through many business sectors in recent years. The resulting loss of focus on our true purpose – to care for the sick and dying and promote health and wellness for all – is painfully clear to unbiased observers.

The time has come for some serious soul-searching in the healthcare community as we ponder an uncertain future. The most fundamental question we must ask ourselves is *why are we in this business?* The answer must come on two levels: as individuals, and as business entities. By honestly answering this question, we can refocus for the future. Providers who place patients – and not excessive profits – at the center of their business strategy will have the greatest opportunities to succeed as the 21st century healthcare system emerges. *The ever-changing “rules of the game” in healthcare are about to change as never before, and now is the time to reevaluate and prepare.*

THE BUSINESS ASPECTS OF THE HOME-BASED CHRONIC CARE MODEL™

A maxim for healthcare reform is *clinical excellence equals financial success*. Stated differently, *patient-centered and evidence-based care produces good business results*. This concept, however articulated, will clearly mark successful healthcare enterprises going forward. The early adopters of this premise will be the first to receive its rewards: immense personal and professional satisfaction in helping change lives, and solid financial performance enabling continuation and even expansion of services. The old notion that you cannot have clinical excellence and good financial results is no longer defensible, *and* will even become laughable as value-based healthcare eventually engulfs all provider types.

In our organization, we did not fully realize these outcomes until we developed and implemented the HBCCM. While this model is fundamentally clinical in nature, we did factor in business realities during research and development. Furthermore, there have been many business implications resulting from its deployment – some of which we expected and some we did not. However, the unanticipated outcomes have been quite positive and pleasant surprises. As we assessed the business climate for our organization several years ago, we identified the following realities:

- *Our patient population with at least one chronic disease was rapidly becoming the majority of those we served (and those we serve are the reason we exist as a business!)*
- *Pay-for-performance payment methodology loomed on the*

horizon, and the key to business success in that environment is clinical excellence validated by great outcomes

- *Fifty percent of our patients with chronic conditions were not receiving evidence-based care. In addition, our staff was not experienced in evidence-based practices and behavior change methods, and as a result they were often frustrated in their interactions with patients who had chronic disease. This led to two undesirable results: a negative impact on clinical outcomes, and staff satisfaction and retention challenges.*
- *The intermittent nature of traditional homecare meant we were often discharging patients who had chronic conditions with goals met, knowing full well they were poised for avoidable emergency department visits and rehospitalizations because we had not sufficiently impacted the self-management of their underlying chronic disease*
- *Hospice referrals were frequently directed to inpatient care with little understanding of hospice as a home-based benefit*
- *We were threatened by an out-of-state disease management company entering our market bidding to be the preferred provider for populations we serve*
- *We realized homecare is considered a minor player in the healthcare marketplace, and we must educate other stakeholders about our value while we simultaneously pursued new lines of business and developed new strategies for long-term sustainability*

These business factors significantly contributed to the creation of the HBCCM. It was constructed as both a comprehensive clinical care delivery model and a sound business model that ensured a positive return on investment. In short, the marriage of clinical and financial operations in our organization brought us new levels of success via the HBCCM.

TAKING THE PLUNGE: HOW WE BEGAN TO IMPLEMENT THE MODEL

In the real world of healthcare, clinical enthusiasm is often tempered by financial realities. However, we have found that through a mutual commitment by clinical and financial staff to the same objectives, the decision-making process is much easier and less fraught with tension. In other words, *if you share the same goals, you're more likely to find a way – together – to reach them.*

It is important to note that our five –member leadership team – composed of our administrator, two clinical and two business members – shared the commitment to clinical excellence as the only viable option for our future. In the context of that working framework, we sought to advance the vision within the parameters of our budget. We recount herein what we did, while recognizing the variables in every provider's circumstances are unique and that no “one size fits all” strategy will work.

In recognition of the rapid escalation of patients with chronic disease, our first step was the purchase of 30 telehealth units and hiring a telehealth program manager. We presented the clinical and financial reasons for this strategy to the senior leadership of our system and obtained their approval to proceed. Their support was crucial to the early stages of our efforts, and the eventual development of the HBCCM.

With the units and a manager in place, we began to deploy the devices to patients with exacerbations of chronic disease. As other homecare agencies have experienced, we initially encountered limited acceptance of these units by our staff, and little enthusiasm from our physician referral sources to order their use in the plan of care. An unflagging education and marketing effort ensued over the course of many months to help internal and external stakeholders understand the value proposition telehealth brought to patients and to our business.

As interest in the program gradually ramped up, the flow of data from the monitors increased. However, we were not expecting the results of all this new and readily available information! The data revealed several disturbing realities:



“As a business that provides services to improve the lives of our customers, we must measure our success both in terms of fulfilling our mission and in a solid financial performance.”

- *Many patients' chronic conditions were poorly controlled*
- *Multiple physicians were involved in each patient's care, complicating care coordination and medical decision-making*
- *Significant gaps were apparent in physician treatment orders - from the primary care physician to the specialist to the hospitalist – often resulting in patients not receiving evidence-based medical care*
- *Patients were experiencing avoidable rehospitalizations due to the confusion and lack of coordination in the healthcare system*

Even though we knew telehealth was an important step in the right direction for our agency, we were not experiencing the outcomes we had anticipated (e.g., decreased rehospitalization rates, lower utilization of emergent care, improvement in management of oral medications, etc.). It soon became painfully clear that just telehealth and traditional homecare visits were insufficient to properly manage our patients with chronic disease. That realization had both clinical and financial implications for our business model and we had to adjust accordingly.

Our next step was to identify the top three chronic conditions in our patient population: diabetes mellitus (DM), Heart Failure (HF) and chronic obstructive pulmonary disease (COPD). We then sought to hire clinical nurse specialists in each of these fields to bring their expertise to the table. As they came on board, they engaged in research to develop evidence-based practices suitable for the homecare environment. They also worked in an advisory and mentoring role with our nurse case managers as they struggled with complex chronic conditions.

As the nurse specialists were integrated into our daily operations, we realized a comprehensive care delivery model was still missing and desperately needed. As we previously related in Section II of our white paper, *Healthcare Promise™*, our search to find an existing model in the literature produced nothing suitable for our agency to employ. At that point, we decided construction of our own model to achieve the clinical outcomes we desired was our only option. *(Please see Healthcare Promise™ for more information about the research and development of the HBCCM. It is available at www.2020HealthSolutions.com).*



“If we can prepare our agencies to offer a truly valuable service that helps hospitals achieve their goals, we position ourselves for a bright and prosperous future.”

After the model was developed, we took the next step to develop a training and certification course for our staff (both nurses and therapists). We made a business decision that upon successful completion of the course and the exam – and integration of model principles into their daily practice – staff would receive a certification pay increase as a Home-Based Chronic Care Professional. We felt strongly that this financial commitment would produce a significant return on investment through improved outcomes that positioned us for financial success. The actual results, as the following section details, have exceeded our expectations.

SOLID BUSINESS RESULTS COURTESY OF A NEW MODEL

Busy people love to ask, “*What’s the bottom line?*” Perhaps the best way to answer that query is through three simple statements of fact from our experience:

1. *Our success as a business is obviously linked to our success in providing high-quality care in the home environment*
2. *Our success in providing high-quality care in the home environment is inextricably linked to our success in the management of chronic disease in our patient population (and we recognize this will be true for the rest of our careers)*
3. *Our success in providing high-quality care to patients with chronic disease in the home environment has resulted from the ongoing process of transformational change stimulated by the HBCCM as it impacts all areas of our organization.*

While it is difficult in some instances to quantify the influence of the HBCCM, there are business metrics that clearly confirm a positive impact. From our perspective, however, these measures are not more significant than the anecdotal evidence of lives literally changed through the application of this model. As a business that provides services to improve the lives of our customers, we must measure our success both in terms of fulfilling our mission *and* in a solid financial performance.

One of the most critical measures of success for a homecare agency is the reduction in their rehospitalization rate. In a pay-for-performance model, this rate will likely carry great weight in the overall reimbursement formula. The rationale for this methodology is clearly seen in several studies which have highlighted potential savings:

- *A recent Commonwealth Fund study (Jencks, 2009) found that 20% of discharged patients are readmitted within 30 days, and 34% are readmitted within 90 days. It concluded that Medicare spent \$17.4 billion on avoidable rehospitalizations in 2004.*
- *A Briggs study (2006) found that just a 3% reduction in rehospitalizations would save the Medicare program \$2.7 billion annually.*
- *A Veterans Health Administration study (Darkins, 2008)) examined efforts to coordinate chronic care through the use*



“Homecare clearly has an incredible value proposition for patients who much prefer our services in the first place.”

of telehealth and certified chronic care managers. It reported a 25% reduction in bed days of care, a 19% reduction in hospital admissions and a tremendous cost savings compared to other care options.

For patients in our chronic care program, we have witnessed a decline in our rehospitalization rate as we have tracked it over time. Our latest calculation reveals a decrease from 29% to 17%. We have also become more proactive in the identification of underlying chronic disease diagnoses when homecare is ordered for other reasons. We have found this effort at the time of admission helps identify patients at greater risk of rehospitalization and allows us to adjust care planning accordingly. As part of the model’s design, we have also incorporated several risk assessments (e.g., fall risk, rehospitalization risk, depression risk, etc.) that further identify patients likely to exacerbate and return to the hospital.

We have experienced an overall decrease of 41% in our rehospitalization rate with the application of our chronic care model. Utilizing data from the Medicare Payment Advisory Commission (MedPAC) report to Congress, “*Reforming the Delivery System*” (June 2008), a 3% decrease in preventable 30-day readmissions for patients with heart failure and COPD would net a total savings of \$43,673,763 per year. Thus, it seems reasonable to expect that the application of our model on a broad scale (in terms of more chronic conditions than heart

failure and COPD, and in terms of widespread implementation) would produce at least a modest decrease in costs. However, even a modest decrease in hospitalizations – which are the most expensive healthcare encounter - can have a tremendous impact on overall healthcare expenditures.

In our experience, the HBCCM has profoundly impacted all aspects of our clinical operations. As a result, we have observed several positive impacts on our business:

- *Case conferences are now devoted to the early identification, patient-centered discussion and cross-disciplinary collaboration for care of our patients with chronic disease. They also serve as an ongoing classroom to educate our staff in best practices and reinforce tenets of the HBCCM. In the process, they support staff behavior change while continually supporting patient behavior change.*
- *Patients who previously would have been discharged for “non-compliance” are increasingly being recertified when they have a skilled need for management of chronic conditions.*
- *Staff engagement and development is a high priority, and is producing dividends in their level of practice and overall satisfaction – which positively impacts our bottom line.*
- *Patients identified in the Outcome and Assessment Information Set (OASIS) assessment as having life expectancies of six months or less are evaluated for end-of-life discussions much earlier than before, and offered the option to transfer to hospice as the most appropriate level of care (if that is consistent with patient goals).*

From a business perspective, these clinical initiatives are positioning our agency for success in a pay-for-performance environment that is imminent in the homecare industry (perhaps as early as 2010). They are also preparing us for the introduction of the OASIS Version C, which is due for implementation in January 2010. In both instances, our ability to accurately identify, portray and serve patients with chronic conditions will be crucial to receive appropriate reimbursement.

One of the unexpected impacts of the HBCCM has been a dramatic reduction in the registered nurse staff turnover rate: from 20% to 6%. The business costs associated with recruitment, training and retention of nurses is well-known; obviously these costs have decreased significantly in our agency. We typically



“We cannot afford to abdicate an innovative leadership role at this crucial time!”

have many applicants when a position is available, and that allows us to recruit and hire “the best of the best” who desire to use the model in their practice. We should also note that staff performance evaluations are based on outcomes and their implementation of the HBCCM.

Our average daily home health census has increased approximately 65% since we implemented the HBCCM. We receive referrals from competing hospitals requesting that their patients be placed in our chronic care program. We also receive referrals from competing home health agencies that prefer we care for the more complex patients with chronic conditions. It is not unusual for a physician to call days or weeks in advance to “reserve a spot” for his or her patient. The increase in referrals and daily census reflects the enhanced reputation the HBCCM has created for us in the communities we serve. This obviously has a very positive impact on our financial performance.

Another unexpected benefit of the HBCCM has been observed in our hospice program. Both physicians and patients or family members have often raised objections to a meaningful discussion of the hospice benefit in the past. It has frequently been equated with “giving up” and that perception suppresses the exploration of the true value of hospice. However, in the context of the HBCCM, we have found that it is a very natural “next step” in the management of chronic conditions. Through the trust established in the program in home health, it is easy to say when



“Providers who act now to prepare for the future will be in the best position to prosper in the new environment.”

the time comes, “We need to talk about the next level of care that will be the most appropriate for you.” As we then discuss the *patient’s* goals as they near the end of life, we rarely find someone who says, “I want to be hospitalized as much as possible.” Instead, most want to experience the greatest quality of life their condition permits at home with family and friends.

It is no secret terminal patients consume vast and expensive healthcare resources as they near the end of life. Incredibly, much of that cost is driven by inpatient care which is not even aligned with the patient’s goals in many cases! According to a Dartmouth Atlas study (Wennberg, 2008), Medicare spends 27% of its budget on patients at the end of life. The study also found the average inpatient cost for the final two years is \$29,495 while the average home health cost is \$2,633 and the average hospice cost is \$2,091.

Homecare clearly has an incredible value proposition for patients who much prefer our services in the first place. This preference, coupled with fantastic savings to the healthcare system, creates a solid business case for homecare’s role in end of life care – through both home health and hospice programs. In our

organization, patients identified through OASIS as having a six-month or less life expectancy receive a non-billable palliative care visit (with patient permission) to discuss patient goals and the most appropriate level of care. We approach this discussion as a normal part of discharge planning for home health patients. As a result, we have seen an increase in patients who desire to transfer from home health and elect the hospice benefit.

This scenario is a win-win-win-win situation for the patient, home health, hospice and the healthcare system: the patient enters the hospice program much earlier (when it can have the greatest impact as their disease trajectory brings them to the end of life); the hospice benefits from more referrals and an increased average length of stay; and, the healthcare system has an overall reduction in costs as these patients access expensive inpatient acute care much less.

The impact of the HBCCM has not been limited to the clinical aspects of our business. It has also dramatically altered our marketing and business development efforts. We have eliminated all advertising and traditional marketing expense since the demand for our services is so great. Instead of a traditional marketing visit to a referral source, we are emphasizing patient-specific, clinician-to-clinician visits to discuss care coordination and outcomes. We are focusing solely on patient care issues. We find most physicians and their staff appreciate and welcome these types of interactions and much prefer them to the typical marketing encounter.

While it is impossible at this time to quantify the potential impact on our business of the doors which have opened before us, we can at least report that it is a wonderful position to occupy during uncertain economic times. In addition, it is equally as exciting to consider the prospect that our colleagues can replicate our success in their communities. We believe homecare agencies, hospice agencies, physician practices and hospital systems can restructure as we have done to reap the rewards of high-quality care to patients with chronic conditions. As they do, the opportunities for collaboration and care coordination across the healthcare continuum will quickly multiply. The cascade of benefits - both clinically and financially - to all stakeholders as this culture is established in healthcare is mind-boggling.

EXPERIENCING MODEL BENEFITS TODAY

There are ample indicators today that homecare (and healthcare) will transition from a service-based reimbursement methodology to an outcome-based, or value-based, payment system. The time to prepare for this historic shift is *now!* Providers who act now to prepare for the future will be in the best position to prosper in the new environment. Those who wait will find themselves in a difficult position of catching up to the early adopters who will reap the initial rewards of this change. This is a classic case of the “purple cow!” (Godin, 2002)

While the clinical desire to implement the HBCCM may be strong, the business hesitation is perhaps best captured in a fair and practical question: “*Can we afford to implement this model now when there is no funding to support it?*” As you consider your response, it may be wise to reframe the question: “*Can we afford NOT to begin implementation now if we plan on being in business five years from now?*” We believe the answer to the first question is clearly “*Yes!*” and the answer to the reframed question is obviously “*No!*” Let us explain our rationale for these answers:

- *Pay-for-performance (P4P) is likely coming to homecare in 2010. If your agency is like ours, the majority of your patients have at least one chronic disease, and your success in a P4P environment will be very dependent on how well you manage these patients to achieve positive outcomes.*
- *Healthcare reform is the hot topic of debate as of this writing. It remains to be seen if comprehensive reform legislation will pass this year, but some attempt by Congress to address the healthcare crisis seems likely. However, even in the absence of legislation it appears certain that regulatory initiatives will continue to advance us toward a value-based system that ties outcomes to reimbursement. In that environment, homecare agencies MUST plan for a future in which they effectively manage patients with chronic disease in order to remain financially viable.*
- *Upon completion of the HBCCM, we began to implement it in phases. Two factors favored a phased-in approach: funding and training. Our funding came from existing operations and accrued over time. Training our staff - much like OASIS training - was a gradual process that occurred by pulling small groups out of the field to become certified in the principles of the model.*

We took “a leap of faith” to implement a new and untested model out of sheer conviction that we had no other choice if we were to continue the pursuit of clinical excellence and financial sustainability. The results we have witnessed as the result of that commitment speak for themselves. However, in the final analysis, implementation of the HBCCM is an individual business decision that must be made by each homecare agency considering it as an option. For those who wish to pursue a phased approach as we did, we offer the following 7-step action plan that will produce the maximum return with the minimum initial investment:

1. EMPHASIZE INNOVATIVE LEADERSHIP

Successful implementation of the HBCCM hinges on leadership understanding and supporting the commitment required to retool your agency. These include, but are certainly not limited to: changing agency culture, reevaluating all processes, closely examining clinical practice patterns and boldly pursuing new lines of business. Without buy-in at all levels of leadership, full implementation will be difficult to achieve and the results will be less than desired. Your agency can gain the benefit of our “lessons learned” and likely shorten the process.

2. SUPPORT ADDITIONAL CLINICAL STAFF TRAINING

Training and certification is available for clinicians in the HBCCM that will immediately equip them to implement the principles of effective chronic care management. Ideally, training should be offered to all clinicians on staff. Practically, it may be best to train a few who then become “champions” for the model and then train other staff (much like the model that has been successfully used in advanced OASIS training).

3. RESTRUCTURE CASE CONFERENCES

With an understanding of the HBCCM, case conferences can be refocused to achieve a maximum return on investment for the time spent. We have found that applying the model to patients with chronic disease improves outcomes, increases patient and staff satisfaction and helps target the clinical areas that have the greatest financial impact. It also supports staff behavior change and agency culture change on a regular basis.

4. UTILIZE TELEHEALTH

If you already own telehealth units, reevaluate their use in light of the HBCCM. They can and should be powerful tools at the disposal of properly trained clinicians who combine model principles with the data provided by the units. If you don't own any units, consider purchasing or leasing a small number to begin a program. When evaluated as part of the total delivery package envisioned in the HBCCM, the return on investment is much easier to justify, AND staff buy-in becomes much easier to obtain. Physician enthusiasm is also greater when patient data can be summarized to give a snapshot of the patient's progress between office visits.

5. REDESIGN YOUR MARKETING PROGRAM

With the previous components in place within your agency – even on a limited scale – you possess powerful new marketing tools. However, if you truly want to position your agency for the future, don't succumb to the temptation to market in the traditional manner. Instead, use your new focus on chronic care management to build genuine professional partnerships with physicians, hospital case coordinators and other referral sources. Transform marketing into discussions about the patients referred to you, and how they are doing in your chronic care program – the money you save with this change alone could fund some of the previous components!

6. WORK WITH YOUR SOFTWARE VENDOR

For long-term success, the HBCCM must be embedded in the software your clinicians use at the point of care. Begin discussions with your vendor about what you will need to move in this direction and how they can support it with changes to their software package. Educate them about the potential this has to revolutionize the homecare industry, and how they should be in full support of an initiative that will ensure the financial stability of their customer base. *(NOTE: If you do not currently use point-of-care software, you can still embed model concepts in the processes and tools you do have.)*



“We must act now to prepare for a future that will undoubtedly be very different from our past.”

7. EDUCATE KEY STAKEHOLDERS

It will cost you nothing but your time, and there can be no better investment at this point than educating key stakeholders about homecare's role in chronic care management. It will be easier than you think to get appointments with hospital leaders, physicians, legislators, policymakers, public and private payers, etc. *They are looking for solutions, and we have one for them!* Identify what your agency can do for them, and build your presentation on that basis. Explain homecare's role as the preferred provider of chronic care management services. As you watch the model come to life in your agency, you will become an ambassador touting the benefits of successful chronic disease management in the home setting to everyone who will listen!

Implementing the HBCCM was a unique process for us, and it will be a unique process for each agency that chooses to implement it. Please carefully note that this is a **process!** *Implementation of a major change occurs as a process and not as an event.* The preceding action plan is a suggested way to begin the process in incremental, inexpensive steps. The Center of Excellence for Chronic Care Management® has developed the training mentioned, and is developing additional options as time and resources permit. Our goal is to be a resource center for *any* healthcare provider desiring to pursue excellence in chronic care management. Please contact us for more information by visiting our website at www.2020HealthSolutions.com.

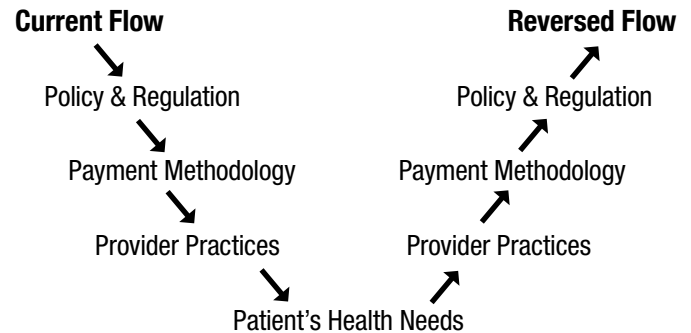
PREPARING FOR MODEL BENEFITS TOMORROW

Dr. Edward Wagner, in his pioneering work on the Chronic Care Model (upon which the HBCCM is based), indicated there were two key components for long-term sustainability of his model: innovative leadership and favorable financing. Many defer innovative leadership to others and consider favorable financing as the tipping point when they will move in this direction. We believe these two components are linked: innovative leadership will eventually produce favorable financing. We presently find ourselves in the gap between innovation and the reimbursement to support and sustain it. However, financing will become favorable if we demonstrate value.

If homecare is to survive – and hopefully thrive – in the new world of healthcare that is coming soon, we must stake our claim *NOW* as innovative leaders committed first and foremost to patient-centered care. It is time to advocate for the patient and what is most appropriate to meet their needs. Three things are critical: (1) Build partnerships with other like-minded providers; (2) Support reimbursement for chronic care management; and, (3) Advocate for new policy and legislation that enables these objectives. *We cannot afford to abdicate an innovative leadership role at this crucial time!*

As we noted in *Healthcare Promise™* – our previously published white paper – the time has come to reverse the traditional flow in healthcare. Recent healthcare history is a story of reimbursement policy dictating practice patterns, which has greatly contributed to the current crisis. The graphic following depicts our present reality and what we should strive for in 21st century healthcare: implementing a sound, proven and comprehensive care delivery model such as the HBCCM is the first step in fulfilling both of Dr. Wagner’s requirements. It demonstrates innovation by leadership to move boldly into the future, and it positions the agency for the day when reimbursement finally becomes available to support chronic disease management in the home. If we do not demonstrate innovative leadership at this time, we should not be surprised when financing is less than favorable because it will be defined by others who do not understand what we bring to the table.

Redirecting the Flow of Healthcare



As reimbursement shifts from volume to value, homecare will be positioned to capitalize on a history of bringing great value to the healthcare system. Our outcomes have been publicly reported for a decade, and the services we provide indisputably save money. For example, the recently released Avalere study (Avalere, 2009) confirmed that homecare was responsible for a \$1.7 billion reduction in Medicare post-hospital spending, and could realize an additional \$31.1 billion savings over the next ten years.

If we have a shortcoming, it is our own failure to adequately educate stakeholders about the nature and quality of our services and the cost-effectiveness of what we do every day. *We must correct this weakness if we are to take advantage of the realignment in healthcare that appears inevitable.* By taking chronic care management to the next level, we have a priceless opportunity to make up for lost time and gain a vital foothold in a redefined healthcare system. Implementing a consistent, systematic approach to chronic disease management offers the best argument for homecare’s central role in reducing healthcare expenditures and increasing quality by successfully managing active chronic conditions in the home environment.

By targeting patients with multiple chronic diseases – those we typically serve in our agencies today – we can quickly demonstrate our value AND show a substantial return on investment. *If we do this*, we could reasonably expect some or all of the following changes, which would rewrite the business rules for agencies nationwide:

- *Payment for long-term chronic care management beyond today's episodic system*
- *Payment for the purchase or lease of in-home technology and data monitoring*
- *Removal of the current "homebound" status requirement*
- *Favorable positioning if bundled payment methodologies materialize*
- *Participation in risk-shared demonstration/pilot projects to showcase our value*
- *Relaxation of regulatory requirements that would promote partnerships with non-homecare providers*

It is quite possible to envision the day when a homecare patient with at least one chronic disease diagnosis qualifies for a new long-term chronic care benefit in the Medicare program. Some patients would enter upon discharge from the traditional home health episode, while others could qualify and enroll simply because of their condition. The business impact on homecare agencies would be unprecedented if these changes were enacted into law; they would clearly be a "game-changer" for our industry.

Preparations for this day must begin now to be ready when it arrives. Clinical staff – both nurses and therapists – should be trained in the tenets of the HBCCM and learn how to work effectively with patients who have chronic disease. Incorporation of telehealth – and nurse monitoring of the data to quickly intervene to avoid unnecessary emergency department (ED) visits and/or rehospitalizations – should already be underway or planned in the near future. *(Keep in mind that above average outcomes will be essential in a P4P system, and it is likely that reduced ED visits and rehospitalization rates will be heavily*

weighted in a P4P model.) Building informal partnerships with willing physicians for patient goal attainment should also be a top priority.

While we cannot be certain at this point how healthcare reform will reshape our landscape, we can be certain that tens of millions of Americans already have a chronic disease and millions more will develop one in coming years. We can also be certain that an acute care system cannot adequately care for them going forward. Thus, perhaps the greatest business opportunity in the history of healthcare is at hand – one that is homecare's for the taking. If we do not seize it, be assured someone else will.



“Homecare can and should be the heart and soul of a transformed national healthcare system.”

APPLYING THE MODEL WHEREVER IT IS NEEDED

The HBCCM was developed specifically for chronic care management in the home by the staff of a home health agency. The principles espoused in the model, however, are universally applicable and the model itself is quite flexible and adaptable in a wide range of settings. The need for chronic care management services exists beyond homecare's traditional boundaries. However, by implementing the model in a traditional home health environment, homecare agencies position themselves for applications of the model wherever it is needed. In the process, they can create new business partnerships, alliances and opportunities. Consider the following three possibilities in this regard:

1. FORMAL PHYSICIAN PARTNERSHIPS

Homecare agencies have had "partnerships" with physicians for decades. The nature of these partnerships is quite varied, covering the gamut from close collaboration to just signing home health orders. The fact remains, however, that many physicians are completely unaware of the complex care we provide to patients at home and have no valid reference points or first-hand experiences with homecare. We have a huge challenge to educate many doctors about homecare's value.

Meanwhile, physician reimbursement is likely to change to a pay-for-performance methodology in the near future. Some are suggesting bundling payments for care with physician payments – which would include homecare payments. In addition, The Patient Centered Medical Home (PCMH) is gaining momentum as a new care delivery model. (*Sadly, physician practices are often turning to disease management companies for assistance to participate in the PCMH instead of reaching out to homecare agencies.*) Whatever the outcome, it will be wise and even necessary for homecare agencies to formally partner with physicians in the future. We have much to offer them in caring for their patients with chronic conditions. The question is: *are we ready to make that offer?*

As one illustration of this opportunity, consider some of the components of the PCMH which homecare agencies are ideally suited to provide in a formal partnership with a physician clinic:

- *Since most physician groups are not equipped to effectively manage chronically ill patients, homecare can be the extension of the physician practice, providing the varied disciplines, patient education and in-home visits*
- *Since homecare agencies already have Quality Improvement (QI) processes in place, they could use their expertise to assist physician practices in developing QI programs if regulations are revised to permit this type of support*
- *Physicians' staff need training in chronic care methods and identification of patients who would benefit from the homecare chronic care program*
- *Homecare agencies could assist in physician Electronic Medical Record (EMR) development for data integration and registry design for chronic disease patients*
- *Remind and encourage patients to keep their physician appointments*
- *Provide a summary of patient-specific data that enables the appointment to be focused and productive (PLEASE NOTE: We recognize that current Stark regulations would need to change for some of the above services to materialize. However, nothing prevents us from building strong physician relationships through ongoing communication about their patients we have on service.)*

The time has come to approach our patients' physicians and offer our value-added services to them. As their reimbursement becomes dependent on quality outcomes, we will find receptive ears *if we can demonstrate our ability to contribute to that goal.* Thus, implementation of the HBCCM provides a solid basis on which to offer your agency as a physician partner. If bundling of post acute payments becomes a reality, this may become a necessity rather than an option. Either way, it's time now to prepare for the future.

2. HOSPITAL PARTNERSHIPS

Acute hospitalizations often indicate the need for care, and homecare is a cost-effective solution. As a result, many homecare referrals originate from hospital discharges. Homecare agencies are therefore dependent on good working relationships with hospital discharge planners for much of their business. However, that is not the same as a formal partnership with a hospital to help them achieve *their* goals as a healthcare provider and business entity. As with physicians, this will require homecare leaders to think differently in order to see the opportunities at hand (within regulatory restraints).

Hospitals are sensitive today to lengths of stay and readmissions for which they receive no additional reimbursement. In many instances, patients with chronic disease are the ones who fall outside the usual parameters and become money-losers for the hospital. If a homecare agency has a fully developed chronic care program, it can offer a value-added service to the hospital to decrease lengths of stay and prevent potentially unreimbursed rehospitalizations.

In the MedPAC “*Report to the Congress: Reforming the Delivery System*” (September, 2008), preventable Medicare readmissions to hospitals within a 30-day period post discharge results in a \$12 billion annual expenditure. This obviously represents a significant opportunity for cost reduction by Medicare. Specifically, MedPAC recommends reducing payments to hospitals with relatively high readmission rates for selected conditions such as heart failure. These disincentives should encourage provider partnerships to make a sizable dent in avoidable rehospitalizations.

While the homecare industry has the *infrastructure* in place that could be tapped for support in reducing unnecessary hospitalizations, most agencies have not equipped their staff with chronic care management competencies and training. Thus, their potential value as a partner in rehospitalization reduction is diminished in comparison to competing agencies who have equipped their staff, and non-homecare companies that will be vying for this business. If “a word to the wise is sufficient,” then the time to invest in staff training is *now*.

As healthcare reform proposals swirl about the nation’s Capitol, it appears quite possible that hospitals will receive bundled payments to cover all patient care post-discharge. If this proposal is enacted into law, numerous provider types (including homecare) will be required to contract with hospitals for their services and payment. If such an environment materializes, hospitals will seek partnerships with homecare agencies which can help them meet *their* goals and financial targets. Since patients with chronic disease are the primary drivers of healthcare costs, hospitals must find a way to effectively manage these patients to lower costs and increase their margins. *Who would be better equipped than a homecare agency with a staff trained and certified in chronic care management to be the hospital’s partner?*

Consider these examples of what homecare can offer hospitals going forward:

- *Hospitals may eventually be denied payment - or receive reduced payment - for rehospitalizations of certain diagnoses. Homecare agencies can play a major role coordinating transitional care with hospitals and physicians to reduce these events.*
- *Homecare agencies can work with hospital systems in developing transitional care processes, including improved referral information needed by homecare agencies for OASIS assessment, medication reconciliation upon discharge, etc.*
- *Heart Failure patients are one of the most frequent and expensive readmissions for hospitals. Homecare agencies could contract with hospitals to admit these patients into a chronic care program to reduce rehospitalizations and decrease lengths of stay for these patients.*
- *Homecare staff should educate hospitalists and hospital case coordinators/discharge planners about the services provided in the home – particularly a chronic care management program if you have one. Help them realize how chronic disease management reduces the hospital’s average length of stay for many patients and prevents costly readmissions.*

Homecare has unfortunately been an afterthought to most hospital-based physicians, clinicians and administrators. For case coordinators and discharge planners, post acute facility care is often the solution to “get the patient out of the hospital ASAP.” The likelihood of bundled payments for post acute services suggests hospitals should seek and arrange the most effective, least expensive post acute level of care – home health and hospice! We have much work to do to change these mindsets. However, if we can prepare our agencies to offer a truly valuable service that helps hospitals achieve *their* goals, we position ourselves for a bright and prosperous future.

3. NEW MARKETS AND LINES OF BUSINESS

Implementing the HBCCM clearly enhances the value a homecare agency brings to the marketplace. It also creates a new environment in which expansion to new markets and lines of business is not only possible, but probable. Many Americans with chronic conditions do not qualify for home health services, but desperately need assistance in managing their disease(s) effectively. With a trained and certified staff in chronic care management, homecare agencies can step outside their historic boundaries and offer programs to a much broader range of potential clients.

Opportunities in this regard are limited only by our imagination and willingness to try something new. We offer the following suggestions to jump-start the creative process:

- *Seek formal partnerships with other providers (physicians, hospitals, etc.) who have, or will soon have, a vested interest in improving the outcomes of patients with chronic disease by offering specialty programs at their point of felt need (e.g., working with patients with Heart Failure to prevent exacerbations and readmissions)*
- *Inquire if a physician group in your area is interested in the PCMH concept, and if so, inform them about the services you can readily provide to help them meet the requirements to participate*
- *Approach self-insured employers who face rapidly rising healthcare costs (often driven by their employees struggling with chronic conditions) and offer a program to assist them*
- *Make proposals to your state Medicaid program of how you can decrease their costs and improve outcomes of their enrollees with chronic conditions, especially by targeting specific populations (e.g., diabetics, pediatric asthmatics, etc.)*
- *Consider partnering with schools and educational institutions to help manage their students with chronic diseases*
- *Offer your expertise in chronic care management to schools of nursing and/or medical schools to train their staff and/or students in the principles of disease self-management, collaborative goal-setting and behavior change theory*

- *Contact health insurance payers and demonstrate how you could work with their subscribers to effectively manage chronic disease and thereby lower their costs (and take advantage of the appointment to educate them on the wisdom of reimbursing for the technology to support chronic care management)*
- *Seek grant funding for demonstration projects with other partners to validate your value*

These are just a few ideas to illustrate the virtually unlimited potential for new business that a formalized chronic care program can bring to your agency. By investing in staff to become trained and certified in the principles of home-based chronic care management and embedding those concepts throughout the organization, the foundation for future growth is made strong and secure.

Beyond chronic care management, homecare agencies could ultimately offer services to those at risk for chronic disease and those who are currently healthy. As we described in *Healthcare Promise™*, assisting individuals manage their chronic disease is just the first phase of a comprehensive plan to redesign our healthcare system. Clearly, homecare agencies should have a very active role in the first phase of this plan. As the return on investment is realized and funding becomes available for subsequent phases, we would envision homecare agencies continuing to play a leading role. With our expertise in chronic care management well established, we would be ideally positioned to work with individuals at risk for developing chronic diseases and focus on prevention. With that experience, we could ultimately partner with healthy individuals in our communities (at home, workplace, schools, etc.) to support and encourage ongoing wellness through wise choices and healthy behaviors.

Home and community-based chronic care management is the logical place for us to begin the transformation of our healthcare system so it is patient-centered, high-quality, fiscally sustainable and universally accessible. Homecare agencies must step up to the proverbial plate and begin now to prepare for a vital role. The road will not be easy or quickly traveled, but the rewards that await those committed to the journey will be well worth the sacrifices and commitment. We invite you to join us!

SUMMARY

Homecare can and should be the heart and soul of a transformed national healthcare system. A convergence of factors – unsustainable economic realities, the sheer volume of the baby boom generation, previously unimaginable technologies for healthcare in the home (just to name a few) – offer an unparalleled opportunity to the homecare industry. *By the second decade of the 21st century, most healthcare will be provided in the home; the unanswered question is whether the current homecare industry will be the primary provider of home-based care or if that business will be taken by others.*

A window of business opportunity is currently open to the homecare industry that has never existed before, and may not return again during our careers. We should obviously pursue clinical excellence as an end in itself, but business concerns realistically balance the equation. With that being said, the business case to elevate chronic care management to a central role in every homecare agency is compelling. Homecare can transition into a new and expanded role in the American healthcare system if we seize the opportunity before us to retool our industry and prepare for the future.



“Patient-centered and evidence-based care produces good business results.”

AUTHORS

Greg Harrison, B.Min, Business Development Manager,
BAPTIST HEALTH Home Health Network and 2020 Health
Solutions

Martha Fagan, MBA, CPA, Director of Business Operations,
BAPTIST HEALTH Home Health Network and 2020 Health
Solutions

Beth Hennessey, RN, MSN, Administrator, BAPTIST
HEALTH Home Health Network and 2020 Health Solutions

Paula Suter, RN, MA, Director of the Center of Excellence for
Chronic Care Management, 2020 Health Solutions

Barbara Norman, RN, BSN, Director of BAPTIST HEALTH
Home Health – Little Rock, Arkansas.

REFERENCES

Avalere Health LLC. (2009, May). *Medicare spending and rehospitalizations for chronically ill Medicare beneficiaries: Home health use compared to other care settings*. Retrieved June 30, 2009, from: <http://www.avalerehealth.net/research/ereport.php?rid=1021>

Briggs Corporation. (2006). *Briggs national quality improvement/hospitalization reduction study*. West Des Moines, IA.

Darkins, A. et al. (2008). Care Coordination/Home Telehealth. *Telemedicine and e-Health*. 14(4), 1118-1126.

Godin, S. (2002). *Purple Cow*. New York: Portfolio.

Jencks, S.F., Williams, M.V., Coleman, E.A. (2009). Rehospitalizations among patients in the medicare fee-for-service program. *New England Journal of Medicine* 360(14), 1411-1428.

Wennberg, J.E., Fisher, E.S., Goodman, D.C., Skinner, J.S. (2008). Tracking the care of patients with severe chronic illness. *The Dartmouth Atlas of Health Care* 2008, 129.