Care Transition Coaching: A New, Community-Based Home Health Program Proposed by the Alliance for Home Health Quality and Innovation

INTRODUCTION

A growing body of independent clinical and health services research documents that the transitions from hospital discharge to post-acute care settings or the community can be a time of particular vulnerability for patients who rely on Medicare. Poorly coordinated care transitions have also been shown to be costly, especially for patients who are readmitted to the hospital because of discontinuities in their care or exacerbations of their health conditions. The research literature includes studies that estimate the costs of emergency department visits and re-hospitalizations around unmanaged care transitions.[i] The conclusions of these studies are that many of these re-hospitalizations are unnecessary and result in unnecessary expenditures for the Medicare system. This is a critical issue at a time when the nation is seeking new ways to control costs.

The Alliance for Home Health Quality and Innovation (the Alliance) **proposes a pilot program** that includes home health providers as well as other community-based organizations designed specifically to manage patient care transitions. The program would be **called the Home Health and Community Based Care Transitions Coaching Program.** Services would be delivered by specially trained clinicians known as **Care Transition Professionals** (Professionals.) These clinicians could be home health nurses, therapists or other qualified community professionals that would **educate and coach Medicare patients as they are discharged** from hospitals to post-acute care environments or the community. The services provided through coaching and educating patients and their family caregivers about navigating the healthcare system could improve patient outcomes, reduce hospitalizations and readmissions, and control costs.

This concept paper establishes that home health should be an integral part of any community-based care transition program. The home health provider community is well positioned to lead the initiative for two important reasons. Home health already has the infrastructure in place to facilitate the program. Similarly, the home health community already provides Medicare beneficiaries with a breadth of clinically sophisticated, cost-effective and patient-preferred services.

The paper also offers recommendations for both home healthcare providers and government policymakers to enable and support the implementation of the Home Health and Community Based Care Transitions Coaching Program.

As the home health community develops and begins a pilot of the proposed Coaching Program, the federal government can and should play an integral, collaborative role. Specifically, the U. S. Centers for Medicare & Medicaid Services (CMS) can take a number of initial steps to support improved care transitions. The paper contains recommendations that would complement existing government activities, such as the CMS Independence at Home demonstration scheduled to begin in 2012, and help ensure a more receptive environment for effective care transitions within the Medicare program.

Transitional Care and the National Focus

The American Geriatrics Society offers the following definition for "transitional care:"[ii]

"For the purpose of this position statement, transitional care is defined as a set of actions designed to ensure the coordination and continuity of health care as patients transfer between different locations or different levels of care within the same location. Representative locations include (but are not limited to) hospitals, sub-acute and post-acute nursing facilities, the patient's home, primary and specialty care offices, and long-term care facilities. Transitional care is based on a comprehensive plan of care and the availability of health care practitioners who are well-trained in chronic care and have current information about the patient's goals, preferences, and clinical status. It includes logistical arrangements, education of the patient and family, and coordination among the health professionals involved in the transition. Transitional care, which encompasses both the sending and the receiving aspects of the transfer, is essential for persons with complex care needs."

Why is there a Focus on Patient Care Transitions?

Over the last decade, many clinicians, researchers and analysts have documented the problems associated with poorly managed patient care transitions from acute care hospitals to post-acute care or the community. These problems have also been associated with hospital readmissions. The literature covering this issue includes Jencks et al, 2009[iii]; Esslinger, 2008[iv]; Kripalani et al, 2007[v]; Coleman et al, 2006[vi]; Naylor et al, 2004[vii;] and van Walraven et al, 2004.[viii]

The findings provide evidence that poorly managed care transitions negatively impact patients and their families in many ways, such as the following:

- exacerbating patient disorientation and confusion
- leaving patients unaware about the details concerning their conditions and history
- limiting provider awareness of escalations or other changes in patient health conditions, known as "red flags," that could send them to the emergency room or into the hospital
- causing patients and caregivers to misunderstand the use of medications resulting in a failure to comply with the recommended medication regimen
- hampering timely access to primary care physicians or specialists, where post-acute care plans can be developed or reviewed with a focus on avoiding re-hospitalization

Thomas S. Bodenheimer, MD, Harvard Medical School Professor, addressed the problem with care transitions and patient care coordination in America in a 2008 *New England Journal of Medicine* article entitled, "Coordinating Care – A Perilous Journey through the Health Care System".[ix] Dr. Bodenheimer described a host of shortcomings in the current system and cites these surveys and studies:

- A 2005 survey of U.S. adults with chronic illness or with a recent acute illness reported that one-third of those who had been hospitalized in the previous two years reported that no physician follow-up care arrangements had been made after hospital discharge.
- One study found that fewer than half of primary care physicians were provided information about the discharge plans and medications of their recently hospitalized patients.
- A literature review of information transfer between hospital-based and primary care physicians found that only 3% of primary care physicians were involved in discussions with hospital physicians about patients' discharge plans; 17% to 20% were always notified that the patient had been discharged; and fewer than 20% had received a discharge summary at one week after discharge. In addition, 25% of discharge summaries never reached the primary care physician, 38% of discharge summaries did not include reports of laboratory results, and 21% did not list discharge medications; and in 66% of cases, primary care physicians contacted or treated patients after hospital discharge before receiving a discharge summary.

One of the most illustrative studies on the problem, "Re-hospitalizations among Patients in the Medicare Fee-for-Service Program," appeared in the April 2, 2009 edition of the *New England Journal of Medicine*. The study cited these alarming key findings[x]:

- Almost one of every five hospital discharges are readmitted within 30 days
- Approximately 34% of discharges were readmitted within 90 days
- The estimated cost to the U.S. Centers for Medicare & Medicaid Services (CMS) for unplanned readmissions was $17.4 billion in 2004 alone

Another study going back to 1992, "Compliance with Medication Orders among the Elderly after Hospital Discharge," by the UCLA Center for Health Sciences[xi] found that among elderly patients discharged from the hospital:

- 64% used at least one medication not ordered
- 73% failed to use at least one medication ordered
- 32% of all drugs ordered at discharge are not taken at all

Organizations and individuals involved in the health care continuum – primary care providers, specialists, hospitals and hospitalists, post-acute care providers, CMS and private insurers, family caregivers and, above all, patients – could benefit from the creation of a new clinical role, the Care Transition Professional. Such a clinical Professional could be deployed by home health and community-based organizations and tasked with guiding patients during their care transitions. The education, coaching, monitoring and assessment provided by a Care Transition Professional would improve the patient experience and clinical outcomes. The care provided would help to avoid hospital readmissions, control costs and, ultimately, help Medicare beneficiaries live more independently and with better quality of life. The Alliance proposal for the **Home Health and Community Based Care Transitions Coaching Program** model offers the organizational structure and administrative tools to make this happen.

The Challenges of Transitional Care

The demand for clinically sophisticated community-based care is increasing as Americans live longer, develop multiple chronic health conditions and prefer to live independently at home for as long as possible. At the same time, healthcare providers in the continuum of care – physicians, hospitals and sub-acute care facilities – often lack the resources to properly manage their patients' needs before, during and after the events of a patient moving from one care setting to another. This results in patients facing significant obstacles as they transition across care settings, such as the following:

Providers often act independently of one another in "silos" – due in large part to the "silos" Medicare payment system among providers. These silos contribute to a significant lack of communication of the kind described in the research above. Care transitions are likely to improve if these silos are reduced or removed. Although changes to the payment systems will take longer, immediate change to the organization and delivery of care to those with chronic conditions can be made.

Hospitals and post-acute care providers do not have the resources or access to the patient within the continuum to ensure a seamless transition of care. While hospitals and post-acute providers transfer some patient information at discharge, the process is not always smooth and the information is not always complete. Furthermore, the ability of patients to absorb and transfer this data to other care providers, including primary care medical practitioners, is often limited.

Hospital discharge units are not profit centers within institutions. These may be **chronically underfunded and understaffed**, and are unable to effectively transition patients.

The hospitalist involved in the patient's discharge generally **does not contact the patient's primary care physician** to ensure an adequate and timely flow of information from one physician to another. (Note: Medicare's new provisions to provide incentives to reduce readmissions will have some impact on this in the future.)

Primary care physicians – already in short supply – **do not have the resources to visit the patient's post-acute care setting** and gain a complete picture of that individual's health status. They **have little control of the patient's care team and may not be adequately compensated for care management oversight**.

On the other hand, **the delivery of home health has become more sophisticated and cost-effective** over the last decade and already is in close touch with many patients who need transition care services. Additionally, **a nationwide infrastructure already exist as home health** provides traditional Medicare services and often serves as the doctor's "eyes and ears" in monitoring and evaluating patient care. Home health is the logical provider as well to help patients who rely on Medicare through the transitional care process.

Some policy-makers contend that hospitals alone should be charged with remediating the problems with patient care transition. However, a January/February 2010 article in *The Remington Report*[xii] calls **for targeting whole communities as the best unit for intervention.** The report offers two reasons for this suggestion:

1. **Many evidence-based protocols demonstrated to reduce readmissions depend on coordinated actions of more than one provider**, and on effective incorporation of patients, families and community healthcare stakeholders.

2. **Local areas vary substantially in healthcare utilization and the infrastructure** available to reduce reliance on hospital services, necessitating a customized approach to improve processes of care.

Home health care is established in virtually every community's healthcare continuum. Home health provides the ideal organizational infrastructure to establish and deploy specially trained Care Transition Professionals to collaborate with and assist other providers.

Promising Developments in Care Transitions

Many promising developments in transitional care have been documented in recent years, including the current CMS-contracted Care Transitions Demonstration project. The demo project is led by the Colorado Foundation for Medical Care (CFMC) and implemented by the Quality Improvement Organizations (QIOs) in 14 states. Well over 1.1 million Medicare beneficiaries are participating in the project, which passed the halfway point in May 2010 and will be completed by summer 2011. Vast resources on transitional care can be found on the project's web site at http://www.cfmc.org/caretransitions .

Coaching of the patient through his or her transition from hospital to post-acute care has become an important component of this project. In an initial review of the utilization of coaches, the Colorado QIO disclosed the following preliminary results[xiii]:

- The coached patient group had 7.7% lower hospital readmission rates than the comparison group
- Approximately 24.1% more coached patients had a physician follow-up appointment within seven days after discharge versus the comparison group
- At least one medical discrepancy was identified among about 82% of coached patients

In preliminary findings, CMS and CFMC identified these factors that seem to contribute to hospital readmissions among Medicare beneficiaries:

- Patients not receiving adequate follow-up care
- Primary care physicians not aware of patient's hospitalization
- Home heath not utilized adequately
- Palliative care not utilized and/or hospice referral not made until last days of patient's life

It is worth noting that the Alliance and a number of home health providers have been committed to working with the CMS quality group on the care demonstration project. They have also taken an active role in the CMS-directed Home Health Quality Initiative (HHQI.) The HHQI is designed to develop best practices through home health interventions to reduce hospitalizations, improve medication compliance and realize other care improvements for Medicare beneficiaries. CMS officials have asked HHQI campaign participants and the Alliance to review the CFMC's preliminary findings and include them in the care transitions best practices for home health later this year.

In another example of its commitment to finding solutions for care transitions, the Alliance held a care transitions summit on October 26, 2010, to highlight the important role home health plays in both care transitions and coaching. We include a number of recommendations from experts presenting at the summit in this position paper.

The Importance of Coaching

Earlier independent research has confirmed the importance of coaching to enhance care transitions and reduce hospitalizations. Much of this research is outlined in the January/February 2010 issue of *The Remington Report* in an article titled, "Improving Care Transitions and Reducing Hospital Readmissions: Establishing the Evidence for Community-Based Implementation Strategies through the Care Transitions Theme." The article examines 21 different programs or toolkits related to care transitions and the supporting research for each.

Mary Naylor, PhD, RN, professor of gerontology and director of the New Courtland Center for Transitions and Health at the University of Pennsylvania, School of Nursing, has been at the forefront of this research. In an April 2009 presentation before the American Geriatrics Society, Naylor reported that "providing hospitalized older adults who have complex health problems with coordinated, comprehensive, multidisciplinary care – care that helps them successfully make the transition from hospital to home – can improve outcomes, lower rates of re-hospitalization and cut Medicare costs by thousands of dollars per patient."[xiv] Dr Naylor's research utilized randomized clinical trial methodology that tests the comparative effectiveness of a care delivery model that is solely nurse practitioner based. Naylor's work provides evidence that nurse practitioner based clinics in conjunction with their care transitions program yields markedly better clinical and financial outcomes than traditional primary care for high risk cardiopulmonary patients.

Eric A. Coleman, MD, MPH, a professor of Medicine and Director of the Care Transitions Program at the University of Colorado coordinated a study between 2002 and 2003 that also looked at care transitions. In his controlled trials, patients were identified at the time of

hospitalization and were selected randomly to receive a care transition intervention or a discharge process lacking a care transition intervention. Patients who received – care intervention had lower re-hospitalization rates than control subjects. The mean hospital costs were lower for intervention patients by about 20%. The conclusion was further evidence of the success of coaching in care transitions.

Both Dr. Naylor's and Dr. Coleman's work indicate that a transitional care model provides the following positive results:

- Improvements in post-hospital discharge health outcomes
- Enhancement in patient and family caregiver satisfaction
- Avoidance of hospital readmission for primary and co-morbid conditions
- Reductions in healthcare costs

The Home Health and Community Based Care Transitions Coaching Program

Given the body of research and the positive results from providing transition care, it is an opportune time to pilot and implement a nationwide care transition program. Dr. Naylor noted that "home healthcare is a component of the healthcare community uniquely positioned to improve transitional care and outcomes for the growing population of older adults with continuous complex needs."[xv] Therefore, the Alliance proposes a pilot for a Home Health Transitional Care Coaching Program to implement a transition model that is separate and distinct from traditional Medicare home health services yet coordinated with traditional Medicare home health.

This program would develop a new service and clinical role called the Care Transition Professional. The Professional would educate, coach and monitor Medicare patients throughout the transitions from the hospital discharge to a post-acute environment and/or the community. The coaching would be deliberative and proactive and would work to manage and monitor patients according to specific, measurable care protocols known to provide value and diminish barriers to empowered health management.

The Care Transition Coaching program would consider the transition period between hospitalization and other care environments as a discrete and focused event that requires a specific intervention – the management and monitoring of the patient's health needs and communicating them to the other clinicians on the team. It would ideally be made available to every Medicare beneficiary, homebound or otherwise, but could be initiated or piloted with targeted risk populations.

Such a program could also cover multiple types of care transitions:

- Transitions from the acute care hospital to a post-acute care facility, or from the physician office to a post-acute care facility;
- Transitions from the post-acute care facility to the home environment; or
- Transitions between community post-acute providers (without a hospital admission).

The care transition "event" would be managed by a single, home-health-led Care Transition Professional that would serve as a separate, uniquely trained and credentialed coach and coordinator of care for the patient. This is quite different from the multiple clinicians who directly provide their own services under the traditional Medicare model (e.g., nurses, therapists, pharmacists, physicians, etc.).

The ultimate objective of the Alliance Home Health and Community Based Care Transitions Coaching Program would be to extend the services of a Professional to eligible Medicare beneficiaries for a focused event. These transition services would be provided at a lower cost-per-patient relative to the savings realized. The actual cost for such services would be determined during a pilot program. The issue of whether deployment of a Care Transition Professional requires a physician orders would also be determined in the pilot.

The proposed Home Health and Community Based Care Transitions Coaching Program is based on Dr. Coleman's four pillars of care transition as adapted for home health by Quality Insights of Pennsylvania for the HHQI national campaign.[xvi] To meet each of the pillars, the Care Transition Professional would have the following responsibilities:

Pillar 1 – *Patient-Centered Record*

- Deep involvement in implementation of comprehensive personal health record (PHR) for patient that could be shared with all necessary providers in healthcare continuum with patient's consent
- Introduce PHR and all components
- Review/update PHR after transitioning patient to next care setting
- Share PHR (with patient consent) with primary care provider or specialists during follow-up visits, and discussions on patient progress

Pillar 2 – *"Red Flag" Identification*

- Monitor patient condition to identify signs needing intervention to prevent unnecessary emergent care visits or hospitalizations
- Encourage collaborations with primary care providers and/or physicians/specialists to develop emergency care plan for patient
- Discuss signs and symptoms of impending changes in health status with patient and his/her physician, while including family caregivers
- Reinforce whom to call and when if patient's condition should change
- Review emergency care plan with other providers, as necessary

Pillar 3 – *Medication Reconciliation*

- Coach and educate patients on medication and ensure medication management and compliance
- Focus on two goals:
  - Reconcile medication lists so patients/families understand and are compliant with regimen ordered by discharging physician, as well as coaching to obtain and follow most current medication profile
  - Provide coaching so patient contacts primary care provider to relay information on any new medication and transfer of care settings

Pillar 4 – *Physician Follow-up*

- Stress importance of linking patient to primary care provider and check to see that patient visits doctor on timely basis
- Assist patient as he/she prepares to inform the primary care provider on recent health status. Develop of questions to ask physician, provide advice on getting prompt medical appointments. If necessary, "role-play" prior to physician/patient meeting

In the proposed program, the Care Transition Professional would be charged with making two personal visits and at least two telephone calls to the patient within 30 days after hospital discharge or a transition event. The first visit would be to enroll the patient in the program and to evaluate that patient's healthcare needs, not only those noted on a discharge plan, but other needs that may be observed in the post-acute environment. The second visit would be to ensure a patient's compliance with the plan of care prescribed by a physician or primary care provider. During this period, the telephone calls would allow for further monitoring and evaluation of the patient's needs and compliance with a plan of care.

What is a Care Transition Professional?

A Home Health and Community Based Care Transitions Coaching Program would be highly selective in determining the appropriate set of coaching skills of each clinician. Selection for the position has to be based on certification. The proposed program could be inclusive by expanding applications beyond nursing to the ranks of all community-based individuals, including qualified social workers, therapists and other healthcare professionals. As discussed in detail below, the home health community will help design a curriculum and selection criteria for considering, selecting and shaping clinicians who can be successful in coaching patients through care transitions.

Home Health Care Transition Professionals would require a different skill set than other home health clinicians. The key would be to select nurses and therapists with professional qualities necessary to be successful in their new role. The ideal candidate would be a coach and educator with the proper education, skills and tools to provide a high degree of critical thinking to handle issues, such as medication management. The Professional must also possess the assessment and evaluation skills needed to report meaningful information to the primary care physician and/or other health care providers. Therefore this position must be capable of exceptional communication skills – both verbal and aural – and have the ability to ask probing questions.

A unique qualification for identifying and developing clinicians for this new role is their ability to understand the learning patterns of the Medicare population. According to Roger Hiemstra, Professor Emeritus, Instructional Design and Adult Learning, Syracuse University, "(t)he major problem facing many people who deal with older persons is how to promote the learning, coping, and adjusting necessary for or related to age-associated change. Yet, inadequate preparation for such promotion or teaching tasks, individual differences among older people in terms of learning needs or skills, and an abundance of stereotypes regarding older adult learning abilities serve as barriers to successful teaching interventions."[xvii]

The change in thinking needed to become a Care Transition Professional can be as simple as understanding that a patient may not be able to read the label on a medication container. Alternatively, it can be as complicated as convincing the person that a care transition program actually exists; as at least one QIO has found among some seniors barring entry to their homes.

The selection and education of Care Transition Professionals should involve competency testing, credentialing, validating skills, role playing and using external resources. The Professional also will require continuing education that includes face-to-face, online and video-

based teaching. Given the ultimate goal of transitioning a patient to the home environment, training should also include a home health curriculum.

The Need for Training, Standardized Information and Physician/Primary Care Provider Education

A Transition Coaching Program will require the creation of new and broader kinds of training, the development of vehicles for communicating standardized information to other members of the team, and the education of primary care providers, physicians and specialists.

Training

While a job description and training program for the Care Transition Professional have yet to be fully defined, this new role will require a set of skills that differ from those currently required for home health clinicians. Although only selected candidates may be chosen for these new positions, home health agencies should provide some care transition training for all employees involved in the process. Providing training and education on the specific risks that patients face during a transition will undoubtedly improve outcomes.

Furthermore, better outcomes for patients will require an improvement of clinicians' professional development. Some experts recommend the development of sponsorship events that recruit students to attend and participate more fully in health care clinical programs in order to increase their exposure to these opportunities. Mentoring activities will also be important in a community where skilled clinicians often work alone and do not have the immediate benefit of sharing critical information and advice with colleagues.

Standardized Information

The Care Transition Professional would need to have access to a core set of health information about the patient before hospital discharge and prior to the first home visit. The exchange of information must be closely coordinated with the hospitalist and discharge planner as the patient is preparing to leave. This is addressed later in recommendations for government action.

The transition event is focused and limited in scope, and may include identifying other care needs. For example, many seniors require more help and information than a reconciled medication list to safely and effectively manage medications in the community.

To facilitate the sharing of quality information, a standardized Patient Transition form, or PTF, would be developed. The PTF will fully capture both the patient's current condition and highlight any potential risk factors that could lead to the patient deterioration and need to re-enter an institution. Standardization is required to better facilitate the lines of communication between hospitals and home health agencies. Currently, the quality and effectiveness of such communication varies widely, especially with regard to patient clinical information. Lack of

communication between providers can confuse the patient, and impede the ability of home health agencies to identify potential risks facing certain patients. The PTF also should capture any psychological barriers that may present themselves during the transition, such as whether a patient has ever experienced a transition from a hospital setting to the home; and/or whether the patient has a history of repeated re-admissions. This kind of information may better enable Care Transition Professionals in particular, and home health agencies in general, to be flexible in adapting to any unusual circumstances on a patient-by-patient basis.

To ensure a smooth patient transition, information must flow to every level of the home health agency, from case managers to therapists to nurses and personal aides (*See Fig. A*.) This should become easier as the home health community moves toward electronic health records and other means of disseminating information electronically. However, agencies must ensure that lines of communication between all levels of employees are formalized and efficient, regardless of the method utilized.

Fig. A: Home Health Agency Staff
Branch Director
Medical Director
Intake Manager
Case Manager
Quality Improvement Manager
Nursing Supervisor
Therapy Director
RNs
LPNs
Physical Therapists
Occupational Therapists
Speech Therapists
Social Workers
Home Health Aides
Social Workers

A home health community-wide standard should require that patients be seen by home health professionals within 24 hours of their return to the home and that the home health community use a standardized re-hospitalization risk assessment form. (Under the Alliance proposal, the Care Transition Professional would ideally be the first contact with the patient.)

An existing form already used within the home health community may be all that is required to develop the PTF; with some adaptation. For example, the Home Health Quality Improvement Campaign over 2010-11 disseminated a comprehensive hospitalization risk assessment tool[xviii] as one of its best practice intervention packages. This tool has been used by thousands of home health agencies participating in this grassroots campaign and could be adopted as the industry-wide standard.

Physician and Primary Care Providers Education

Today, physicians are the gatekeepers for their patients' care at home. The Alliance Home Health and Community Based Care Transitions Coaching program must develop continuing education and university curricula to ensure that physicians remain an integral part of the care transition process and gain optimum understanding of the work of home health

nurses or therapists as they practice in the community. As other mid-level practitioners, such as nurse practitioners, enter into the model, we would also evaluate education needs to include these primary care providers.

What a Care Transition Program Could Mean to Members of the Healthcare Continuum

Patients, families, and providers in the healthcare continuum will benefit from a Care Transition Coaching program lead by the home health community. The following table outlines the benefits for patients and their families:

Recipient of Benefit	How and Why They Would Benefit from Care Transition Coaching
Patients/ Family Caregivers	▪ Better manage health conditions and improve outcomes ▪ Provide patient-centered focus and empower individuals and families toward greater self-care ▪ Work with physicians to scope out health plan answering questions about care at home ▪ Help patients identify symptoms and triggers, and assist them in determining when to call physician ▪ Build bridge between patients and physicians to create or strengthen relationships and gain access to care from physicians and community health resources ▪ Use personal visits and calls to reassure and reaffirm concerns for patients and families, thus reducing stress and anxiety ▪ Change focus from “care providing” to more complex role of care coaching during costly stages of chronic disease management and palliative care for elderly ▪ Make transitional care event a starting point for changed focus

Other members of the healthcare continuum, from physicians to post-acute care provider to Medicare, would also benefit, as follows:

Recipient of Benefit	How and Why They Would Benefit from Care Transition Coaching
Physicians	▪ Regain control of patient health information during and after patient hospital stay ▪ Help practices become centers of community-based care ▪ Enhance ability to manage growing patient population ▪ Enhance monitoring/evaluation of patients outside office setting ▪ Familiarize physicians with sophistication and quality of care available to patients at home ▪ Build relationships between physician office “extenders” (nurse practitioners or physician assistants) and home health professions responsible for post-acute care outside institutions ▪ Help plan for implementation of electronic health records by encouraging patient adoption ▪ Permit partnering with home health clinicians for appropriate Medicare reimbursement of post-acute services ▪ Improve patient outcomes and reduce hospitalizations

Recipient of Benefit	How and Why They Would Benefit from Care Transition Coaching
Specialists	▪ Gain same advantages as above if acting as patient's primary care physician ▪ Assist with transition of patient to primary care physician ▪ Support focus on specific procedures and outcomes by reducing re-hospitalizations ▪ Help cardiologists, for example, implement patient medication changes and monitor conditions ▪ Help oncologists, who often act as primary care physicians temporarily or at end of life, to form palliative bridge with home health/hospice and foster better end-of-life care decisions
Recipient of Benefit	**How and Why They Would Benefit from Care Transition Coaching**
Hospitals	▪ Support renewed interest in keeping patients well and discouraging readmissions, given 2012 re-hospitalization penalties under comprehensive health reform ▪ Support health reform's creation of accountable care organizations (ACOs) as one of several demonstration programs administered by Medicare, with launch set for 2011 (According to the American Hospital Association[xix], ACO concept envisions development of agreements between hospitals, primary care providers, specialists, and other providers to align incentives, improve healthcare quality and slow growth of healthcare costs. ACOs would reach goals by promoting more efficient use of treatments, care settings and providers.) ▪ Support hospitals' incentives to move forward as they share cost savings with CMS ▪ Make up for hospitals' inability to generate needed outcomes and savings, and inability to execute four pillars of transition due to inadequate structure and staffing ▪ Supplant and improve upon work of discharge departments, which are chronically understaffed and overwhelmed, and not a center for investment because they don't generate revenue ▪ Discharge departments understaffed and overwhelmed and not a center for hospital investment because they don't generate revenue ▪ Help hospitals manage costs and reduce readmissions, especially for chronic illnesses that have highest readmission rates ▪ Reduce patient referrals to overburdened emergency departments (another cause of readmissions) thanks to care transition interaction with primary care physicians and specialists
Post-Acute Care	▪ Assist with role of skilled nursing facility (SNF) and other post-acute care settings in receiving patient from hospital, sending them back into community, or, in high acuity cases, transitioning them between SNF and home without hospitalization ▪ Help SNFs to reduce record of frequent re-hospitalizations, even though they are not currently penalized by Medicare ▪ Make up for SNFs' inadequate clinical staffs needed to perform four pillars of care transition ▪ Manage handoff from hospital to SNF, act as information link between hospitalist and SNF clinical staff and confer with patient's primary care physician on transition itself ▪ Help SNFs test themselves on ability to reduce readmissions and, thus, reduce costs
Medicare	▪ Improve outcomes for patients, reduce hospitalizations and potentially reduce billions of dollars in expenditures for relatively low cost per transition ▪ Reduce inpatient healthcare costs and drive care into the community to provide more value for Medicare dollars ▪ Reduce costly emergent care visits and drive care of the patient back home into lowest-cost and most-patient-preferred setting ▪ Break down silos between Medicare providers and resolve current care coordination challenges Again, make transitional care event a starting point for these changes

The Impact of the Care Transition Coaching Program on Existing and Future Medicare Beneficiaries

The largest percentage of Medicare expenditures are driven by services provided to beneficiaries who develop multiple chronic illnesses and require prolonged treatment. A 2006 Health Affairs article[xx] by economists Kenneth Thorpe and David Howard contended that virtually all of the growth in Medicare spending over the previous fifteen years could be traced to patients treated for five or more medical conditions during the year. The economists further noted that the number of Medicare beneficiaries with multiple conditions had risen sharply over time, from 31% of Medicare patients receiving treatment for five conditions or more in 1987, to more than half of Medicare patients in 2002. These beneficiaries accounted for 76% of total Medicare spending in 2002, up from 52.2% 1987. Beneficiaries with three or more conditions during the year accounted for more than 92% of health spending in 2002, the report said. Hypertension, diabetes, and hyperlipidemia (an elevation of lipids, including cholesterol, in the bloodstream) accounted for 16.1% of increased Medicare spending in the 15-year period. Spending on heart disease accounted for 12% of the increase.

According to the Medicare Payment Advisory Commission, the most costly 25% of Medicare patients absorbed 82% of program expenses in 2006;[xxi] i.e., those with multiple chronic conditions, using inpatient hospital services, those who are dually eligible for Medicare and Medicaid and those in the last year of life. In every state in the Union, chronic illnesses such as chronic obstructive pulmonary disease, congestive heart failure and diabetes are among the top five to ten leading causes of death.[xxii]

These reports and others, point to a clear and compelling need to target intervention toward a range of chronic illnesses. This intervention can both enhance the quality of care for the increased aging population and control Medicare's rapidly rising healthcare costs. The proposed Alliance Home Health and Community Based Care Transitions Coaching Program can facilitate the achievement of these goals.

Rationale for Delivering Care Transition Services through Home Health

Home health already has the infrastructure necessary for implementing the transitional care services. This home health infrastructure currently provides services in virtually every important U.S. population center, as well as hard-to-serve rural areas. In many cases, home health serves as a liaison between primary care physicians or specialists and patients at home, providing physicians and other care providers with "clinically trained eyes and ears on the ground" able to detect patients' responses to their care plans and changing clinical conditions.

Over the last decade, home health has become more clinically sophisticated and innovative, in demonstrating its ability to reduce the vulnerability of patients at home and control costs through the reduction of unnecessary hospitalizations.

Home health care is well positioned within the healthcare continuum to understand the long-term experiences and needs of Medicare beneficiaries. According to 2008 Medicare reports, the home health community provided Medicare-reimbursed services to 3.1 million Americans in the form of 120 million visits.[xxiii] It should be noted that home health has a growing, successful track record of treating and managing chronic diseases. The proposed Care Transition Coaching Program would further augment this growing capability.

Still, the home health community has not yet demonstrated its ability to succeed in care transitions for the following reasons:

- Reimbursement is focused on treatment that is curative and restorative versus the coaching, care management and empowerment focus required for disease state management and palliative care
- The priorities in admission are driven by the Oasis C process. Although important, the process is so detail oriented that it does not encourage the listening and coaching required of a Care Transition Professional
- Multiple complex needs are addressed over a service episode and the urgency of the care transition event is not addressed intensely at the start of care
- Home health is often providing skilled care with clinicians who have competency in skilled tasks, but who may lack coaching skills and education
- Home health has been inconsistent and without the appropriate measurements to foster well-developed implementation skills and train clinicians to raise the bar of expectation

Home health can implement and provide professional guidance for a focused care transition event that demonstrates and measures real value. Selecting, developing, and focusing the Care Transition Professional on the four proven pillars are a foundational element of this model. **Ultimately success will be reliant on engaging the consumer and empowering them in the management of their own health**. The following section presents recommendations for the home health community and for government policymakers.

Recommendations for Consideration by the Home Health Community

Concurrent with the recommendations above, we also believe the home health community should take the following steps:

1. The Home health community should encourage care transition training for Professionals and other employees involved in the discharge process until further guidelines or a certification is established.

2. Home health agencies should participate in the development of process and outcome quality measures of "transition coaching success."

3. Home health agencies should undertake a national campaign to educate all sectors of healthcare – including government officials and thought leaders – about the benefits of a Care Transitions Program.

4. Home health agencies should encourage better collaboration between the home health community and government agencies, such as the U.S. Department of Health and Human Services, CMS and the Medicare Payment Advisory Commission.

Recommendations for Consideration by CMS

While this concept paper focuses largely on the role of the home health community in care transitions, government can take a number of steps to support better care transitions. CMS should consider the following steps to create an environment more conducive to enhanced care transitions:

1. **CMS should sponsor pilots and demonstrations** of Home Health and Community Based Care Transitions Coaching based in the beneficiary's home.

2. **CMS should enable home health agency staff visits to patients in the hospital before discharge to the home.** CMS should provide further guidance on the feasibility and impact that would result from allowing home health representatives to visit the patient in the hospital prior to discharge. Allowing home health representatives to gain access before the transition would not only provide patients with a greater awareness of what will occur and what to expect prior to discharge. It would also allow home health agencies to better address the readmission risks each patient represents and develop a care plan that addresses specific risk factors before the patient even gets home.

3. **CMS should clarify for hospitals the privacy constraints of the Health Insurance Portability and Accountability Act (HIPAA) so** that hospitals and home health agencies can collaborate on care transitions. CMS needs to correct the misconception among some hospital officials that the presence of a home health nurse on patient rounds in the hospital is a HIPAA violation. As stated above, we believe it would be positive for home health clinicians to gain admittance to

hospitals prior to patient discharge. Furthermore, it would help to strengthen relationships and collaboration between hospitals and home health providers.

4. **CMS should consider revising Medicare's "homebound" definition to permit more beneficiaries to be treated in the home** as part of the Care Transitions Program. The current definition is overly inflexible and inevitably results in greater patient readmissions to institutions (*See Fig. B.*) Allowing more Medicare patients to be treated in their homes would permit home health agencies to care for a much wider scope of patients and ensure that they have the best opportunity to avoid a return to an institution. The Medicare Payment Advisory Commission's own analysis of post-acute patients from 2004 to 2006[xxiv] demonstrated that home health could deliver significant savings over other care environments by treating patients who had suffered a stroke, had hip or femur procedures, cardiac bypass with catheterization, or who suffered from heart failure.

Fig. B: Medicare 'Homebound' Criteria

You must be homebound, and a doctor must certify that you are homebound. To be homebound means the following:

- Leaving your home is not recommended because of your condition.
- Your condition keeps you from leaving home without help (such as using a wheelchair or walker, needing special transportation, or getting help from another person).
- Leaving home takes a considerable and taxing effort.

A person may leave home for medical treatment or short, infrequent absences for non-medical reasons, such as attending religious services. You can still get home health care if you attend adult day care, but you would get the home care services in your home.

CONCLUSION

There is a clear need and opportunity to develop, pilot and implement a Home Health and Community Based Care Transitions Coaching model to address the problems and concerns associated with care transitions in the United States. This model for care services would enhance the quality of care for patients who rely on Medicare, benefit physicians and other healthcare stakeholders, and control costs for the Medicare program. This initiative will provide education and a better exchange of information among a broad spectrum of providers involved in the healthcare continuum serving Medicare beneficiaries. It will demonstrate models involving nurse practitioners, physician assistants and hospitalists in a team/community approach to care transitions.

As suggested by a growing body of independent research, the Home Health and Community Based Care Transitions Coaching Program will be successful in reducing hospital readmissions, keeping Medicare patients living in their homes for as long as possible and reducing our Nation's healthcare costs.

About the Alliance for Home Health Quality and Innovation

The leaders of several prominent home health care providers joined forces in 2008 with a common recognition and a shared goal. Their recognition – that that home health care should serve as a critical component of the health care system of the future. Their shared goal – to tell the story of today's modern home health care community – a health care system that can meet the needs of a rapidly aging population, keep pace with escalating health care costs, and serve patients' demands for high-quality health care within , all with the comfort and dignity of remaining at home.

Today the Alliance for Home Health Quality and Innovation (the Alliance) is comprised of more than 20 leading members of the home health sector – including the largest national trade association, the national association of nonprofit agencies, and technology and educational services providers from around the country. The Alliance raises awareness about home healthcare and its proven ability to deliver quality, cost-effective, patient-centered care. Collectively, the members of the Alliance provide over 90% of all Medicare home health services nationwide. The Alliance supports education and research to demonstrate the value of home-based care to patients, their families, physicians and policymakers. The Alliance is dedicated to improving the nation's health care system through development of high quality and innovative solutions aimed at achieving optimal clinical outcomes. To learn more about the Alliance and home healthcare, please visit our website at www.ahhqi.org

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