Home-Centered Care Is the Model for the Future

Presented by
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C. Sam Smith
Senior Vice President of Business Development

• Senior Vice President, Business Development at AXXESS
• Responsible for all business development advisory and expansion of the company’s industry relations
• Nearly 40 years’ experience in strategic planning and entrepreneurship
• 2016 Affiliate Member of the Year @TAHCH, Texas Association for Home Care and Hospice
• Prior to joining AXXESS:
  – Founder and president of Vi3 Technologies, an information technology consulting firm
  – Involved in the establishment of several companies in the technology and data industries
  – Founded and served as president and CEO of Synergy Bank and First Waco National Bank

Merrily Orsini, MSSW
Innovative Thought Leader in Aging Care

• President/CEO corecubed
• A pioneer in the home care industry, celebrating 36 years of eldercare specialty this year
• Entered home care in 1981 starting a private duty home care company sold in 1996
• Received EY Entrepreneur-of-the-Year award for success in the care-managed model home care business
• In 2011 and 2012 served as Chief Strategic Officer for the National Association for Home Care and Hospice (NAHC) for the Private Duty Homecare Association of America
• Nationally recognized industry thought leader
• Healthcare at home marketing expert
• Works with an award-winning team of SEO experts, branding and sales strategists, content creators and designers, all experienced and specializing in selling and educating about in-home care
• A home care futurist (now-ist)
Objectives

• Explore the changes that are occurring with the industry and how to best face them for future success
• Gain understanding of an expanded home-centered care vision with patient and family at the center of the larger integrated healthcare delivery system
• Discover trends for the future that will impact agencies and care settings to assist in better positioning for the future of home health

The Demand Will Grow and Grow and Grow

• By 2029 (the next 12 years), there will be 71 million baby boomers over age 65, an increase of 73% from today's numbers. (US Census Bureau)
• Not only do patients want their healthcare in the home (and want to age in place), but healthcare at home is usually significantly less costly than hospital or SNF care.

2017 Is THE Crossover Point of No Return

The (crossover) point of no return...

Source: Eric Dishman
“Toward Personal Health; Going Home and Beyond”,
October 1, 2014
The Impact of Demographics of Aging

- Requirements for more services are exceeding the supply of care providers
- Pay for service models emerging in ACOs, local non-profits, proprietary businesses, physician practices (IPAs)
- Greatest transfer of wealth in the world’s history
- Congregant neighborhood aging communities
- Care recipients that are older, healthier, more demanding and with financial resources
- People living longer and longer

The Impact of Chronic Disease

Projected Rise in Cases of Chronic Diseases, 2003-2023

Milken Institute: Every one of the 7 major chronic disease populations is projected to grow at a rate that significantly exceeds that of the total population.

Reimbursement and Payment Dynamics

- The current system is fragmented, in silos, and non collaborative, but it is moving to cohesive collaboration, centered around population health management.
- Reimbursement systems are changing, and are becoming more and more outcome- and value-driven.
- Systems are slowly moving towards meaningful use, meaning interconnectedness of the technologies of hospitals, physician clinics, SNF’s and HHA data.
- Remote patient monitoring will be reimbursed by Medicare and Medicaid, as well as insurers.
- Privately paid services are becoming more utilized nationally for both clinical and non-clinical services.
A More Holistic Look at the Care Continuum

• No person experiences disease in isolation
• ‘Psychosocial’ status defines where an individual is as he or she starts care, and impacts the plan of care:
  – Psychiatric / mental health, physical co-morbidities
  – Treatment barriers and resources – coping, social system, culture, needs and goals expressed by the individual / family
  – Roles of family caregivers: who does the care vs. who has the power
• Understanding intervention within the context of time with the home care patient

The Social Model Meets the Medical Model

Breaking Medical / Discipline Silos

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Source: Barbara McCann, Interim Healthcare
“Optimizing the Home Health Interdisciplinary Team”, September 30, 2014

The Medical Model Care Continuum

Well/Healthy
- Wellness prevention
- Mitigation of risk prevention of healthy lifestyle choices

At Risk
- Chronic Care Management
- Preventing re-hospitalization Care coordination across providers

Chronic Care
- Complex Care Management
- Care coordination across providers

Advanced Illness
- Palliative care
- Hospital

Continuum Diagram (Courtesy of VNAA)
Focus on the Heavy Users

Population Needs + Resource Use

Source: Peter Boling

NEEDS
- Sick, frail, co-morbid, functionally impaired
- Mostly ambulatory, home chronic health conditions that require treatment
- Limited or no illness burden, episodic care, prevention

COSTS (%)
- 10% - 70%
- 30% - 25%
- 60% - 5%

Population (%)

Managing the Care for the Heavy Users

Core-Mapping Patients with Complex Needs

Source: Eric Rackow, Humana At Home
"New Models of Care and Approaches to Payment"
September 30, 2014

Home-Centered Care

- Home-centered care is patient-focused care that involves the patient (client), the family and the extended care team.
- It is widely believed that functionality is the key to what care is needed (ordered), and industry change is underway currently to determine how best to move the industry into one that is more responsive to patient and family needs, provides care at a lower cost, and improves the health of our population.
Place-shift, Skill-shift, Time-shift

Intel Strategy for Innovation: Place-shift, Skill-shift, Time-Shift from Mainframe to Personal Health

Challenges and Barriers

Key Challenges and Potential Barriers

- Payment
  - Covering the cost of delivering the services can be challenging (not yet an issue with bundled payment)
- Regulatory requirements
  - Homebound status and skilled need
  - Medicare conditions of participation
- Competition
  - Home health care agencies and other organizations
- Coordination
  - Starting to see multiple providers in the home

Source: Robert Rosati, Ph.D., VNA Health Group

The Role of the Medicare Certified Agency

Medicare 2020

- Shared risk/shared losses, “packaged” payments
- Customized care
- Predictive analytics: “real time” controls on reimbursement
- Accreditation, certification, CoPs
- Emphasis on care management and consumer tools
- Patient, allied health professional-centric

Colin Roskey
Home Health Policy Update
NL Leadership Summit, Jan 2017
Specific Industry Changes and Challenges 2017

- Pre-claim review 30-day “hold”
- Home health value-based purchasing
- New conditions of participation
- Emergency preparedness
- AHCA and Medicaid uncertainty
  - Block grants
  - Increased Medicaid managed care
- Spending cuts
- Political uncertainty, and the future of the ACA as it relates to services, employment laws, coverage

Payments…They Are A-Changin’

Future of Medicare Payments

> Objective of 32% of traditional FFS Medicare payments through Advanced Payment Models by the end of 2016 and 50% by the end of 2018

Strategic Themes Emerging

- Person-centered
  - Stay home (avoid hospitalization)
- Post-acute care
  - Partnerships are essential
  - Share information with partners
  - Good communication reduces risk
  - Value must be proven
- Federal policy and health information technology
  - Triple Aim: Better Care for every individual, Better health for the nation, Lower cost of care
  - Align programs and payment
  - HealthIT is a means, not an end
  - Alignment and community partners need to be electronically enabled and connected

Source: Larry Wolf, Kindred Healthcare

“Health Information Technology: Overcoming Challenges to Optimal Use”
September 2014
Defining Value in Care

Define Value in Accountable Providers’ Terms

Data as a business development tool

- **SHOW** what service is provided and for whom
- **TRACK** what happens to your patients from admission to discharge
- **TREND** improvement over time (LOS, return to ED, readmissions)
- **DEMONSTRATE** consistency through standardized processes
- **DESCRIBE** services and outcomes in terms that hospitals and others in the healthcare continuum recognize

Tips ‘n Tricks

Success in Alternative Payment Methods

- Identify and manage the high risk patients
- Ongoing patient monitoring
- Effective care transitions in both care and triage practices
- Excellent communication and coordination with all parties
- Define and communicate the value proposition you bring
- Physician involvement can be key to success

Health Information Technology

How Best to Achieve Better Care / Better Health / Lower Cost?

- Interactive HIT systems that engage patients in their care and provide decision support
- Personal health records integrated with the HER for patient support
- HIT that captures the patient perspective via electronic recordkeeping
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HIT-Enabled Care

- Data availability 24/7
- Informed decision-making
- Mutually agreed on patient-centered plan of care
- More timely actions
- Automated capture of data for clinical decision-making, quality reporting and research

Source: Cipriano, Bowles, Dailey et al. (2013). Nursing Outlook 61(6), 475-489.

Change Happened

Source: Larry Wolf, Kindred Healthcare “Health Information Technology – Overcoming Challenges to Optimal Use” September 30, 2014

Opportunities for the Future

Source: Kate Jones, RN, MSN, CCM is the Chief Financial Officer for Amedisys Home Health and Hospice presented at the January 13, 2015 AHHQI workshop.

Broader care coordination role
Support outside of “episodes”
Wellness model vs illness model
Increasing role of Nurse Practitioners
Greater use of data to guide and support practice
Integrating technology into practice
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The Family Caregiver Responds: A Combination of Family/Private Pay

- Medication reminders
- Chronic disease symptom monitoring reminders
- Family notification of worsening symptoms
- Making appointments
- Arranging transportation
- Meal preparation and shopping
- Supporting safe ADLs
- Socialization/life enrichment

Source: Barbara McCann, Interim Healthcare
“Key Issues and Trends to Consider in Planning for the Future Ideal State of Home Health Care”
September 30, 2014

As Consumers Get Informed.....

Empowered Consumers Drive New Demands

Source Left: 2011 EBRI/MGA Consumer Engagement in Health Care Survey

Four Key Characteristics of the HHA of the Future
“Vision is not the ability to foretell the future—no one can. Vision is to see an opportunity in the current circumstances and jump on it.”

— Rick Warren

Expand Your Vision

- Healthcare at home as a goal for your agency expands the vision from being a certified home health agency to being a partner, a provider in care, a problem solver and a solution to a problem.

The Dynamics of Change

The need to change never ends.

Once you change, it is time to change again.
Even if you are on the right track, if you don’t keep moving, the train will run over you.

— Will Rogers