Home – The Best Place for Health Care

A positioning statement from The Joint Commission on the state of the home care industry

The Joint Commission

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Home Care is the Patient-Preferred Setting

Just about everyone agrees: the home is the best setting for providing health care to increasing numbers of patients.

Not only can care be provided less expensively in the home, evidence suggests that home care is a key step toward achieving optimal health outcomes for many patients.[1,2,3,4] These studies show that home care interventions can improve quality of care and reduce hospitalizations due to chronic conditions or adverse events. The Joint Commission is working to further improve home care interventions by including the prevention of avoidable causes of hospital readmissions, such as medication errors and falls, in its Home Care National Patient Safety Goals, says Wayne Murphy, associate director of The Joint Commission's Home Care Program.

For these and many other reasons, says Tyler Wilson, president and CEO of the American Association for Homecare, home care is preferred by patients.

Kristy Wright, CEO, Visiting Nurses Association, Western Pennsylvania, says the home is the preferred setting for health care because the patient is most comfortable there. "There are less patient incidents and safety issues in the home setting" than in most other settings, she states, citing Sentinel Event data.[5] "It has a lot to do with the patient being in control."

A safe environment, despite sicker patients and the use of more sophisticated technology

Wright says home care is no longer just about talking to patients, giving baths and taking their blood pressure. "We now get critically ill patients who are being discharged from hospitals and sent back into the community," she states. "Our care is very high tech and very skilled and we know how to provide this service in a less controlled environment than what you have in any other health care setting."

Amy Berman, senior program officer at the John A. Hartford Foundation, leads its Integrating and Improving Services portfolio, which focuses on creating cost-effective care models that improve health outcomes for older adults, by far the largest consumers of home care services.

She cites research by Stephen F. Jencks, M.D., Mark V. Williams, M.D., and Eric A. Coleman, M.D. – published in the *New England Journal of Medicine* and covered by the *Wall Street Journal* – to explain why home care is important now and will be more so in the future. The research[6] found that 2.3 million, or nearly 20 percent, of hospitalized Medicare beneficiaries were readmitted to the hospital after 30 days over a one-year period. These unplanned return visits – associated with gaps in follow-up care – cost the federal government $17.4 billion.

The gaps occur when a patient moves from a hospital or physician's care to home without proper information or preparation. The risks become greater as patients are released from traditional health care settings quicker and with higher acuity. The John A. Hartford Foundation has, for more than a decade, supported the development of leading models to make transitions safer for older adults. "How we handle these transitions of care becomes central and perhaps the greatest opportunity for home health care," Berman states.

Better transitions between care providers can reduce medication errors and falls. One study found that 64 percent of older people receiving home care experienced medication errors.[7] These errors are especially prevalent within a few weeks after discharge. Unintentional falls cause more than 18,000 fatal and 2.2 million non-fatal injuries among adults over age 65 each year,[8] at a cost of about $19 billion a year.[9] By 2020, this cost is expected to reach nearly $55 billion.[10]

Home care's promise in reducing medication errors and in improving performance on safety, quality and cost measures – coupled with growing numbers of older adults with chronic conditions – point to a tremendous influx of patients moving toward the home setting. But these trends don't necessarily make work any easier for those in the home care industry. Meeting The Joint Commission's standards and National Patient Safety Goals can assist an organization to provide a firm foundation for practice, Murphy states.

Downward pressure on reimbursement expected to continue

Along with other health care sectors, the home care industry is facing significant downward pressure on reimbursement. Joanne Cunningham, president of the Home Care Association of New York State, describes the financial state of home care in New York as fragile after a number of years of Medicaid reimbursement cuts and with Medicare reductions – of up to 5 to 7 percent – expected to come. "Two-third of our agencies in New York have negative operating margins," she says, with 44 percent borrowing money to meet operating costs. She adds that some publicly supported county agencies have closed. "I think these are canaries in the coal mine and we're probably in for more of that and more consolidation of the market."

This reimbursement environment not only affects home health care providers but home medical equipment manufacturers and suppliers, as well. Wilson, who leads the association representing these businesses, says their challenge is "to continue to provide appropriate home medical equipment and the required services to frail Medicare beneficiaries at home in the face of years of severe cuts to reimbursement rates, which are affecting quality and access to care."

The Joint Commission's accreditation process: keeping up with rapid change

As the demands to improve patient outcomes, decrease costs and integrate technology increase for home care providers, there is an even greater need for accreditation to help organizations keep up with new advances. The Joint Commission is anticipating rapid change and is working to provide valuable assistance.

Berman says the accreditation process plays a critical role in linking providers along the care continuum – hospitals, primary care, nursing homes, pharmacy, home care and more. "Quality and cost need to be measured to determine whether or not we're getting the outcomes that we want. The accreditation process is a way for organizations to look at themselves, to look at whether or not they're providing optimal services," she states.

An analysis of Centers of Medicare & Medicaid Services' (CMS) outcomes data shows that Joint Commission-accredited home health organizations have fewer hospital readmissions after an episode of care than do non-accredited or competitor-accredited organizations.[11]

Organizations eligible for Joint Commission home care accreditation include those providing home health care, home medical equipment, hospice, pharmacy, and personal care and support services, says Margherita Labson, executive director of The Joint Commission's Home Care Program.

A focus on evidence-based approaches to care

Joint Commission surveyors do an in-depth review of the organization's patient safety and care delivery processes. They focus on areas that critically impact patient care and safety, including adherence to the 2011 Home Care National Patient Safety Goals, which identify areas where credible evidence supports that compliance leads to safer practices. These areas include hand hygiene, fall risk reduction, and identifying patient safety risks such as home fires associated with home oxygen therapy.

The surveyor traces patients' experiences with a home care organization to determine how well the staff members and leadership comply with the accreditation standards. This process includes reviewing patient records and visiting patients and staff members. These activities provide the surveyor with a realistic picture of the size and scope of the organization and the processes used to provide care and service to patients. The survey process does not only review policies but the actual implementation at the patient-centered level, Murphy emphasizes.

The surveyor also conducts an interactive discussion with the organization's leadership to explore the structures, systems and processes in place to promote safety and quality. At the conclusion of the on-site survey, the surveyor provides an exit briefing to the organization's CEO, along with a preliminary written report of observations and conclusions. These findings are sent electronically to The Joint Commission where, following a comprehensive review by central office staff, a final accreditation decision is rendered, Labson explains.

Berman says it's important for the accreditation process to continually reflect changes in how home care is delivered. "For example, there is a tremendous body of evidence around supporting a good transition," she explains, mentioning the work of a number of experts, including Mary Naylor, Ph.D., R.N., and Drs. Coleman and Williams. These experts emphasize how good transitions between settings and health care providers help the patient and family to understand how to best manage his or her condition throughout each day.[12,13] "There are so many aspects to doing a good transition, and when it goes wrong, we have serious problems," Berman emphasizes.

The accreditation process can help home health agencies, for example, foster understanding among all the providers along the care continuum of what's at stake during a care transition, she explains. "Do they all understand what happens and what's at risk for an individual when they cross from one setting or one provider of care to another, and what their responsibility is in all of that?" she asks.

Accreditation is a sign of quality both to consumers and potential partners

Cunningham says she believes that, in the near future, consumers will look for accreditation when choosing home care services. "Baby Boomers are information driven and will look for quality measurement and data and accreditation, especially if they're spending out of pocket," she states. "Accreditation is one more way for an agency to differentiate itself ... and to showcase their quality."

Earning The Joint Commission's Gold Seal of Approval™ also can be an asset for home care organizations looking to partner with health systems, physicians groups and other providers on care transition teams, accountable care organizations, and pay-for-performance initiatives. A list of Joint Commission-accredited organizations and their survey results are posted in the Quality Check™ section of The Joint Commission website at www.qualitycheck.org.

The View from 30,000 Feet – An Overview of Home Health Care

In the United States, the home care industry serves about 8.6 million patients, with needs ranging along a continuum that includes primary care, pre-acute care intervention, post-acute care services and hospice and palliative care. More than 1 million home health care and hospice employees serve these patients, as well as a home care equipment and services sector with another 250,000 employees.

To achieve optimal health outcomes for patients, home care providers must collaborate increasingly with hospitals, physicians, nursing homes, pharmacies and other providers as patients transition to and from these various care settings. Evidence shows that seamless communication, transitions and coordination among providers can improve patient outcomes.[12,14,15] New technologies, including electronic health records, help all providers to make care patient-centered and cost efficient.[16]

To facilitate more effective collaboration, the American health care system must better align incentives, reimbursements and resources across the total care continuum through a National Healthcare Quality Strategy and Plan.[17] But the devil is in the details. "The trick is how to make that vision a reality," Berman says.

Home care must develop a stronger voice

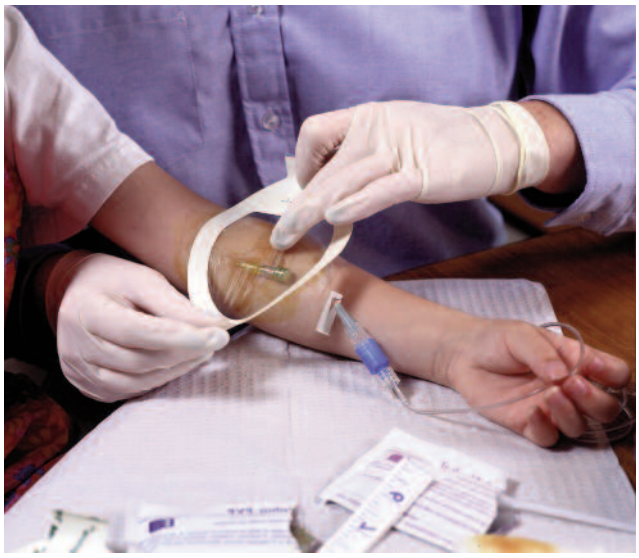
The first step toward an optimal outcome for the home care industry is to be a stronger voice at the table where health care system reform is being discussed. Wright says it's imperative for home care to be recognized for the skills and knowledge it already has. "When I'm listening to physicians and hospital administrators talk about their challenges – 'how do you stay in touch with the patient, how to you provide that level of care when you don't see the patient every day, and when you don't have control over what they're doing?' I'm raising my hand and saying 'we know how to do that – look to home care.' Our opportunity is huge. Our challenge is how do we as an industry step up and get ourselves at the health care table?"

Wilson says the American Association for Homecare is working to form a broad coalition of the various home care sector segments to present a united front to policymakers. "We don't present ourselves in a coordinated way, and we do it to our disadvantage," Wilson states. "We're portraying ourselves in segments or silos when the outside world is not looking at us in that regard. They don't get the full impression of what home care is all about."

Wright adds that the home care industry cannot wait to react to changes as they occur. "We need to become more assertive – we need to get ahead of the change," she emphasizes. "We need to be able to prove and substantiate the value that we bring."

Agreement on greater home care reliance, but consensus and funding yet to come

Wilson cites a recent Rand Corporation study commissioned by Philips Healthcare that says health care systems will have a greater reliance on home care as a rapidly aging population lives longer with chronic illnesses.[18] Health care stakeholders agree that home care technology can relieve pressure on staffing and capacity constraints, the study reports, while pointing out that consensus to successfully shift the structure of health care toward more home health must be still reached among patients, providers and payers.



Wright notes that most of the government funding to encourage this kind of change and consensus is going to hospitals and physicians, not to home care. For instance, incentives to implement electronic health records (EHRs) are not available to home care agencies. Wright says that's why it's important for home care to position itself as an important part of the value proposition that hospitals and physicians offer to patients by demonstrating how home care reduces hospitalization rates, for example. "We're adding to their value," she emphasizes.

Cunningham points to new incentives for hospitals to address the "revolving door" of patients returning to the hospital after discharge as creating opportunities for collaboration with home health agencies. Cunningham's colleague, Al Cardillo, executive vice president of the Home Care Association of New York State, says there is increased recognition of the inherent collaborative connections between hospitals, home health agencies and physicians. "Home care has been increasingly used as a way to ensure an earlier and safer discharge from the hospital and an avoidance of institutionalization in a nursing home," he says, adding that hospitals are now discharging a much more diverse patient population with more intense and acute home care needs. These patients may have had hip and knee replacements, transplants, treatment for mental illness and other conditions not associated with home care in the recent past.

These conditions are challenging home health staff to increase their knowledge of pharmacology, their technological skills and much more. Still, Cunningham says the agencies in New York are ready for the future. "It's part of a health care continuum that has been used to doing more with less," she says. "These are agencies that have been around for 100 years – they've got unbelievable commitment from staff and their leadership."

The Opportunities for Home Health Care

Demonstration projects, pilots and rebalancing initiatives are occurring across the country in an effort to improve quality and bend the health care cost curve. Cunningham says many of them can benefit from home care's expertise and experience. Some have been funded by the Affordable Care Act, which also will expand payments for primary care and promote better care coordination, integration of services and patient-focused care through system delivery reforms.

Among the more promising reform concepts are ***accountable care organizations (ACOs), medical homes and Medicare bundled payments.*** ACOs facilitate coordination and cooperation among providers to improve the quality of care for Medicare beneficiaries and to reduce unnecessary costs. The medical home is defined as a model of care where each patient has an ongoing relationship with a primary care physician or nurse practitioner who leads a team that takes collective responsibility for the patient's care. A bundled payment describes a single reimbursement from Medicare for all hospital and physician care associated with a procedure rather than separate payments.

All three of these reforms provide incentives for teamwork, as well as a framework for collaboration between hospitals, physicians, and home care and other providers. Already, for example, reforms of this nature have provided incentives for physicians to create home care physician groups that specialize in the management of patients participating in medical homes. By tying collaboration to reimbursement, CMS wants to achieve optimal outcomes cost-efficiently while offering patients comfort and convenience. "I am very optimistic that home health will be a strong partner in all of these discussions nationally and will play an important role in the accountable care organizations but, being a new effort, time will tell," Berman says.

Home care will be a 'linchpin' in National Health Care Quality Strategy

"Value represents the combination of cost and quality," Berman continues. In recognition of this equation, Kathleen Sebelius, the secretary of the Department of Health and Human Services, is leading the development of a National Healthcare Quality Strategy and Plan with the aims of making health care better and more affordable while improving the health of people and communities. "Home health organizations will be a linchpin" for this strategy, Berman says, due to their ability to help people avoid hospital readmissions, manage complex chronic disease, prevent illness and stay out of high-cost hospitals and nursing homes by remaining independent in home and community settings.

Berman says following evidence-based approaches will enable home care to contribute greatly toward achieving this national strategy, citing CHAMP program resources, led by Penny Feldman, that raise the geriatric competence of home care providers, as well as efforts by important work by Naylor, Coleman and Williams focused on how to improve care transitions. Labson says that using tools such as those provided by the Home Health Quality Improvement National Campaign and achieving disease-specific certification are also ways that organizations can begin implementing evidence-based approaches. "Consider the achievement of 'First to Care', a joint venture between Metropolitan Jewish Health System and Maimonides Medical Center, the first home care organization to become both accredited for home care and certified for heart failure through The Joint Commission," she adds.

Cardillo says when the various entities in the health care system function in an integrated, coordinated way, the results for the patient are "extraordinary improved." Home care is "the place we need to go to make all this happen – it's an opportunity to be the driver of where the system is going," he states, in partnership with hospitals, physicians and other providers.

He warns, however, that health care payers must support home care as the entire health care system becomes more dependent on what home care brings to the equation. Rather than having sophisticated or organized strategies relating to Medicare and Medicaid cost containment, he says federal and state governments often apply across-the-board cuts that achieve budget goals but create havoc within the health care system. At a time when providers are becoming more dependent on home care and are ready to accelerate the movement of patients into home care, fiscal policies are pushing back in the opposite direction, he states. It makes no sense to "cut back on home care when home care is the lynchpin in keeping people out of much more expensive hospitalizations," Cardillo says.

Initiatives of Special Interests

Focused on reducing avoidable hospitalizations and improving the management of oral medications, the ***Home Health Quality Improvement National Campaign*** is funded by CMS. Started in January 2010, the campaign has nearly half of the nation's home health agencies participating in it, says project director Shanen Wright.

These agencies benefit from resources such as the campaign's Best Practice Intervention Packages (BPIPs), which so far have covered reducing avoidable hospitalizations, medication management, fall prevention, care transitions and coordinating care across settings. The BPIPs are organized along various tracks, such as a track for leadership and others for various caregivers such as skilled nurses, therapists, medical social workers and home health aides.

In addition, the campaign works extensively with providers in settings other than in the home. He says the resources found at the campaign's website (www.homehealthquality.org) are designed to unite all home care stakeholders in multiple care settings. Materials are free to those who register, Wright says.

To set improvement targets and view rates related to the publicly reported acute care hospitalization and oral medication measures, agencies have access to a free target setting tool, the Home Health STAR (Setting Targets Achieving Results) website.

Wright and Eve Esslinger, the campaign's lead registered nurse and project coordinator, agree that the campaign is helping home care agencies, hospitals, nursing homes, physicians and other providers to better coordinate efforts for the benefit of the patient. Esslinger says she can tell many stories of progress in reaching across settings – of home health agencies working more effectively with hospitals, of hospital pharmacies getting more involved in the discharge process and medication reconciliation, and more. She specifically mentions a physician advisory group that requested that the home health agency regularly fax the primary physician a list of the patient's medications upon discharge. "That's pretty low-tech, isn't it?" she says. "It really is. But the communication that occurs and the potential to avoid a patient safety incident is huge." This communication is also consistent with The Joint Commission's National Patient Safety Goal of accurately and completely reconciling medications across the continuum of care.

Across the nation, many patient-centered medical home pilot programs are occurring. One such program is the ***New York Medicaid's Statewide Patient-Centered Medical Home Incentive Program,*** which was implemented to provide incentives for the development of medical homes to improve health outcomes through better coordination and integration of patient care. The program facilitates the use of registries, information technology, health information exchange and other means to ensure that patients obtain the proper care in a culturally and linguistically appropriate manner.

Primary care practices are assigned a level from one to three according to their level of EHR sophistication and are scored for achieving competency in the use of patient self-management support, care coordination, evidence-based guidelines for chronic conditions, performance reporting and improvement, and other measures. Practices receive incentive payments according to their scores and EHR levels, with practices at the higher EHR level of three receiving the highest possible incentive payments.

Designed by CMS with the assistance of Abt Associates, the ***Medicare Home Health Pay for Performance Demonstration*** achieved $15 million in savings in 2008 through the performance of 166 home health agencies. Starting in January 2008 and ending in December 2009, this value-based purchasing initiative showed the impact of making incentive payments to home health agencies linked to the quality of care provided to Medicare beneficiaries and to costs.

A top priority for CMS, pay-for-performance describes any reimbursement system that provides financial rewards for measured improvements of health care quality, efficiency and outcomes. Performance was measured using seven home health quality measures: reduced hospitalization; reduced emergent care; and improvements in bathing, ambulatory/locomotion, transferring, oral medications management and surgical wound status.

All Medicare-certified agencies in the seven states participating in the demonstration were invited to participate. The states – representing four regions – were Alabama, Georgia and Tennessee (South); California (West); Connecticut and Massachusetts (East); and Illinois (Midwest). The savings generated by the demonstration is being shared with 59 percent of the participating agencies: those that either maintained high levels of quality or made significant improvements in quality of care.

CHAMP (Collaboration for Home Care Advances in Management and Practice) is a national initiative to advance geriatric home care excellence that focuses on enhancing the geriatric competence of frontline nurse managers and clinicians within home care agencies across the nation.

To accomplish its mission, CHAMP developed a wide range of resources designed to help professionals to implement evidence-based approaches to home health. The resources range from checklists and risk assessments to clinical practice guidelines to presentations and peer-reviewed articles focused on problems associated with poor transitions of care. They can be found at www.champ-program.org. Access to all of the evidence-based resources on the CHAMP website, and participation in the online learning community, is free to those who register. The website also offers self-paced e-learning opportunities for a fee. CHAMP is operated by the Center for Home Care Policy & Research of the Visiting Nurse Service of New York and funded by the John A. Hartford Foundation and The Atlantic Philanthropies.

To encourage more private savings for long-term care, the Affordable Care Act established a new voluntary program through which employees can deduct premiums from their paychecks to pay for long-term care. The ***CLASS (Community Living Assistance Services and Supports)*** Act* provides in-home care – such as a home health aide, adult day care, or assisted living – to beneficiaries who become disabled. It will pay at least $50 per day -- $18,250 a year -- with no lifetime limit. Sponsors of the legislation say benefits are expected to average roughly $75 per day. The Secretary of Health and Human Services is expected to set benefits by October 2012, and then to begin enrolling workers.

*In October 2011, after this paper published, the Obama administraion announced that it would be unable to implement the CLASS Act.

"Most people don't have long-term health policies," Cunningham says, resulting in Medicaid filling the gap. The CLASS Act opens the door for more non-public support for long-term care. "There's a lot of opinions about whether or not the CLASS Act is the right model," she admits. "But if it does work, it could be a game changer."

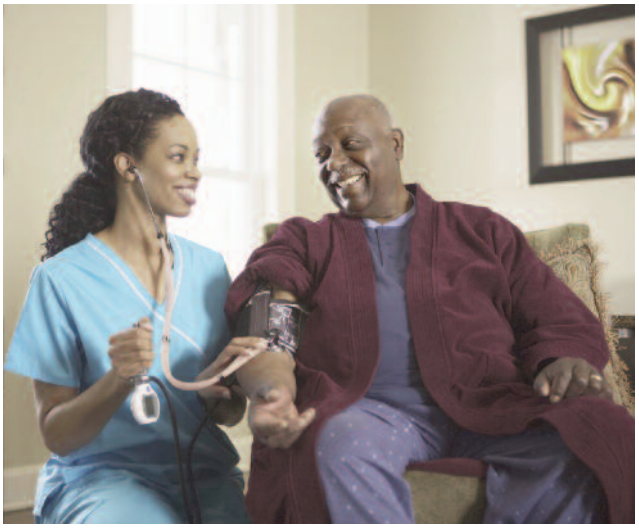
When the program takes effect in 2011, students and those below the poverty level can participate for only $5 per month. For others, the Congressional Budget Office estimated last year that monthly premiums would be about $123 and will be adjusted each year for inflation. Participants must pay premiums for at least five years before they qualify for benefits.

CMS' ***Outcome and Assessment Information Set (OASIS)*** is a group of data elements that provides an opportunity for consumers, through CMS' "Home Health Compare" program, to measure the performance and quality of home health agencies. Designed to foster improved health outcomes, the OASIS quality measures give patients, their families and health providers information about how well home health agencies perform basic activities and whether or not they have helped patients improve their ability to get around, perform the activities of daily living and avoid emergencies.

Other measures evaluate home health's performance in managing patients with conditions such as heart failure, diabetes, pain and wounds, as well as its effectiveness in providing interventions such as depression screening, immunizations, fall prevention, medication reconciliation, pressure ulcer assessment and coordinated interactions between home health professionals and physicians.

The ***Program of All-inclusive Care for the Elderly (PACE)*** supports individuals age 55 or older with chronic care needs who wish to reside at home. To participate in PACE, an individual must be screened by a team of doctors, nurses and other health professionals and be found to require that state's nursing facility level of care. If a PACE enrollee does need nursing home care, the PACE program pays for it and continues to coordinate the enrollee's care.

PACE's services include all needed medical and supportive services along the entire continuum of care, including adult day care with nursing; physical, occupational and recreational therapies; meals; nutritional counseling; social work; personal care; and respite care. Medical care is provided by a PACE physician familiar with the history, needs and preferences of each participant. All necessary prescription drugs are provided, as well as medical specialty services including audiology, dentistry, optometry, podiatry and speech therapy.



The Challenges Facing Home Health Care

As CMS continues to wield its considerable influence to increase quality and contain costs, it must be careful not to impose unnecessary burdens on home care providers and suppliers. Cardillo says there can be an excessive level of rigidity in the regulatory and programmatic structure in regard to qualifying for participation in federal government programs.

For example, certain federal provisions requiring conflict-free case management and a single point of entry run counter to initiatives promoting case management and coordination consolidation and creating multiple points of entry – structures promoted by New York state for a number of years. "The federal provisions are well-intended policies, but they impose a rigidity that is not conducive to where the system needs to go," Cardillo argues. He says even home-based community waiver requirements originally intended to make the system more flexible have become a major hindrance to a clinician providing services in a home. "We have been arguing and advocating for flexibility," he says.

Labson adds that the federal PECOS (Provider Enrollment, Chain and Ownership System) regulation requires a physician to register to be a Medicare provider of home health. While home health agencies have little control over the physician's registration or behavior, they are required to determine if the referring physician has registered with PECOS.

Competitive Bidding Program may stifle competition

Wilson says Medicare's new Competitive Bidding Program will ultimately create a less competitive landscape by causing dislocation and an alarming reduction in the number of home medical equipment suppliers. He says the program, which requires competitive bidding for nine commonly used durable medical equipment (DME) product categories, "reduces this type of home care to a commodity and overlooks the services that are integral to being able to provide the equipment."

Wilson says that he fears the program will result in a less competitive landscape, with far fewer providers. He also argues that the program will cause problems for discharge planners and case managers who had been able to work with a range of DME providers. Under the new program, they may be able to work with only a limited number of providers who have won contracts under the new program.

As DME providers face increasing cost pressures, some may look for new business opportunities that are more lucrative. For example, Wilson says DME providers may become more active in product lines – such as orthotics or prosthetics – that are not regulated by competitive bidding and are reimbursed by private insurance.

Consolidation will also affect home health agencies

The same desire to achieve cost efficiencies will affect home health agencies, Wright says, stating that health systems will see the need and demand for home health care to be incorporated into their care continuums. Strategic alignments will serve as an alternative to absorption. Recently, at a Healthcare Capital Conference, a panel presentation of hospitals and health care systems identified reluctance on the part of hospitals to absorb home care programming but that "strategic alignment" was attractive.

Wright expects this consolidation to take on various forms, from health systems forming strategic partnerships with home care agencies to small home health agencies being absorbed into larger home care organizations or chains. Wilson says home health staffing providers merging with equipment providers is even a possibility. As a result, "it will be harder and harder for an agency to be independent" in many markets, Wright says.

Raising the Bar for Home Health Care

Home health care is adapting successfully toward treating more acute conditions with advanced biotechnology. More and more, self-treatment based on self-monitoring and self-testing is becoming the norm. For example, a patient can use a PT/INR machine to monitor and self-adjust coumadin doses (as ordered by the prescriber).

For patients to have the skills and knowledge to self-manage, they must first have home health providers to train and monitor them and technology to support them. Berman says patients and families often have a limited time to work with technology during hospitalization. Home health providers can expand upon whatever training patients receive in a hospital and use techniques such as "teach back" to gain a comfort level with both self-management and technology, she says.

Telehealth improves patient monitoring

Telehealth is also helping home health providers make an impact, even when they are not physically in the home. "(Telehealth) is huge and is in its infancy," Wright says, emphasizing that telehealth enables more effective, 24/7 monitoring of a patient and the ability to predict a potential crisis and intervene before it happens. Through remote monitoring of patients via telehealth, the Visiting Nurses Association of Western Pennsylvania has reduced a hospital readmission rate of about 30 percent down to less than 10 percent, she states.

In addition to checking on patients by telephone, telehealth services may incorporate technology such as a vital signs monitoring unit for blood pressure, pulse, blood oxygen level and weight. Medication minders remind patients to take medications and, if they don't, remotely notify home health providers. PERS (Personal Emergency Response Systems) are used as a method of notifying help in case of an emergency and, for example, can be placed in the home of a patient at high risk for a fall as a preventive measure, Wright says. Patients who feel dizzy or that they may fall are able to notify home health providers, who can respond immediately, circumventing the problems that can be caused by lying unattended for hours after a fall.

Rapid advances in biotechnology have created specialty pharmacies that bring high-cost injectable, infusion or biotech drugs to home care patients. Along with the medications, specialty pharmacies often offer case management services to patients, contributing a strong knowledge of the disease associated with the drug being provided. Some pharmacies deliver medications and supplies such as needles, syringes and alcohol swabs directly to the home; offer injection training and 24/7 access to health care professionals; and coordinate with manufacturer or not-for-profit financial assistance programs. These extra services engage patients in self-care and can improve patient medication compliance, as well as the clinical outcome.[19,20]

Wright adds that even more sophisticated technology – including echocardiograms, blood sugar monitors, motion detectors that monitor for falls and routine daily activities such as eating or bathroom use, and even urine tests installed directly in the commode – are being used and developed in the home care setting.

Social media, online tools used to educate providers and form communities

The power of the Internet is also being harnessed to improve the quality and cost-efficiency of home care. The Home Health Quality Improvement National Campaign's Best Practice Intervention Packages use Webinars, recordings, PDF files, and other materials accessible online to educate home care providers. The CHAMP program was showcased at the Grantmakers in Aging national meeting in recognition of its innovative social media infrastructure, which incorporates a website with a blog, Facebook and Twitter posts, webinars, and other online tools.

Berman emphasizes that other lower-tech ways can be used in homes to prevent readmission, such as being able to e-mail a provider to get an answer to a question. She says gaining this kind of simple access is part of the notion of a patient-centered medical home. "That is an essential part of what I see of the future of telehealth as well – not just the bells and whistles and all the gadgetry – but the ability to access – in a timely way – information."

She sees these tools not only empowering providers and patients but family caregivers as well. Berman says these unpaid caregivers provide more hours of support than paid caregivers, and that home care providers can do more to help them and therefore reduce their mutual burden.

Focusing on delivering higher-value care, through evidence-based approaches

Over the last two decades, Naylor and her multidisciplinary team at the University of Pennsylvania have tested and refined the Transitional Care Model,[21] which improves health outcomes and reduces costs for high-risk older adults. Developed from evidence gained through a series of randomized controlled trials funded by the National Institutes of Health,[22,23,24] the model has demonstrated reductions in preventable hospital readmissions, improved health outcomes, enhanced patient satisfaction and reduced costs.[21]

She says the evidence points to the importance of in-person communication, collaboration and teamwork, information, management and coordination by a single clinical manager in achieving higher-value care.[12] "What's evolved consistently in our findings is how important it is to have a point person – to have someone who's on top of all that's going on, especially during episodes of acute care, to enable patients to have important conversations about goals, preferences, and values. We have the evidence of how important it is to people," Naylor says.

Two-way information flow is also critical, she says, pointing out how important it is for home care staff to have direct communication with all health care professionals who delivered inpatient care, as well as with patients' family caregivers. According to Naylor, a critical question is, "What happened during a hospitalization that is relevant to assure great continuity during the handoff?"

Naylor also says her studies and others have found that even the best, evidence-based approaches must be applied within the context of a carefully constructed and personalized plan of care for each patient. "Management is more than just coordinating or, even at its best, integrating care. It's making sure that this is the right plan of care ... that collectively the entire plan is targeting what an individual's needs are."

The overriding challenge is ensuring that the health care system, designed to deliver population health, is flexible enough to facilitate the delivery of evidence-based care to each patient. To this end, the identification and implementation of proven interventions and innovations must occur more rapidly. "We do not have the environment right now that's delivering the highest value health care to a burgeoning population of chronically ill people," she states. "I feel a sense of urgency and I think the system should feel a sense of urgency to maximize what we know to create a more efficient and effective system."

Toward creating a better health care system, The Joint Commission continues to look for ways to integrate evidence-based approaches into its standards, performance measures and National Patient Safety Goals. By implementing standards with an increased focus on communication and patient safety, Joint Commission-accredited organizations prepare themselves for the future of health care delivery, Murphy says, noting, "Using a patient-centered approach, The Joint Commission collaborates with each home care organization to improve the quality and safety of service delivery."

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