

Contents

Preface **xi**

Peter A. Boling

The Past, Present, and Future of Skilled Home Health Agency Care **1**

Rachel L. Murkofsky and Karen Alston

This article reviews the past history of home health agency care from its beginnings to the present day, evidence regarding the effect of recent changes in financing on these services, the state of skilled home health care in 2008, and a discussion of future directions. Home health care serves several million patients per year, many of whom are recuperating from acute illness episodes. Due to illness burden and Medicare funding, a large proportion of care that home health agencies deliver is geriatric care. However, home health care plays an important role for patients of all ages with significant acute and chronic illnesses. Medicare home health care suffered a significant downturn following the 1997 Balanced Budget Act and is recovering under Prospective Payment. Like most sectors of care, home health care has often operated in a “silo” but there is increasing recognition of the need to bridge care settings and provide care continuity for sick, chronically ill individuals. This is an important challenge for the future. Agencies that have strong information technology infrastructure and chronic care management systems along with a seasoned clinical workforce will be well positioned for key roles in home health care in decades to come.

The Past, Present, and Future of House Calls **19**

Helen Kao, Rebecca Conant, Theresa Soriano, and Wayne McCormick

This article describes: the origin and evolution of house calls; what is uniquely gained from house calls for both patients and providers; key clinical issues managed at home; evidence that house calls improve outcomes; organization of house call practices; and changes in Medicare reimbursement, technology, and interdisciplinary team care that have influenced the delivery of home-based medical care.

Advances and Issues in Personal Care **35**

Robyn Stone and Robert Newcomer

The focus of this article is paid personal assistant service (PAS) workers in community settings, and the converging current and future trends affecting the need to strengthen and expand the PAS workforce. A number of ways in which the federal and state governments, and the private sector can begin to solve the short and long-term workforce challenges are highlighted.

Elder Abuse and Neglect: When Home Is Not Safe

47

L. Abbey

The prevalence and seriousness of elder abuse and neglect require the collaboration of health care professionals with many other disciplines for adequate assessment and intervention. The home visit provides a unique opportunity for the visitor to evaluate risk factors. Interventions and reporting depend on available resources, expertise and local reporting laws. Possible reasons for low physician and victim self-reporting are reviewed. Domestic violence persists into late life and requires different approaches than dealing with caregiver burnout or self-neglect. Involvement of health professionals in educating others in the community about elder abuse and neglect may allow isolated at-risk elders to be identified.

Assistive Technologies in the Home

61

Kenneth Brummel-Smith and Mariana Dangiolo

Assistive technologies are critical to elders maintaining independence in the home. Adequate assessment of the patient's needs, the appropriateness of the device that need, and the patient's motivation to use of a device is required for successful outcomes. A team approach is needed to ensure that devices are correctly prescribed, and the patient is taught how to use it effectively. A wide range of devices is available to support activities of daily living, mobility, home management, and safety. The use of personal computers is significantly expanding the possibility of independent living through support systems, monitoring systems, and information resources.

Hospital at Home

79

Jennifer Cheng, Michael Montalto, and Bruce Leff

Although the acute hospital is the standard venue for treating acute serious illness, it is often a difficult environment for older adults who are highly susceptible to functional decline and other iatrogenic consequences of hospital care. Hospital care is also expensive. Providing acute hospital-level care at home, in lieu of usual institutional care, is viable. As an emerging service model, the definition of hospital at home (HaH) remains unsettled. Data favor HaH models that provide substantial physician inputs and are geared toward substituting for hospital care, provide service that is highly satisfying to patients and their caregivers, are associated with less iatrogenic complications, and are less expensive. Dissemination of HaH in integrated delivery systems is feasible. Widespread dissemination of HaH in the United States will require payment reform that acknowledges the role of HaH in the health care system.

New Diagnostic and Information Technology for Mobile Medical Care 93

C. Gresham Bayne and Peter A. Boling

Medicare reimbursement for home visits average around \$100 without ancillaries, so making 10 home visits to prevent even a single \$1,000 ambulance ride is cost-neutral for Medicare. Home medical care is only an added cost if it fails to offset acute care use. The government's demographic and financial pressure suggests a need to press ahead with the enhanced mobile care model, so the explosion in point-of-care devices should continue. The main challenge is to decide which ones provide dispositive value to patients.

Workforce Development in Geriatric Home Care 109

Jennifer Hayashi, Linda DeCherrie, Edward Ratner, and Peter A. Boling

With the rapidly aging population, it is anticipated that within two decades several million more individuals in the United States with functional impairment and serious ill health will need home health care. This article discusses workforce development, which is a critical issue for future planning, as recently highlighted by the Institute of Medicine (IOM). Key aspects of recruitment, training, and retention of home care workers are discussed, including those who provide basic support for activities of daily living as well as a variety of skilled professionals: therapists, nurses, pharmacists, and physicians. Although the geriatric workforce shortage affects all care settings, it is especially critical in home health care, in part because we are starting with far too few clinicians to meet the medical needs of homebound elderly. A combination of actions is needed, including educational programs, such as those developed by the American Academy of Home Care Physicians (AAHCP), changes in financial incentives, and changes in the culture and practice of health care, to make the home the primary focus of care for these vulnerable, underserved individuals rather than an afterthought.

The History of Quality Measurement in Home Health Care 121

Robert J. Rosati

Quality improvement is as central to home health care as to any other field of health care. With the mandated addition in 2000 of Outcome Assessment and Information Set (OASIS) and outcome-based quality improvement (OBQI), Medicare home health agencies entered a new era of documenting, tracking, and systematically improving quality. OBQI is augmented by the Medicare Quality Improvement Organization (QIO) program, which is now entering the ninth in a series of work assignments, with the tenth scope in the planning stages. Evidence has shown that applied quality improvement methods can drive better outcomes

using important metrics, such as acute care hospitalization. This article reviews key findings from the past 2 decades of home care quality improvement research and public policy advances, describes specific examples of local and regional programmatic approaches to quality improvement, and forecasts near-future trends in this vital arena of home health care.

Care Transitions and Home Health Care

135

Peter A. Boling

Transitions of care are becoming recognized as an important area for improvement in health care quality and patient safety. Yet there remains consistent evidence from multiple studies in varied settings of failures to complete safe, effective hand-offs from one location of care to the next. Major lapses include absent or limited clinical information and care plan content, plus errors related to medications. There are identifiable problems with half or more of the transitions that occur between care settings, and adverse consequences occur in 15 to 25 percent of patients. Undoubtedly these lapses contribute to the rates of re-hospitalization in post-acute care which affect 20 to 30 percent of patients within 60 days after hospital discharge. This article reviews models of transitional care intervention that have been tested and shown to be effective including less intensive coaching or guided care approaches, and more intensive case management strategies. Effective transitional care processes, linked with strong home care programs can reduce re-hospitalization by a third in some less intensive models and by half or more in some more intensive models.

Veteran's Affairs Home Based Primary Care

149

Julie Leftwich Beales and Thomas Edes

In response to the anticipated growth of the veteran population with chronic disabling diseases, the Department of Veterans Affairs (VA) established Home Based Primary Care (HBPC). This article focuses on that program, a home care program that specifically targets individuals with complex chronic disabling disease, with the goal of maximizing the independence of the patient and reducing preventable emergency room visits and hospitalizations. HBPC programs provide comprehensive longitudinal primary care by an interdisciplinary team in the homes of veterans with complex chronic disease, who are not effectively managed by routine clinic-based care. HBPC is very different from and complementary to standard skilled home care services, in population, processes and outcomes. HBPC targets persons with advanced chronic disease, rather than remediable conditions. HBPC provides comprehensive care of multiple co-morbidities, rather than problem-focused care. HBPC is delivered by an interdisciplinary team, rather than one or two independent providers. Currently operating in three-fourths of VA facilities, HBPC expansion continues to be driven by clinical success and the highest satisfaction of all VA services. VA HBPC is a model to emulate for the care of persons with complex, chronic disabling conditions, improving quality without added cost, and maximizing their

independence through comprehensive longitudinal interdisciplinary care delivered in their homes.

Independence at Home: Community-Based Care for Older Adults with Severe Chronic Illness

155

K. Eric DeJonge, George Taler, and Peter A. Boling

By most clinical and economic measures, our health care system is not providing effective or affordable care to Medicare beneficiaries with severe chronic illness. Two million elders, constituting most of the 5% who account for nearly half of Medicare costs, have multiple chronic conditions, functional disability, and average per capita costs of over \$50,000 per year. Prior reforms aimed at this population did not change the flawed delivery system, which remains centered in the doctor's office, hospitals, and nursing homes. This article describes a model of coordinated home-based medical care, called Independence at Home (IAH), which operates on a limited basis in many US communities and in the Veterans Affairs system. IAH-type teams deliver a full range of medical and social services at home to seriously ill elders and thereby reduce overall health care costs. We review the evidence that this approach can lower total costs by 25 percent or more while improving patient satisfaction and outcomes. We discuss funding for the new model, which also produces net savings for Medicare. A Medicare reform bill, called the Independence at Home Act, was introduced in the US House and Senate in 2008 to promote replication of this mobile elder care model.

Index

171