Home Health Care – An Essential Part of the Solution to America’s Health Care Challenges

Addressing the nation’s health care challenges is a key focus for the Administration and the U.S. Congress. The Alliance for Home Health Quality and Innovation (AHHQI) is eager to work with the country’s leaders to find solutions that improve quality, expand access to health care, and help control ever rising costs. As the country explores solutions to its many health care challenges, home health care is uniquely suited to play a critical role.

One specific area targeted for savings by Congress and the Administration is reducing hospital readmissions, particularly among seniors relying on Medicare. A recent *New England Journal of Medicine* study found that unplanned hospital readmissions may be costing Medicare as much as $17 billion annually. Chronic diseases, like diabetes and congestive heart failure, afflict 86% of people who qualify for Medicare, and carry high health care costs as well. A growing body of research demonstrates the value that home health care offers in controlling costs and avoiding hospital readmissions among chronic disease populations. In May 2009, Avalere Health LLC released study findings of a population of chronically ill Medicare beneficiaries and reported these results from the two-year 2005-2006 period:

- When home health was used soon after a hospital stay, there was an associated $1.71 billion savings to Medicare.
- $216 million of the savings was due to a reduction in hospital readmissions.
- The home health study population had an estimated 24,000 fewer hospital readmissions.
- The savings were seen in all of the chronic disease populations studied (diabetes, COPD and CHF), and across all levels of severity of illness.
- An additional savings of $1.77 billion could have been achieved in this same time period if other chronic disease patients had used home health care rather than other types of post-acute care.

Avalere’s research confirms what skilled home health professionals see every day in patients’ homes. Providing skilled, home health services improves healing, serves as a critical link between patient and physician, can better identify when a patient shows signs of deterioration, and often intervenes to prevent the need for hospitalization.

According to a 2009 Mathematica Policy Research study, “‘Care coordination’ is a client-centered, assessment-based interdisciplinary approach to integrating health care and social support services in which an individual’s needs and preferences are assessed, a comprehensive care plan is developed, and services are managed and monitored by an identified care coordinator following evidence-based standards of care.”

Home health care combines all of these important components, meeting people where they already are – at home – and moving them to self care management in a cost-effective, clinically-sophisticated and patient-preferred setting. The value of home health care can be evaluated for effectiveness based on measures such as rehospitalization, emergent care use, admission to other care settings, and disease progression. Specifically, the home health care practices that follow contribute to the quality outcomes and cost-savings being realized today as reflected in the Avalere study findings. Home health care plays a critical role in our nation’s health care system, and AHHQI looks forward to sharing information and serving as a resource as decision makers craft policies to improve the health care system.
Medicare Home Health Best Practices

I. Curative Skilled Care
   a. Promotes healing
   b. Provides hands-on support and education to patients and caregivers who monitor compliance with complex care regimes in the reality of a home environment

II. Restorative Care
   a. Promotes mobility, independence and endurance while adapting to new limitations
   b. Removes barriers to function and improves safety in the home

III. Transitional Care Interventions
   a. Hospitalization pre-discharge health coaching
      i. Post discharge instructions
      ii. Medication management
      iii. Symptom management
      iv. Physician visit follow-up
   b. Comprehensive in person clinical assessments with standardized data collection
   c. In-home medication reconciliation across multiple prescribers

IV. Self Management Education Interventions
   a. In-home, in-person clinical assessment of environmental, safety and social issues
   b. Teaching and training of self-management of chronic disease processes
   c. Caregiver education and interventions to promote self management

V. Coordinated Care Interventions
   a. Interdisciplinary care planning and referrals (therapy, social services)
   b. Ensure physician follow-up appointments
   c. Coordination and communication among multiple physician providers using a patient-centered and primary care physician focus

For more information about AHHQI, please contact us at info@ahhqi.org

---

\(^1\) New England Journal of Medicine, Jencks et al., “Rehospitalizations among Patients in the Medicare Fee-for-Service Program,” April 2, 2009.

\(^2\) Avalere Health LLC, “Medicare Spending and Rehospitalization for Chronically Ill Medicare Beneficiaries: Home Health Use Compared to Other Post-Acute Care Settings,” May 2009.

\(^3\) Mathematica Policy Research, “The Promise of Care Coordination: Models that Decrease Hospitalizations and Improve Outcomes for Medicare Beneficiaries with Chronic Illnesses,” March 2009.