Managing Complex Conditions in Home Health
Strategies for Improved Care Coordination, Reimbursement, and Outcomes

Kathleen Heery, RN, MS, CCM, CCP
Managing Complex Conditions in Home Health: Strategies for Improved Care Coordination, Documentation, and Outcomes

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## Contents

### About the Author

 ix

### Introduction

 Transforming the Way Care Is Delivered

 Chapter Descriptions

### Chapter 1: A Game Changer

 Changing Healthcare Environments

 Understanding How We Got Here

 Managing Complex Chronic Care for Aging Populations

 A Look at Population Health Management

 Across Organizational Boundaries: Opportunity and Teamwork

 Emerging New Models Means New Roles

### Chapter 2: Using the Same Playbook When Managing Complex Chronic Illness

 Examining Chronic Illness: Its Prevalence, Costs, and Risk Factors

 Chronic Conditions in the Home

 Managing Multiple Chronic Conditions

### Chapter 3: Lifestyle Changes for Keeping in Shape

 No Quick Fix

 Recognizing the Main Forces of Chronic Illness

 Combating the Forces of Chronic Illness

 The Role of Diet in Managing Chronic Illness
Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Role of Weight, Exercise, and Activity</td>
<td>102</td>
</tr>
<tr>
<td>Physical Activity for Patients With Chronic Illnesses</td>
<td>104</td>
</tr>
<tr>
<td>Impact of Stress on Health</td>
<td>106</td>
</tr>
<tr>
<td>Planning for Now and for the Future</td>
<td>108</td>
</tr>
<tr>
<td>Chapter 4: From Telling to Coaching</td>
<td>115</td>
</tr>
<tr>
<td>Letting the Patient Take the Lead</td>
<td>115</td>
</tr>
<tr>
<td>Evaluating Readiness to Change Behavior</td>
<td>121</td>
</tr>
<tr>
<td>Health Coaching as a Healthcare Intervention</td>
<td>123</td>
</tr>
<tr>
<td>Employing Motivational Interviewing Techniques</td>
<td>129</td>
</tr>
<tr>
<td>Pulling It All Together</td>
<td>131</td>
</tr>
<tr>
<td>Chapter 5: Maximizing Team Performance</td>
<td>149</td>
</tr>
<tr>
<td>Complex Chronic Care Management</td>
<td>150</td>
</tr>
<tr>
<td>Overcoming Multiple Challenges of Chronic Care Management</td>
<td>152</td>
</tr>
<tr>
<td>The Six Domains of Community Case Management</td>
<td>160</td>
</tr>
<tr>
<td>Establishing Cross-Continuum Teams</td>
<td>163</td>
</tr>
<tr>
<td>The 12 Commandments of Community Case Management</td>
<td>166</td>
</tr>
<tr>
<td>Dealing With Challenging Situations</td>
<td>178</td>
</tr>
<tr>
<td>Dealing With the Avoidance of Death</td>
<td>182</td>
</tr>
<tr>
<td>Chapter 6: Paying the Teams: Reimbursement Challenges</td>
<td>187</td>
</tr>
<tr>
<td>The Health and Economic Costs of Poorly Managed Transitions</td>
<td>188</td>
</tr>
<tr>
<td>From Disease Management to Chronic Care Management</td>
<td>193</td>
</tr>
<tr>
<td>Financing Emerging Delivery Models</td>
<td>196</td>
</tr>
<tr>
<td>Getting the Right Financial Prescription for Medicare</td>
<td>201</td>
</tr>
<tr>
<td>Getting the Right Financial Prescription for Medicaid</td>
<td>206</td>
</tr>
<tr>
<td>Collaboration and Integration: Blending Payers</td>
<td>209</td>
</tr>
<tr>
<td>Collaboration and Integration: Blending Provider Services</td>
<td>212</td>
</tr>
<tr>
<td>Funding Technology in Home Health</td>
<td>217</td>
</tr>
<tr>
<td>Now, and a Look Into the Future</td>
<td>219</td>
</tr>
</tbody>
</table>
Appendix: Resource Listing .......................................................... 227

I. Financial .................................................................................... 227
II. Legal ........................................................................................ 228
III. Medical/Personal Care ............................................................ 229
IV. Transportation ......................................................................... 229
V. Social and Support .................................................................... 229
VI. Community Resources ........................................................... 230
VII. Quality .................................................................................... 230
About the Author

KATHLEEN HEERY, RN, MS, CCM, CCP, is a small business owner and consultant providing community case management and homecare service support to elders, their families, and other providers. She is a certified case manager with more than 30 years of professional healthcare and eldercare experience. Heery is a founding partner of the Elder Life Care Network™ in Plymouth, Massachusetts, which is building a new model for eldercare by leveraging proven case management techniques and innovative technologies that connect and communicate with cross-continuum providers.
Introduction

A recent report by the National Research Council (NRC) stated that “Health care is returning home.” That may be, but the main reason for bringing health services back into communities is money: The continuing increases in healthcare costs are the main drivers of this change (Forum on Aging, Disability and Independence, 2015).

Landscapes have altered significantly for all healthcare providers since the passage of the Affordable Care Act. For community and homecare providers in particular, however, these changes move their work beyond the narrow world of home healthcare and into a world of cross-continuum care. From a payment perspective, every healthcare service is shifting away from a fee-for-service mindset to value-based methods, which means that home healthcare providers are now responsible for coordinating, communicating, and assisting patients with their complex and chronic care needs.

Chronic diseases, such as heart disease and diabetes, remain leading causes of death and disability in the U.S., creating functional limitations in daily living for more than 30 million people (Centers for Disease Control and Prevention, 2016). These lifestyle-related realities can neither be vaccinated against nor cured, and there is no single approach, no silver bullet, and no medication that can cure chronic illness. For that reason, although patients with chronic conditions will continue to have acute episodes of care, the overall challenge for them and their providers will be minimizing those acute care episodes and managing chronic illness situations.

In today’s healthcare environments, such chronic conditions are not only the main threat to public health and public spending but are also the greatest threat to independence and ability. The push toward aligning reimbursement and financial incentives to connect multiple services and supports continues, and the more duplicative and fragmented methods of delivering care are going away. The focus today is on outcomes (what we did, did it help or not, why, and how do we fix it), following evidence-based recommendation (i.e., avoiding gaps and variations in recommended care), and working in teams across the continuum.
Introduction

Finally, patients prefer health and healthcare services at home when they are managed well. The operative phrase here is “managed well.” While maintaining independence at home is a priority for patients who are aging or living with chronic illnesses and complex care situations, the increasing complexity and intensity of home healthcare services continues to challenge all providers.

**With all that has changed, not much remains the same**

Chronic diseases are responsible for 7 out of every 10 deaths each year, and treating people with chronic diseases accounts for 86% of our nation’s healthcare costs. Preventing chronic diseases and/or their complications is a top priority among healthcare purchasers and payers and is the driving force behind payment changes. In addition to being the biggest threats to health and independence at the individual level, chronic illnesses are also the greatest threat to economic security at government levels.

The Affordable Care Act charges Medicare with making payment and delivery reforms to improve care, slow cost growth, and forge systemwide change. With the Affordable Care Act entering its sixth year, where does home health fit in? Consider that the Medicare home health benefit, which was designed nearly 50 years ago, focused on a much younger population recovering from acute illness or injury. The acute care system set up in the 1960s does little to address the chronic care needs and conditions that exist today. Just a few decades ago, patients stayed in the hospital for weeks after an appendectomy; today, they are out in less than a week after open-heart surgery. Over the past few decades, Medicare has stretched to cover a much older population living with multiple chronic illnesses as well as social support challenges.

Today, home health has entered the era of Value-Based Purchasing (VBP) models, with pilots in nine states. The goal for home healthcare, as for every level of care, is to examine and explore more innovative models and methods to achieve the triple aim of improving the patient experience of care (including quality and satisfaction), improving the health of populations, and reducing the per capita costs of healthcare.

**Personal health management**

To a large extent, the major chronic diseases (including cardiovascular disease, diabetes, and chronic obstructive pulmonary disease (COPD)) are extensions of what people do, and do not do, in their day-to-day living. Consider that a single behavior—tobacco use—is responsible for more than 80% of deaths each year from COPD (American Lung Association, 2016). With so much chronic illness caused by behaviors, the challenge for home health care providers is not just to treat the disease but also to work with patients and families to mitigate its impact, using techniques such as health coaching and motivational interviewing.
Transforming the way that healthcare in general and home health more specifically is delivered means shifting into an overall framework that includes promoting healthy behaviors, preventing complications, engaging patients in self-managed care, executing a care management model, and improving quality. Underpinning this framework is ongoing surveillance that consistently gathers data to reach targeted outcomes.

For many years, patient education has been the cornerstone behind every homecare clinician’s actions. Yet despite the effort involved and the amount of time spent, traditional patient education approaches have not really addressed the needs of people who are chronically ill. In fact, helping people learn how to manage chronic conditions requires not only a different approach but an entire transformation in how clinicians and staff respond to patients.

**Transforming the Way Care Is Delivered**

Of the people enrolled in Medicare today, most have three or more chronic conditions (65%), half live below the poverty line, nearly one-third (31%) have a cognitive or mental impairment, and about 5% live in long-term care facilities (Cubanski et al., 2015).

To address the human and financial costs of chronic conditions, home health clinicians must support complex, high-risk patients with complicated medical and social needs. This shift to focusing not only on the medical but social needs as well requires that home health clinicians be knowledgeable about care gaps and, more importantly, how to close these gaps and reduce the overuse of care delivery services that serve no purpose.

Unfortunately, there is not a strong link between medical care provided in the home and the necessary social services and supports required for patients to remain in their homes. Therefore, home health agencies are rising to the challenges of meeting the needs and demands of these populations by exploring alternative models of care, retooling their workforces, and implementing various technologies.

These innovative changes include examining current workforce structure (i.e., current roles and future roles needed), determining its ability to provide high-quality and efficient care that promotes healthy aging, and implementing various technologies (including mobile, digital, monitoring, health information, therapeutic, and diagnostic needs) that enable and support the care of patients at home.

**Changes and challenges to the home health benefit**

With Medicare reimbursement changes driving financial change, home health services remain a critical component of integrated health systems. However, agencies need to release the old
roles and embrace a move toward value creation. The new world order now measures homecare providers on patient-level results rather than on services delivered or episodes of care. For that reason, the healthcare system is shifting from an acute care–oriented delivery model to one that is more proactive and responsive to people who are living with one or many chronic illnesses.

In recent years, the federal government has cut Medicare reimbursement for home health services, with another $25 billion to be taken out of the home healthcare system in the near future (MedPAC, 2016). Individual states are moving Medicaid recipients into managed care and accountable care organization (ACO) programs, which curtails patient care hours provided in the home. Additionally, other payers are reducing reimbursement and expecting improved care quality and better outcomes. The face-to-face challenges, audits due to fraud and abuse, and discussions around pre-authorization for home health services threaten the viability of many agencies. Finally, VBP payment models are underway in nine states, with the plan to include many more states in the next couple of years.

Given all of these pressures, today’s approach is all about managing complex cases, as care for these patients shifts to the least restrictive settings. Agencies need to examine the level of staff needed for the management of complex, chronically ill patients and stop fighting the licensure and protectionism turf wars as payments shift from individual providers to teams of care providers. Many agencies are employing community health workers to engage patients and family members in making difficult changes.

For example, care plans now focus on self-management, care coordination, information transfer, and clinical stabilization with the thoughtful use of various technologies between encounters to aid with the management of problems that arise between visits and to improve triage and the overall efficiency of care.

Trends and changes affecting the practice of home health exist on four levels: national, state, agency, and individual. Although the number of programs covered by federal and state payers has increased since passage of the Affordable Care Act, the overall arena of healthcare reimbursement remains politically charged.

**At the federal level**

At the federal level, a population health approach is driving changes, including the penetration of ACOs, with expansion into next-generation versions. Payment models now include taking on greater financial risk through shared savings, bundled payments, and global payment methods. Hospitals continue to take hits through their own VBP as well as through readmission and acquired condition penalties. Additionally, dual eligible financial alignment demonstrations continue across the country. Population health management depends upon data (integration,
analysis, reporting, and communicating) and looking at risk factors that keep patients healthy and reduce hospitalizations.

Rapid consolidation crosses all sectors and continues with unprecedented merger and acquisition (M&A) activity. Providers are becoming payers, and providers need increased scale to compete in consolidating markets. This activity drives the need to expand services, which means that smaller, independent agencies will face increasing competitive challenges as the market morphs to pay for value.

**At the state level**

State-level reforms are driving value-based care by moving Medicaid programs into ACOs and more managed care approaches. Through Medicaid waivers and programs such as Money Follows the Person (MFP), community first choices, Home and Community Based Waivers (HCBS), and Health Homes for chronic care, states remain on the forefront of innovation.

It is important to remember that not all states expanded their Medicaid programs under the Affordable Care Act. Therefore, in many states, there are patients without access to healthcare: They are not financially eligible for their state’s Medicaid program and cannot afford to purchase health insurance on the exchanges. As of January 2016, 19 states had not expanded their programs, so patients in these states fall into the “coverage gap” (Garfield, 2016).

**At the agency level**

At the agency level, home health organizations have the most opportunity to generate value. Their value isn’t based on the provision of marginal services but rather on the basis of service provision that produces health and cost outcomes directly related to the agency’s presence. Care redesign focuses on how many visits the patient really needs, not just on doing things the same way. Expanding the use of technologies as well as integrating long-term services and supports will be critical success factors.

Home health providers conditioned to operate in silos need to build cross-continuum relationships, engage in using patient engagement techniques, and determine how to share information. Success depends on looking at patient care management through the lens of the other and watching the “line of sight between the desired change and level of care capacity.” Personal health management support is the challenge for now and the future.

**At the individual level**

At the individual level, patients are taking control and are making decisions as they spend more of their personal income on rising contributions to FSA accounts as well as copays and
Introduction

coinsurances. They now want to find the best providers through online information sites, using data provided through resources such as star ratings.

However, note that at the same time that patients have more control, one in three patients is dis-engaged, reporting diminished desire for care, less commitment to prevention, a lack of interest in technology, and a lack of financial preparation, according to the Deloitte Center for Health Solutions (Deloitte, 2015).

Supporting this networking of care services requires a technology infrastructure, better business models, and organizational models that allow care to shift from solo to team-based practice. This represents the shift from institutions to mobile, home-based, and community-based care.

Chapter Descriptions

Chapter 1 examines the industry changes driving healthcare home. It includes a look back and a look forward at industry changes, such as management of complex care situations for aging populations, working across organizational boundaries, the role of population health, and expanding models and methods of care delivery.

Chapter 2 looks at chronic care management at home, including the prevailing costs and risk factors as well as the impact of managing chronic illness at home. It includes shifting to a partnership method and discusses condition-specific approaches based on a consistent methodology. It examines top conditions such as heart failure, COPD, diabetes, and dementia.

Chapter 3 examines lifestyle factors that contribute to chronic illness, as well as disease exacerbations. This chapter includes the roles of inflammation and oxidative stress, diet and nutrition, mobility and exercise, integrating mind and body health, planning, and realizing that aging itself is not a disease.

Chapter 4 reveals new methods for patient education practices that put the patient in the lead role. This chapter introduces new approaches, such as motivational interviewing, based on the idea that behavior change is the only way to manage chronic illness at home. It includes 10 changes that can help providers shift from patient education to patient engagement.

Chapter 5 examines the role as case manager in the community, which takes a more longitudinal view rather than an episodic one. Included are the six domains of community case management, along with the 20 building blocks for patients living with chronic illness.

Chapter 6 looks at changing payment models that drive the need for collaboration and changes to the Medicare and Medicaid programs, including integrating providers and payers into changing models and merging acute care services with long-term services and supports.
Appendix includes resources that cross the main domains of community and homecare case management.

References


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Home health patients with chronic, complex conditions present care coordination challenges that are hard to overcome without proper understanding and training. Poor coordination and planning for these patients can result in poor patient outcomes, rehospitalizations, poor star ratings, and lower reimbursement. Managing Complex Conditions in Home Health is a complete manual through which staff can prevent declines and adverse events with sound patient planning, while ensuring reimbursement and positive outcomes for their home health agency. This manual discusses multiple payer and reimbursement solutions, frontline clinical care techniques for chronic disease management, care coordination strategies, and patient engagement for lifestyle and behavioral changes.

This book will help your home health agency:
- Cut down on hospital readmissions
- Obtain accurate reimbursement
- Avoid adverse events
- Improve patient outcomes