The Role of Home Health in Managing Serious Illness

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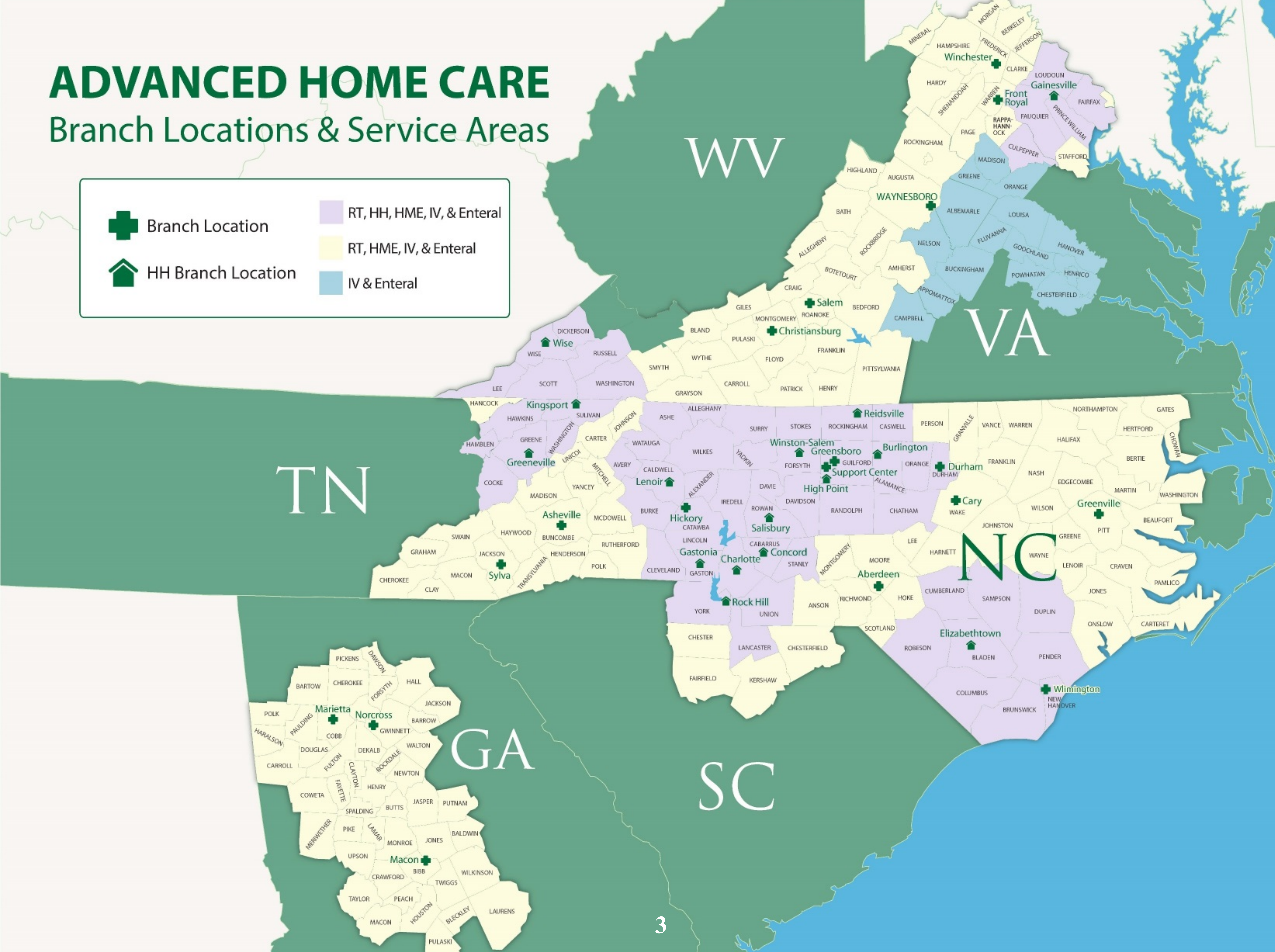
Advanced Home Care, Inc.
Membership Structure
April 1, 2019

Member	Membership Percentage
Ballad Health	5.498%
Mountain Care	0.909%
CaroMont Health	2.315%
Cone Health	34.725%
UNC Health	16.829%
ANC Healthcare	5.645%
Navicent Health	0.917%
Novant Health	23.371%
UNC Rockingham	1.180%
Valley Health	2.787%
Vidant Health	3.882%
WellStar Health System	1.942%

Advanced Home Care
501 (c) (3)
509 (a) (3)



ADVANCED HOME CARE
Branch Locations & Service Areas
Branch Location
HH Branch Location
RT, HH, HME, IV, & Enteral
RT, HME, IV, & Enteral
IV & Enteral
WV
VA
TN
NC
GA
SC
Winchester
Gainesville
Front Royal
WAYNESBORO
Salem
Christiansburg
Wise
Kingsport
Greeneville
Asheville
Sylva
Reidsville
Winston-Salem
Greensboro
Burlington
Support Center
High Point
Durham
Cary
Greenville
Lenoir
Hickory
Salisbury
Gastonia
Charlotte
Concord
Rock Hill
Aberdeen
Elizabethtown
Wlimington
Marietta
Norcross
Macon
MINERAL
HAMPSHIRE
MORGAN
BERKELEY
JEFFERSON
FREDERICK
CLARKE
HARDY
LOUDOUN
FAIRFAX
SHENANDOAH
WARREN
FAUQUIER
PRINCE WILLIAM
RAPPA-HANN-OCK
PAGE
ROCKINGHAM
CULPEPPER
STAFFORD
MADISON
GREENE
ORANGE
HIGHLAND
AUGUSTA
BATH
ALBEMARLE
LOUISA
ALLEGHENY
ROCKBRIDGE
NELSON
FLUVANNA
GOOCHLAND
HANOVER
BOTETOURT
AMHERST
BUCKINGHAM
POWHATAN
HENRICO
CRAIG
APPOMATTOX
CHESTERFIELD
GILES
ROANOKE
BEDFORD
MONTGOMERY
CAMPBELL
BLAND
PULASKI
DICKERSON
RUSSELL
WYTHE
FLOYD
FRANKLIN
PITTSYLVANIA
SMYTH
SCOTT
WASHINGTON
LEE
CARROLL
GRAYSON
PATRICK
HENRY
HANCOCK
SULIVAN
HAWKINS
ALLEGHANY
ASHE
SURRY
STOKES
ROCKINGHAM
CASWELL
PERSON
GRANVILLE
VANCE
WARREN
NORTHAMPTON
GATES
HERTFORD
CHOWAN
JOHNSON
HAMBLEN
GREENE
CARTER
WATAUGA
WILKES
YADKIN
FORSYTH
GUILFORD
ORANGE
ALAMANCE
FRANKLIN
HALIFAX
BERTIE
NASH
EDGECOMBE
MARTIN
WASHINGTON
UNICOI
AVERY
CALDWELL
MITCHELL
ALEXANDER
DAVIE
COCKE
MADISON
YANCEY
IREDELL
DAVIDSON
ROWAN
RANDOLPH
CHATHAM
WAKE
WILSON
PITT
BEAUFORT
BURKE
CATAWBA
MCDOWELL
HAYWOOD
BUNCOMBE
SWAIN
JOHNSTON
GREENE
LINCOLN
CABARRUS
RUTHERFORD
GRAHAM
JACKSON
HENDERSON
LEE
HARNETT
MOORE
MONTGOMERY
WAYNE
LENOIR
CRAVEN
PAMLICO
STANLY
CLEVELAND
GASTON
POLK
TRANSYLVANIA
CHEROKEE
MACON
CLAY
CUMBERLAND
SAMPSON
JONES
HOKE
RICHMOND
ANSON
YORK
UNION
DUPLIN
ONSLOW
CARTERET
SCOTLAND
CHESTER
LANCASTER
CHESTERFIELD
ROBESON
BLADEN
PENDER
FAIRFIELD
KERSHAW
COLUMBUS
NEW HANOVER
BRUNSWICK
PICKENS
DAWSON
BARTOW
CHEROKEE
FORSYTH
HALL
JACKSON
POLK
PAULDING
COBB
GWINNETT
BARROW
HARALSON
DOUGLAS
DEKALB
WALTON
CARROLL
FULTON
ROCKDALE
CLAYTON
NEWTON
COWETA
FAYETTE
HENRY
BUTTS
JASPER
PUTNAM
SPALDING
MERIWETHER
PIKE
LAMAR
MONROE
JONES
BALDWIN
UPSON
BIBB
CRAWFORD
WILKINSON
TWIGGS
TAYLOR
PEACH
HOUSTON
BLECKLEY
LAURENS
MACON
PULASKI

Services We Provide

Home Health Services

Respiratory

Infusion Therapy

Durable Medical Equipment (DME)

Disease Management (Nutritional & Respiratory Care Teams)

Home Health Patient Population

- Home health volume:
  - Home health patients served FY 2018 = 27,037
  - Home health visits performed FY 2018 = 547,419
- Length of stay:
  - Average length of stay FY 2018 = 46.6 days
- Age:
  - Average age at admission FY 2018 = 72 yo

Home Health Patient Population Served

- Circulatory System
- Injury & Poisoning
- Respiratory System
- Other Abnormal Findings
- Nervous System
- Musculoskeletal System
- Endocrine & Metobolic
- Neoplasms
- Digestive System
- Skin Diseases
- Genitourinary System
- Infectious Diseases
- Aggregated INS MDC's

22.8%
13.5%
13.4%
9.9%
7.3%
6.8%
5.6%
5.5%
5.4%

Source: Excel Health Home Health Diagnostic Breakdown

Home Health Patient Population Served

Hospitalization Risk Factors

Risk for Hospitalization: Which of the following signs or symptoms characterize this patient as at risk for hospitalization? (Mark all that apply.)	You				SHP Multistate		SHP National	
	Patients Identified at SOC/ROC		Patients Identified & Hospitalized		Patients Identified at SOC/ROC	Patients Identified & Hospitalized	Patients Identified at SOC/ROC	Patients Identified & Hospitalized
	#	%	#	%				
History of falls	**6,269**	**23.7%**	**1,361**	**21.7%**	33.4%	24.1%	32.1%	23.7%
Frailty indicators	**16,736**	**63.3%**	**4,373**	**26.1%**	40.5%	26.5%	44.4%	26.0%
Unintentional weight loss	1,898	7.2%	587	30.9%	8.5%	31.3%	8.6%	31.4%
Currently reports exhaustion	16,207	61.3%	4,242	26.2%	36.3%	26.2%	40.5%	25.8%
Unspecified*	7	0.0%	2	28.6%	0.0%	53.9%	0.0%	49.0%
Multiple hospitalizations	**9,079**	**34.3%**	**3,088**	**34.0%**	32.8%	35.1%	32.7%	34.4%
Decline in mental, emotional, behavioral status	**2,405**	**9.1%**	**644**	**26.8%**	15.7%	27.1%	16.1%	27.1%
Currently taking 5 or more medications	**25,514**	**96.4%**	**5,887**	**23.1%**	92.8%	23.7%	91.4%	23.4%
Other	**15,153**	**57.3%**	**4,038**	**26.6%**	49.4%	28.0%	51.0%	27.2%
Multiple emergency dept visits	6,564	24.8%	2,190	33.4%	27.2%	34.9%	26.2%	34.2%
Difficulty complying with medical instructions	4,780	18.1%	1,302	27.2%	18.7%	27.3%	19.4%	27.4%
Other risk(s) not listed	9,921	37.5%	2,488	25.1%	21.0%	23.2%	23.7%	23.2%
Unspecified*	3	0.0%	1	33.3%	0.0%	39.4%	0.0%	50.5%
None of the above	**173**	**0.7%**	**10**	**5.8%**	1.7%	8.5%	2.0%	8.5%

*Frailty indicators and Other risk factor breakouts not supported in OASIS-C

Source: Strategic Healthcare Program (SHP)

Home Health Comprehensive Assessment: Addressing Serious Illness

New Advance Directive

Patient:	**House, Account Bob**		
Patient ID:	**00035348**	**SOC: 02/19/2018**	**Discharge:**
Admit ID:	**00490098**	**DOB: 04/04/2005**	**Adm Type: CT**

Directive: Advance Care Plan

Physician ID: Search

Date executed: 6/4/2019

Preferences

- ☐ Medical Treatment
- ☐ Mental Health/Behavioral Treatment
- ☐ Cultural/Social
- ☐ Spiritual/Religious

Discussion Outcome (choose one, if applicable)

- ☐ Discussed but did not wish to provide advance care plan
- ☐ Discussed but was unable to provide advance care plan
- ☐ No discussion related to advance care plan

Memo:

Ok Cancel

Source: Netsmart electronic medical record of Advanced Home Care

Managing Patients with Serious Illness in the Home

- Proactive protocols
- Integrated care models
- Action plan
- Provider Access

Home Health Staff Resources and Partnerships

- Acuity based care
- Home health trigger tools
- Social work services
  - Social work navigation
  - Social work home visits
- Home and community based hospice and palliative care partnerships
- Collaborative staff education events
- Interdisciplinary care conferences

Home Health Transitional Screening Template

Resources Screening Questions

Would you be surprised if the patient died within the next year?

Has the patient received a palliative care consult? ☐ YES ☐ NO If YES, which agency:

Which Advance Directives does the patient actively have in place:
☐ Medical Power of Attorney ☐ Financial Power of Attorney ☐ Living Will ☐ Legal Guardian ☐ DNR ☐ NO ADVANCED DIRECTIVES

Does the patient have a MOST form? ☐ YES ☐ NO If YES, can we have a copy? ☐ YES ☐ NO

Source: Advanced Home Care's Advancing You Home Case Conference Template

ADVANCED HOME CARE

Advanced Home Care Has Partnered with Carolina Caring

&

Carolina Caring

Advanced Home Care

Successful Patient Outcomes Through Collaboration

Carolina Caring offers a community-based palliative medicine program that cares for patients in 12 counties of western North Carolina. Advanced Home Care is a not-for-profit, hospital-affiliated company that operates over 30 branch locations in 5 states. They service over 40,000 patients each day making them one of the largest Medicare/Medicaid-certified home care organizations in the Southeast. With Carolina Caring and Advanced Home Care both participating in innovative models with CMS in 2016 (CMMI and BPCI), they were eager to integrate their care to identify and measure the impact on patients served. Both organizations are recognized within the community for providing high quality of care. Through the Carolina Caring-Advanced Home Care collaboration individuals have shown significant improvement in quality of life, satisfaction with the services being provided, and the ability to successfully remain at home.

Objective: CC and AHC believed coordinating home health and community-based palliative care services would improve the health of populations, reduce the overall cost of healthcare, enhance the patient experience of care and improve the experience of health care providers.

Palliative Care

Hospice Care

As patients are served throughout the continuum of care there is a consistent, replicable focus on improved outcomes for patients and community providers.

Summary:

To date, CC and AHC have collaboratively served over 400 patients across 11 counties in North Carolina. We continue to identify strategic partnership opportunities to expand on delivery of care. Our programs have expanded from home-based to community-based to the integration of clinic locations. Through the success of our partnership, we have used our learnings to replicate positive outcomes with other networks across the full continuum of care (i.e. ACOs, collaborative networks, and payor source pilot programs.)

WWW.CAROLINACARING.ORG

Primary Diagnosis- All Referrals

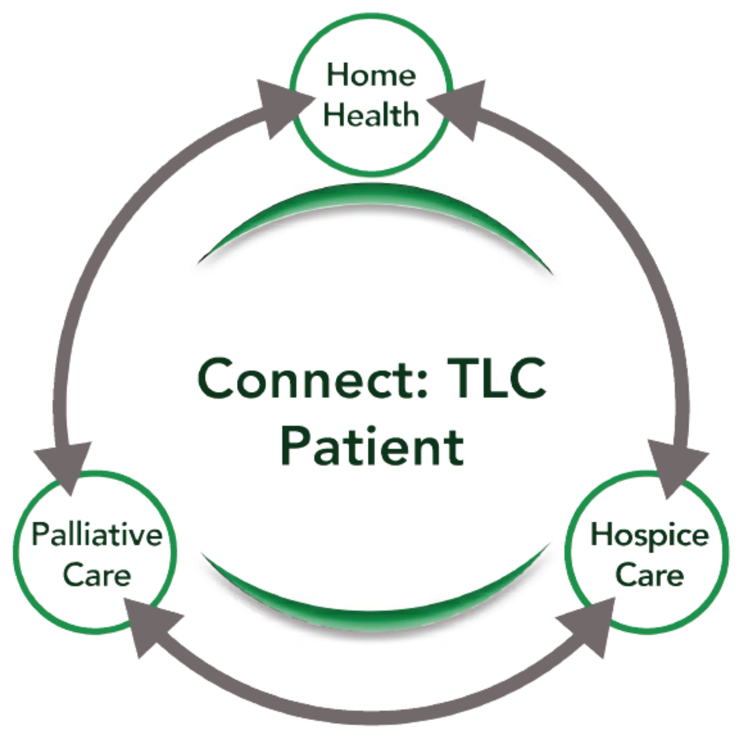
(November 2016- May 2018)

Volume Per Primary Diagnosis

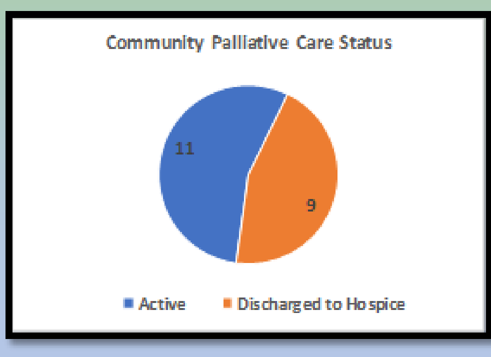
COPD	CHF	CANCER	NEURO	COMPLEX MEDICAL
184	150	31	48	64

Source: Advanced Home Care and Carolina Caring partnership data

Connect: Transitions and Life Changes (TLC)

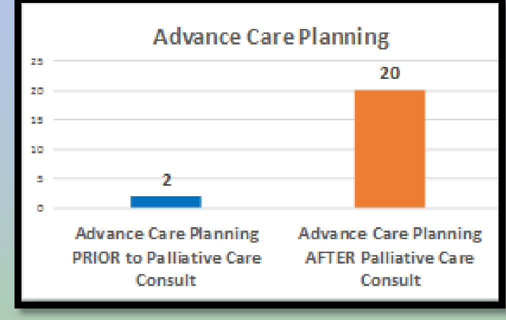


Palliative Care Patient Disposition



- 9 out of 20 patients have discharged to hospice
- 100 % conversion rate for patients discharged from palliative care program to hospice care program at HPCG
- 3 out of 9 patients admitted to the HPCG Hospice Program have expired

Advance Care Planning



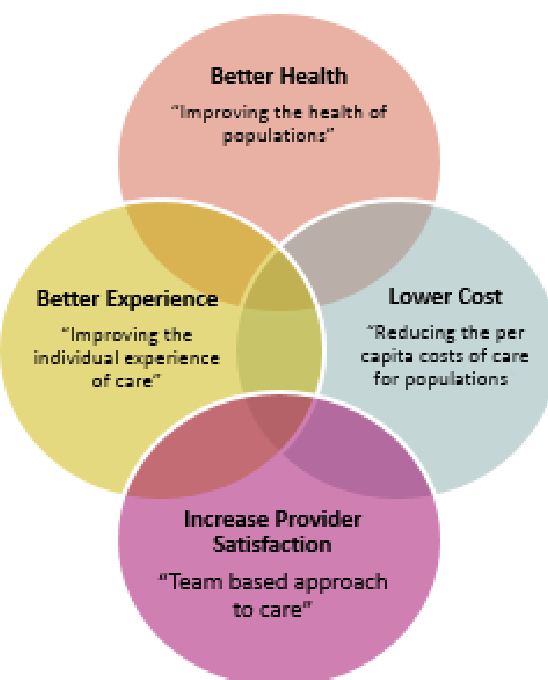
- ***10%*** of the patients had an Advance Care Plan in place prior to the Palliative Care Consult
- ***100%*** of the patients had an Advance Care Plan in place after Palliative Care Services provided

Palliative Care & Home Health Clinical Collaboration Outcomes

March 1, 2018- May 31, 2018

Serious Illness and the Impact on Home Health Outcomes

- Quality of Care Star Rating
- Value Based Purchasing
- Home Health Compare
- High Quality Network Provider



Impact of Home Health Services: 30 Day Readmissions

- Over the course of one year, 11 facilities across North Carolina had > 1,500 patients coded at facility discharge for home health service needs
  - 30 % of those coded for home health services were not admitted to care by a home health agency within 30 days of facility discharge

- Rising Risk for Readmissions

Percentage of 30 Day Readmissions

	State Average- North Carolina	State Average- South Carolina
Patients admitted to Home Care	14.6%	13.80%
Patients not admitted to Home Care	23.0%	22.20%

Source: Excel Health. Data based on claims for July 2017 to July 2018. Accessed on February 13, 2019

Questions

Allowing older patients to age in place…