How Two Practices Partner with Home Health to Better Serve Their Patients

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To succeed in value-based care, practices need to help patients get the right care at the right time in the right setting. At Aledade, we help practices do just that by reducing unnecessary emergency department (ED) use, improving care coordination with specialists, and managing chronic conditions.

Another way we improve quality is by engaging home health providers as key partners. Home health care accounts for eight to ten percent of total spending across our ACOs.

A primary care physician (PCP) can order home health for a patient in a hospital or another setting. Every 60 days after that, the physician needs to recertify the services as medically necessary for the patient. In the past, PCPs had limited insight into home health quality. They might not know when patients started home health care. They might not have clear communication during the recertification (or recert) process. This often leads to significant care gaps, and risks for the patient.

Our partner practices in Arkansas grew frustrated with the recert process, so they decided to revamp it. When a home health agency submits a recert request to the PCP, the practice's care manager reviews it right away. The care manager checks if the patient is improving, and calls the home health agency to learn more. The office then schedules the patient for an appointment to review their progress towards their health care goals. Together, the PCP and the patient decide if the patient should continue with home health care. Sometimes another service, like Chronic Care Management, social support, transportation, or education, is more appropriate.

One patient in the Arkansas ACO had received home health services for diabetes management for more than a year. Both the patient and the PCP were frustrated. The patient's A1C hadn't improved and their ED utilization had increased. The practice stopped home health, and enrolled the patient in an in-office diabetic education program. There, the patient learned about triggers and how to manage insulin levels. The patient was also able to meet with the practice's nutritionist for help with planning groceries and meals.

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According to the team at Dr. Walker's Clinic in De Queen, Arkansas, the new home health workflow ensures the

We have a nurse that manages this population and meets with our home health agencies bi-weekly to discuss goals, recerts, and discharges."

In West Virginia, our partner practices worked with home health agencies to reduce preventable admissions and readmissions. The home health agencies created a Collaborative Performance Review. They identify the hospital utilization of home health patients and find out how many hospital admissions were readmissions. They also look at patients who screened positive for depression, falls risk, and ED overutilization. This summary finds gaps in patient care, showing how the practice could have prevented a patient's admission or readmission.

All of this starts with a question: "What information from would be most helpful when making a recert determination?"

According to Dr. Tom Bowden of Charleston Internal Medicine in the Aledade West Virginia ACO:

"The transition from hospital to home is a critical step in the well-being of our patients. Partnering with home health agencies that can assist us in this process is vital. Finding the home health agencies that are willing to work with us, make changes, provide the care our patients need and track quality metrics will certainly help reach the triple aim of improving health outcomes, improving the patient experience and lowering health care costs."

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By focusing on this question, we've developed a form for home health agencies. We found home health agencies were eager to provide the necessary information, as were the PCPs. This summary, and the conversations that came with it, are still in the early stages. However, we expect that more communication will identify the most necessary recerts.

Better home health care means patients get the right, high quality care. We work with our home health partners to transition patients from skilled nursing facilities, nursing homes, and hospitals safely and sooner when possible. Home health also helps to proactively keep high risk patients safely out of the hospital. This requires close partnerships with home health agencies, and the communication to paint a full picture of the patient's health. Armed with this, Aledade's partner practices can ensure their patients get coordinated care in the right place at the right time.