Improving Care Transitions: Implementation of a Hospital-Based Home Health Agency

By

Dawn Welch

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We hereby recommend that the Final Project submitted by: **Dawn Welch**

Entitled: **Improving Care Transitions: Implementation of a Hospital-Based Home Health Agency**

Be accepted in partial fulfillment of the requirements for the degree of Master of Healthcare Administration.

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We certify that in this Final Project all research involving human subjects complies with the Policies and Procedures for Research involving Human Subjects, Saint Mary-of-the-Woods College, Saint Mary-of-the-Woods, Indiana 47876

Abstract

The aim of this paper is to outline improvements in the transition of care from the hospital setting to the community setting and to suggest initiatives to improve the level of support aiding in the successful transition of care. Improvements in medical care have helped increase the life expectancy of Americans. It is expected by 2030, 20 percent of the American population will be 65 or older, meaning close to 71 million people. This suggests that more Americans are and will be dealing with added chronic conditions. Research has indicated that collaboration along the continuum of care is essential for a successful transition of care from the acute hospital setting back to the patients' previous setting. This paper focused on the formation of a hospital-based home health agency to care for the patients being discharged from one critical access hospital back to their previous setting of home as an intervention for a successful transition.

Keywords: Accountable Care Organizations, care coordination, continuum of care, home health, hospital discharge, hospital-based home health agency and transition of care.

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The older population in the United States is growing at a fast pace. "People aged 65 years or older represented roughly 13.1% of the population in 2010" (AoA, 2011). This percentage is estimated to increase to approximately 20% by the year 2030, which will represent 71 million older Americans (Zakrajsek, Schuster, Guenther, & Lorenz, 2013). Life expectancy of the American population has also increased with the improvements in medical care. The improvements in medical care mean that more and more Americans are experiencing chronic diseases and degenerative illnesses. "More than a quarter of all Americans and two out of every three older Americans have multiple chronic conditions, and the treatment for this population accounts for 66% of the country's health care budget (Centers for Disease Control and Prevention, 2013). The CDC also notes that people with multiple chronic conditions have an increased risk for adverse drug effects, avoidable hospitalizations, and unnecessary and duplicate tests (2013). With the increase in the older population who have chronic and comorbid conditions, the transition of care from the acute care hospital setting to the home is increasingly more challenging. The aim of this capstone project is to develop an improved level of support to aid in the successful transition of care along the continuum.

Background

The focus of this capstone project is to improve care transitions through the implementation of a hospital-based home health agency in Paris Community Hospital (PCH). PCH is a critical access hospital in east-central Illinois, 25 miles from Terre Haute, Indiana. The hospital is a 25-bed facility, certified as a critical access hospital in accordance with Centers for Medicare and Medicaid Services (CMS) guidelines. These guidelines also mandate an annual average length of stay of 96 hours or less, and a maximum of 25 patients; either acute inpatients or observation patients at any one time, not include the emergency

department. The average length of stay for patients in the acute care setting at Paris Community Hospital in 2016 was 2.6 days. This short length of stay creates a challenge to ensure patients have adequate education and post-discharge support to prevent readmissions and returns to the emergency department (ED). The readmission rate to inpatient status was 8% in 2017.

Centers for Medicare and Medicaid Services in response to the implementation of the Patient Protection and Affordable Care Act (ACA) of 2010, moved to develop a strategy that would align quality, safety and cost reduction for the beneficiaries. This strategy is known as the "Triple Aim". Whittington, Nolan, Lewis, & Torres cite "in 2010 the Triple Aim became part of the US national strategy for tackling health care issues with the inception of the ACA" (2015). In conjunction with the Triple Aim came the development of Accountable Care Organizations (ACO). The goal of ACO's is to "provide higher-quality of coordinated care to their patients while helping to slow healthcare cost growth" (IRCCO, 2017). The incentive for joining an ACO is the shared dollars that can be generated by decreasing the amount of Medicare dollars spent on the Medicare beneficiary unnecessarily due to uncoordinated care. To qualify for this shared savings payout, the ACO must meet specified quality targets as a whole entity (IRCCO, 2017). Paris Community Hospital became a member of an Accountable Care Organization (ACO); Illinois Rural Community Care Organization (IRCCO) was formed by the Illinois Critical Access Hospital Association in 2015. IRCCO consists of 24 critical access hospitals (CAH) throughout Illinois.

Health care is ever-changing and now the challenge is to provide quality care at lower cost while preventing readmissions and returns to the emergency room for unnecessary reasons. The transition of care from one setting to the next has been recognized as the period to optimize

the available resources from the acute setting to the post-acute care providers in the community. The transition of care is encouraged in the Affordable Care Act of 2010 "through its focus on reducing 30-day hospital readmission rates" (Kessler, Tsipis, Seaberg, Walker, & Andolsek, 2016). Care transitions occur when patients move along in the continuum of care. The continuum of care is the never-ending circle of health encounters of a person from birth to death which includes all of the health-related encounters, hospitalizations, care by primary physicians and specialist. This can be viewed as an ongoing process including both illness and wellness with care transitions happening perhaps many times in this endless cycle moving the patient from one setting to the next appropriate setting (Cesta, 2017).

Utilizing the quality framework of Plan-Do-Check-Act Paris Community Hospital has changed the way a discharge from the inpatient unit or the emergency department (ED) is handled. PCH has implemented four different interventions to decrease the readmission numbers and the use of the ED for unnecessary visits. These interventions were implemented one at a time as a performance improvement initiative upon evaluation of the transition of care process to home.

The first intervention was to start follow up phone calls on all discharged patients and ED patients. Phone calls to newly discharged patients within the first 48 hours are important to assess the patient's initial ability to comply with discharge instructions and obtaining prescriptions. The call is able to ascertain if the patient has filled the prescriptions that were prescribed, if there are any questions concerning the discharge instructions, and if the patient has a way to get to the follow-up appointment with their primary care provider. According to Soong et al. (2014), follow-up phone calls are just one component of a discharge bundle to prevent readmissions. The second intervention was implementing nurse practitioner visits in the local

nursing homes that utilize Paris Community Hospital. A nurse practitioner is able to assess and treat changes in the patient's condition in the nursing home earlier, possibly avoiding a return to the ED or a readmission. The third intervention was to form a care coalition to meet with outside providers, extended care facilities, home health agencies and assisted living facilities. Developing an open working relationship with partners along the continuum of care is imperative for improved communication and working together to fully benefit the patient. The care coalition is held quarterly with participants discussing the wins of the previous quarter and to identify what could have been improved. The fourth intervention started in July 2017, is the nurse navigation program. The nurse navigator is a registered nurse is assigned to the ED to assess and assist with the patients that utilize the ED frequently or that are sent to the ED from post-acute care providers. Another focus of the nurse navigator is to also follow the patients that are readmissions. The purpose of focusing on readmissions by the navigator is to determine why the readmission occurred and are there any interventions on the hospital side that could be implemented to prevent this from occurring. The nurse navigator also follows those patients at risk for readmission for 30 days post discharge. These patients are identified by diagnosis, and/or who have had a previous readmission in the last 30 days. The follow-up is accomplished by two home visits by a navigator, one within 48 hours of discharge and one visit made at the end of the 30 days tracking period. Communication with the patient continues for the 30 day period with telephonic contact following the first home visit. Home visits can also be a way to determine medication safety and adherence by reviewing all prescription and over-the-counter products in the household. Kripalani et al. note that "close follow-up of at-risk or elderly patients after discharge can help to minimize hospital readmission and total health care costs" (Kripalani, Jackson, Schnipper, & Coleman, 2007).

The four interventions that are being utilized by Paris Community Hospital are making an impact in decreasing the numbers of readmissions and returns to the ED. However, to be in line with the required benchmarks for shared savings with the ACO, the returns to ED and readmission numbers still need to be lower. The patients with comorbid conditions are the ones that are more likely to return to the ED or to be readmitted (Russell, Rosati, Sobolewski, Marren, & Rosenfeld, 2011). A safe transition plan from hospital to home even with the current interventions in place at PCH needs to be enhanced to provide a more controlled transition with greater involvement with the primary care provider. The need for a home health agency that has a vested interest in the patients of PCH has become an increasing priority given the ever-changing healthcare environment.

Problem Statement

Despite the transition of care initiatives in place to aid in this process, patients are readmitted or sent to the ED even when home health services are being utilized. It is considered the majority of these issues could be addressed in the home by the home health agency. Effective communication among providers in the transition process is imperative to decrease the percentage of adverse events and in turn, decrease the number of returns to the hospital. There have been issues identified with home health care which are related to the communication of instructions during the transition from one setting to the next. Readmissions and returns to the emergency department of patients who have a home health agency providing care post discharge are found to have an adverse event involving medication 20-33 percent of the time (Roamagnoli, Handler, Hochheiser, 2013).

Literature Review

A scholarly search was conducted to select the most relevant articles related to the following: the transition of patients to home from the hospital setting, home health benefits to prevent readmissions, and care coordination during the transition to home. The search was initiated using electronic databases CINAHL and MEDLINE, and websites. The searches for literature used keywords including accountable care organization, home health, hospital discharge, care coordination, the continuum of care, and care transition. The original search yielded 2,572 articles. The search was further narrowed by selecting academic journals or articles with abstract and full text available. The time period searched was from 2010 through 2018. The topics relevant to this project are placed in categories for the literature review.

Transition of Care

The transition of care has been defined as a "complex and compromising period in the management of a patient" (Abrashkin, Cho, Torgalkar, & Markoff, 2012). Transitional care presents many opportunities to hospitals and community-based organizations to improve the quality of care to patients with complex diagnosis and/or complex needs (Russell, Rosati, Sobolewski, Marren, & Rosenfeld, 2011). In 2011, approximately "20 percent of all Medicare-fee-for-service patients (traditional Medicare) were readmitted within 30 days following discharge, and up to three-quarters of these readmissions may have been avoidable" (Abrashkin, Cho, Torgalkar, & Markoff, 2012 p. 535). Several components have been identified to affect the success of the transition process from the hospital back to the community. These patient-specific components are patient safety and the compliance (Abrashkin, Cho, Torgalkar, & Markoff, 2012). Another component to a successful transition of care is communication of information that is relevant, timely, and accurate (Ryvicker et al., 2013). Communication with the primary

care provider is imperative to ensure successful care transitions, especially with those patients who have chronic illnesses and comorbid conditions (Abrashkin, Cho, Torgalkar, & Markoff, 2012). Support to the family and patient is also a component of success to the transition of care. Patients and their family members or other support system need to have open communication of what the needs of the patient are and will be at home, the expectation of the family and/or caregivers. If the level of care is not understood by all involved, the communication between the case manager coordinating services needs to reinforce explaining the needs of the patient and the magnitude of care (Zakrajsek, Schuster, Guenther, & Lorenz, 2013). Appropriate post-discharge support "can improve the quality of care, reduce hospitalizations, and decrease healthcare costs" (Ryvicker et al., 2013). The transition from acute care to the community setting is more likely to succeed if the communication is open and collaborative (Hospital Case Management, 2014). A study conducted by Russell, Rosati, Sobolewski, Marren, and Rosenfeld (2011) suggest "patients who receive transitional care in conjunction with a home healthcare agency are significantly less likely to be readmitted to the hospital."(p.21). There is supporting evidence for the use of "evidenced-based initiatives addressing transitional care and chronic disease management in the home healthcare setting" (Russell, Rosati, Sobolewski, Marren, & Rosenfeld, 2011. p. 21).

Identified barriers to a successful transition of care have been identified to be lack of coordination, collaboration, and communication among the hospital and the community-based providers (Zakrajsek, Schuster, Guenther, & Lorenz, 2013). Poor coordination of care during the discharge process from the hospital back to the community setting has been linked to returns to the ED and re-hospitalizations (Ryvicker et al., 2013). The Affordable Care Act of 2010 has outlined penalties for hospitals with unacceptably high readmission rates for both Medicare and Medicaid patients (TJC. 2012).

There are several models to improve the transition of care that are evidenced based. One such model is Project BOOST which stands for Better Outcomes for Older Adults through Safe Transitions, it is a model that focuses on the hospital to home transition. The focus population is only Medicare beneficiaries. This model for the transition of care improvement has been endorsed by the Illinois Hospital Association and utilized in 31 CAH in the state of Illinois (Distel, Casey, & Prasad. 2016).

Home Health

Home health care is a valuable service that helps patients to stay healthier, reduces cost, and helps the patient avoid hospital and long-term care stays (Romegnoli, Handler, & Hochheiser, 2013). Patients are discharged from the acute care setting, where the environment is structured and there are numerous professional disciplines to assist the patient with or perform their care for them, to the home setting. In the home, there is not a structured medical environment and the caregivers are often informal caregivers such as family or friends. The patient is expected to be engaged in their care and manage their medical conditions on their own or with assistance from family or friends. Additional support from a skilled home health care agency may be crucial for patient success in certain circumstances (Romegnoli, Handler, & Hochheiser, 2013).

Home health care has been shown to "decrease costs, improve health outcomes, and reduce hospital stays (Romegnoli, Handler, & Hochheiser, 2013). Despite the benefits of home health care, there are still problems associated with patients receiving home health care services. Approximately thirteen percent of home health care patients experience an adverse event; the major adverse event is related to medication, 20-33 percent of home health patients have a medication problem or adverse drug event (Romegnoli, Handler, & Hochheiser, 2013).

In the era of the Affordable Care Act, "hospitals must coordinate care throughout the continuum to avoid penalties. Strong relationships with post-acute care providers are needed to guarantee a smooth transition of care and to improve care" (AHC Media, 2015). One of the identified barriers to home health care success has been inadequate information sharing between the discharging facility, primary care providers, and the home health agency. Improving information sharing with the home health agency and all other post-acute care providers involved during the transition of care process, could potentially have a positive influence on the occurrences of readmissions (Romegnoli, Handler, & Hochheiser, 2013). Studies have shown that between 5 to 79 percent of hospital readmissions from home health agencies might be avoided if correct and complete information was given to the home health agency when the patient was discharged (Romegnoli, Handler, & Hochheiser, 2013). In conjunction with improvement efforts brought on by the Affordable Care Act, many hospitals are joining accountable care organization (ACO) partnerships. In the ACO structure of shared savings, the hospital bears the risk for what happens with the patient after the patient has been discharged for an allotted amount of time, whether 30, 60, or 90 days post discharge. To make the partnership beneficial, the hospital needs to be able to influence the care of these patients along the continuum of care (AHC, 2015). Many hospitals that are in partnerships with an ACO are becoming more selective about which organization they work with along the care continuum (Robeznieks, 2017).

Readmission Reduction

The Centers for Medicare and Medicaid Services have penalized Prospective Payment System hospitals for having unacceptably high readmission rates since October 2012. Although the Critical Access Hospitals are not penalized under the current system, the CAH are involved

in the Medicare Beneficiary Quality Improvement Project (MBQIP) which readmission rates are one of the areas of focus (Distel, Casey, & Prasad. 2016). Preventable readmissions to an acute care facility "are considered to be a marker of poor-quality care and may reflect problems with care coordination" (Distel, Casey, & Prasad. 2016). There are several programs (models) aimed at reducing readmissions to acute care facilities. The adoption and endorsement of a selected model for readmission reduction for Paris Community Hospital could possibly prove beneficial to tie the current initiatives together to enhance the improvement of the transition of care process.

Collaboration along the continuum of care is essential for hospitals to reduce readmissions. When the hospital works in collaboration with a post-acute care provider, the hospital can make sure patients receive quality, cost-effective care that helps the patient recover and avoid a hospital readmission (Hospital Case Management, 2017). The use of patient navigators in the ED has also been shown to reduce the readmission rate. Patient navigators can talk with the patient, physician and other members of the team and a readmission may be avoided if arrangements can be made for a home health nurse to visit the patient the next day (Hospital Case Management, 2017).

Project Description

Situational Analysis

In the past, when a patient was admitted to the hospital they were hospitalized until they were well. Now once the acute phase of the illness is addressed and the patient is starting to recover, this is when they are being discharged. According to Laugaland, Aase, & Barach, the "tendency in today's healthcare is to 'discharge quicker and sicker'"(2012). In quite a few cases the patient is not ready to return home with no further medical support. Home health

becomes an essential alternative for the patient transitioning from the acute care setting to the home.

It is the aim of Paris Community Hospital to improve the quality of the transition of care process to the home setting by developing a hospital-based home health agency to better serve the patients cared for by PCH. It is also an objective of the hospital to be fully involved in the post-discharge aspect of the patients care to mitigate unnecessary returns to the ED or readmissions which are avoidable. The readmission rate for Paris Community Hospital is an 8% annual average for 2017. This is only using data for readmissions from this facility and readmissions back to this facility. Data sharing for readmissions from outside institutions are sporadic and the information is behind in eClinicalworks, the data warehouse provided by IRCCO, because it is based on claims data for Medicare beneficiaries. The tracking of readmissions to outside facilities is limited at the current time. In order to achieve the goals of the participating ACO, the hospital is striving for the 2018 goal for the amount of $842.10 spend for each member per month, otherwise known as "per member per month" or pmpm. The current Medicare per member per month cost is $ 935.67 at PCH. IRRCO plans to go to risk sharing in 2019, meaning that the hospital would stand to lose money if it is not meeting the established benchmarks; they could lose money if other facilities in the same ACO are not meeting their own set benchmarks.

The primary goal of starting a hospital-based home health agency would be to increase the success of the care transition from hospital to home/community setting while preventing unnecessary readmissions and returns to the ED. It is also important for the hospital to have a close working relationship with post-acute care providers, if a hospital-based home health

agency is utilized in the post-acute care period, then the hospital has a measure of the care the patient is receiving along the continuum of care.

Strength, Weakness, Opportunity and Threat Analysis

Thompson, Peteraf, Gamble, and Strickland (2016) define the analysis of strengths, weakness, opportunities, and threats (SWOT) as a "simple but powerful tool for sizing up a company's strengths and weaknesses, its market opportunities, and the external threats to its future well-being". A SWOT analysis allows for the strategic planning of a new business or service line. The SWOT analysis for a hospital-based home health agency for Paris Community Hospital was conducted with the following results.

Strengths

One of the identified strengths in analyzing the capabilities of initiating a hospital-based home health agency is the long-standing history of the hospital in the community. Paris Community Hospital has a strong reputation in the community. The hospital also employs the primary care providers which are generally the provider the patient will follow-up with after discharge from the hospital. Starting in 2017, the hospital has established a Care Navigation program that will emphasize the patients who could benefit from a home health referral and meet the guidelines for home health services. There are a number of internal employees who have extensive experience in the home health setting, including both of the care navigators.

Weaknesses

This is a new service line for Paris Community Hospital. The hospital had a hospital-based home health agency twenty years ago but with the strong competition in the area at the time, the organization decided to focus on other endeavors. There were three other home health agencies in the area during that time period. One strong competitor remains in the area

with Lincolnland Home Healthcare which is an affiliate of Sarah Bush Lincoln Health Center. There is no allocated budget for home health. The budget would be developed on a small scale from the beginning. The intended patient population focus would be on the patients discharged from our facility. Staff would need to be trained to the current standards for home health, and allocation of staff would need to be completed.

Opportunities

A hospital-based home health agency for Paris Community Hospital would allow the seamless transition of patients that are discharged from PCH and who require home health services. There is also an opportunity for greater cost awareness with a hospital-based home health agency. Cost containment interventions are more accessible to the hospital-based home health agency allowing the agency to align with quality of care and cost containment benchmarks of the ACO. The presence of a home health agency that is hospital-based would allow for increased communication with the primary care provider who is ordering the home health services.

Threats

This is a new service line for Paris Community Hospital. There is a strong established competitor in the area. There is a moratorium in place for any new licensure in the state of Illinois until January of 2018, at which time CMS will re-evaluate and decided whether or not to lift the moratorium. On January 29, 2018, CMS ruled to continue the moratorium for another six months.

Goals and Objectives

The goals and objectives for the hospital-based home health agency are listed as follows:

Goal

- To reduce the 30 day all-cause readmission rate to 8 % within a year from the start of business of the agency.

Objectives

- Patients will be assessed for needs in the home while still in the hospital setting.
- Referrals to home health will be triggered by and based on patient diagnosis, physician order, and presence of polypharmacy or complex disease management needs.
- PCH will offer patients choice of home health agencies but is allowed by CMS regulations to advise the patient which agencies are the preferred provider for the hospital.
- Paris Community Hospital based home health agency staff will meet the patients face to face in the hospital setting to facilitate the improved communication and timely receipt of important discharge information.
- To obtain referrals from other acute care facilities which have been utilized because of the tertiary need of the patient.

Goal

- To reduce the returns to the ED for disease-specific complaints by 10% by July 2018.

Objective

- Utilize disease-specific education sheets known as "Zone Sheets" as an algorithm for steps to be utilized at home prior to presenting to the ED. These steps will be utilized by the home health nurse and education will be provided to the patient on steps to utilize prior to contacting the home health nurse.

Goal

- To market the Paris Community Hospital home health agency to hospital-based primary care providers starting within two months of receiving notice that the license application has been forwarded to the State Department of Health for Illinois.

Objective

- Develop print material to distribute to affiliated clinics of Paris Community Hospital.
- Develop internet based advertisement for Paris Community Hospital home health agency. The advertisement will be placed on the Paris Community Hospital website. Information will be available 30 days prior to the home health agency going live.

Goal

- Market to area hospitals that provide care to area residents who could potentially be assigned ACO members of Paris Community Hospital.

Objective

- Face to face marketing to area hospitals that care for local residents. Provide print material to points of contact at each facility.

Business Plan

Executive Summary

Paris Community Hospital is a critical access hospital in east central Illinois. The hospital is a 25-bed facility in accordance with Centers for Medicare and Medicaid Services (CMS) guidelines for a critical access facility. The aim for this business plan is to explore the

advantages of a hospital-based home health agency to serve the patient population of PCH. A hospital-based home health agency will achieve the following objectives; increasing communication during the care transition process, increase communication with primary care providers, decrease readmissions, and decrease returns to the ED in the chronically ill with comorbid conditions.

Market Analysis

There are two major competitors in the home health arena in the area that serves the population utilizing PCH as their source of primary care and emergency care. First is Lincolnland Home Health Care which is a hospital-based home health agency through Sarah Bush Lincoln Hospital, in Mattoon Illinois. The agency has been in operation in Edgar County since 1990. The majority of the patients (70%) discharged from PCH chose this provider for their home health needs. For the fiscal year of 2017, Lincolnland Home Health had 62 referrals from PCH. Lincolnland Home Health is a skilled home health agency that offers skilled nursing, physical and occupational therapy, speech therapy, certified nurse's aides, and a licensed social worker. This agency will no longer accept a health insurance plan that is heavily used in the county, both for private insurance and for the Medicare population as a Medicare replacement policy. Carle Home Health Care is the second major provider for the county. In 2017, Carle Home Health received 18 referrals for home health services from PCH. Carle is a skilled hospital-based home health agency and it has the same offering of skill sets that Lincolnland offers. The issue that has been identified with this agency is when physical therapy or occupational therapy is ordered for the home health patient, this agency is not able to start the case within the mandated 48 hours from receiving the referral to the start of care.

Approximately 20% of the discharged patients from PCH that require home health care choose this agency. The other 10% of the discharged patients that require home health services choose between some varied other small freestanding home health agencies that offer skilled services. The population of Edgar County where PCH is located and draw the majority of the patients from is 17,828 residents and 3,604 are age 65 or older. The over 65 age group is the group most likely to use home health care.

Company Description

The hospital-based home health agency of Paris Community Hospital would be a Medicare-certified skilled home health provider offering skilled nursing that would include a certified wound care nurse, certified nursing assistants, physical and occupational therapy, speech therapy, and a licensed social worker. All of these staff are currently employed by the hospital and would make home visits as necessary. The staff allocation would not be changed from the current home department but would only pick-up visits as required. The estimated monthly census for the PCH home health agency would be approximately three patients per month initially for the first year.

Organization and Management

The hospital-based agency would be a service line of Paris Community Hospital. The Chief Executive Officer (CEO) of the hospital would serve as the CEO for the home health agency and the Board of Directors would also be the same. The director of the home health agency would be appointed by the CEO and this position would report directly to the CEO. Having a license as a registered nurse is mandated by CMS regulations to serve as the manager responsible for directing the day-to-day activities of the agency and reporting to the director. The startup period would be staffed in the following pattern, the staff registered nurses (RN)

for the home health agency would consist of the two care navigators who are employed by PCH and would continue in the care navigation positions and also see home health patients. The wound care service would be provided by the wound care manager who has home health experience. The physical and occupational therapy services would be provided by the therapy staff of the hospital. Certified nursing assistance would be provided by the certified nurse's aides from the medical floor. This would compensate for low census days on the inpatient unit and utilize staff. Staffing patterns would change and be allocated to a newly formed cost center as the agency grows. Staffing initially would start out with RN coverage, 24 hours a day, and 7 days a week. As the agency grows, staff that is solely dedicated to the home health agency will be added.

Marketing

Marketing for the home health agency will be handled by the Marketing and Grant Writing department of the hospital. This department has a staff of three full-time employees which could market the agency heavily to the hospital employed primary care providers. Marketing efforts internally would be the first step, the target would be the hospital employed providers and the ED physicians. A home health referral can be made by the ED physician with the home health agency following up with the primary care physician within an allotted timeframe. The second focus for marketing would occur for facilities that are used as tertiary care centers of Paris Community Hospital. Face to face visits with the case management staff and discharge planners at these facilities would help place the patients that are transferred for a higher level of care back with the facility that originally transferred the patient.

Print advertising would also take place approximately 30 days prior to the start of the agency. This would allow the older population, who might need home health services the

most, to be made aware of the new service line by publishing advertising in the local newspaper. Another approach to advertising would be by internet advertisements placed on the PCH website. This would target the population that might be involved in the decision making process for an older family member needing home health services.

Service/Product Description

Services provided to the patient requiring and qualifying for home health care will range from the following: skilled nursing assessment and education for disease process, medication reconciliation, and education, wound care treatments and other services. These services will be directed by a physician for a skilled need. Physical and occupational therapy will be provided to evaluate and treat the patient with total joint replacements, fractures of joints, after effects from a cerebral vascular accident (CVA) and other gait disturbances that require skilled therapy interventions. Speech therapy will complete an assessment and evaluation for treatment on all patient referrals with a diagnosis of CVA to address the after effects and the cognitive disturbances that accompany this diagnosis.

Funding Requirements

The agency will be funded by the hospital during the first start-up year. The majority of the cost allocation will be made to nursing administration or administration. Hours by registered nurses would be allocated to the nursing administration budget. The hours from the physical therapy department which includes all therapy disciplines would be allocated to this department and noted for home health services. In addition to the staff hours, there are administrative costs involved with the agency. This would include items such as the OASIS transmission software HAVEN, which is provided by the State of Illinois. Additionally, the purchase of a home health documentation program and the purchase of two laptops would be

needed for the startup home care staff. Also included would be the additional phone line, fax line with a dedicated machine, which is a requirement by CMS.

Initial funding would include, in addition to the previously mentioned items of staff and electronic devices, a home health software program. This program would be required to include the scheduling component for patients and staff, and include the OASIS datasets. The OASIS datasets are required by CMS for all Medicare patients and could be used on all patients over the age of 18 as a comprehensive assessment tool. The anticipated cost of this software program would be approximately $25,000.00. Coding of the home health patient diagnoses would occur at the nursing level; followed by validation by a coder, knowledgeable of home health coding guidelines. Service invoices would be handled by the billing office for the hospital. Both the coding and billing could be absorbed into the current workloads if projected census was less than 100 patients annually, if the patient census increased above this amount then a dedicated biller and coder would be potential staff additions.

Financials

The financials will be further developed with the aid of the Chief Financial Officer input for the fiscal year 2019. Financial planning will be ongoing at the beginning of 2018, with budget forecasts made for 2019, during the fall of 2018.

The forecasted census for the first 12 months would be three patients per month or 36 patients for the first year. According to Medicare Fee schedules, the episodic payment received for each admission would be $3,039.64 per 60-day episode (CMS. 2018). Projections for the year would have a monthly net of $9,118.92, meaning a total net of **109,427.04** for the first year. The first year's startup cost of $28,000.00 and staff costs projected to be approximately $1000.00 per patient, this includes therapy evaluations and treatment, nursing

evaluation and treatment and personal care assistance by the home health aide. Monthly staff costs would be $3,000.00 for field staff. The first year of operation the office staff, branch director, and manager would have no billable hours to the home health agency and would absorb those duties in to already existing assignments. The yearly cost for staffing based on the projection above would be $36,000.00 for the first year and the initial startup cost would be $28,000.00. This would show a total cost of **$64,000.00** for the first year, with a projected profit of **$45,427.04**. The projected profit would be reduced in the amount of mileage for the staff making home visits. This mileage would be reimbursed at the standard government rate for the current year. It is anticipated the mileage costs would be relatively low for a home health agency, with the consideration being the majority of the patients PCH serves are predominately from Paris, with almost all living within Edgar County.

Discussion

The aim of this project is to improve the transition of care from the acute inpatient setting to the post-acute setting. The focus on reducing hospital readmissions was brought more in the spotlight by the ACA and the other changes in reimbursement by Medicare. This has been the incentive for acute care organizations to assess and to work more collaboratively with the providers in the post-acute care setting. These changes have also prompted some hospitals and health systems to buy or build post-acute care service providers as part of their network (Anthony, Morin, Raphael. 2017). A hospital working with a post-acute care provider that has the same incentives to provide quality patient care and contain the cost is beneficial for both entities. From the perspective of the hospital, a relationship with a home health agency that has the same incentives would offer consistent and immediate access to services. The consistent and timely access would benefit the patient by providing reliable quality care

thereby potentially decreasing readmissions and emergency department visits. This would also allow for patient management that is collaborative and provides seamless access to providers along the care continuum. The consistency in a treatment plan in the acute care setting transitioning to the home health setting would be another quality improvement in patient care. This type of service addition would also allow for standardization in protocols and patient transitions in care regardless of the post-acute care provider. Critical Access Hospitals are not reimbursed through value-based payment initiatives at this time. The future reimbursement schemes and how they may evolve are not known. The practice of value-based care would prepare for the future if this type initiative took hold as part of the CAH payment model. A hospital-based home health agency would also allow for alignment with the ACO initiatives and the home health agency would be aware of which patients were higher cost members and plan accordingly. This planning might include enhanced home visits during the first two weeks after discharge to ensure adequate transition in care. A social worker may need to be involved to assess the social determinants of health that are not being met which are a factor in the patient returning to the ED or being readmitted, resulting in a higher cost patient.

The population focus objective for this hospital-based home health agency in a critical access hospital would initially be the population that is discharged from the facility itself. These patients are generally patients of the primary care providers that are employed by the hospital thereby allowing enhanced communication with the post-acute care process of home health. Information sharing would be immediate since the home health agency nurses would be employed by the CAH and housed close to the primary care physician offices. The face-to-face communication of patient status and progress would be improved. The focus on the

patients discharged from the facility means that the agency will not accept neonatal or pediatric patients under the age of 16 at this time. The hospital does not have a pediatrician on staff and pediatric patients are rarely hospitalized at this facility.

The formation of a hospital-based home health agency has been suggested as one approach to improving the care of the patient in the continuum of care. The overarching goal is to improve the transition process and provide safe, quality care to the patients during the transition of care. The other suggestion would be to implement a transition of care model to provide the same consistent discharge communication and assistance with every discharge.

Summary

Improvement in the transition of care process is imperative to increase the quality of care patients are receiving. There are numerous models for transition of care that have shown to be beneficial in addressing the barriers mentioned previously in this paper. The benefits of using such a model could be realized with or without a hospital-based home health agency.

The aim of this project was to outline the benefits to both patient and facility for a hospital-based home health agency. The benefits to the hospital would be improving alignment with the ACO benchmarks, to have a vested interest of the discharged patient along the continuum of care and to be positioned to impact the transition of care in the post-acute care period. The benefits to the patient being cared for in the post-acute care setting by a hospital-based home health agency would include several components. Those components are the following; the seamless transfer of information to the primary care provider, the standardization of processes of the care transition, continuity in the plan of care set for the patient while in acute care, and incorporated acute plan of care into the post-acute care setting.

The startup for a hospital-based home health agency in a CAH, in this case, would be to focus on the patients that are admitted and discharged from the facility who meet guidelines for home health. Those patients transferred to a higher level of care being referred by the accepting tertiary facilities at discharge would also be a population that the agency would strive to capture the admission. The growth of the agency would occur over time and would include patients in the surrounding communities who potentially use other facilities as their choice of primary care.

The agency would be involved in the transition of care activities from the hospital to the home setting to ensure correct medication reconciliation, discharge instructions and physicians' orders for care in the home, while focusing on a consistent plan of treatment from acute care to the post-acute care setting. A staff nurse would be on call 24 hours a day, 7 days a week for any questions or concerns of patients or families. Contact with primary care providers will occur the day the patient is admitted to the agency to facilitate the open communication and to verify all orders.

There are three main components increasing the patient benefit from post-acute care provided by a hospital-based home health agency. The three components are the seamless transfer of information to the primary care provider, the standardization of processes of the care transition, and to have continuity in the plan of care beginning in the acute care setting then being incorporated into the post-acute care period. These three components would translate to improved quality of care for the patient; potentially decreasing the risk for readmission and returns to the ED.

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