ACOs, Medical Homes, and Home Health: A Collaborative Model

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# Table of Contents

- An Environment of Reform .................................................................................................................. 2
- Accountable Care Organizations (ACOs) .............................................................................................. 2
- Patient-Centered Medical Homes (PCMH) ............................................................................................ 3
  - PCMH Principles .................................................................................................................................. 4
- Community-Based Care ........................................................................................................................... 5
- Summary of community-based services referenced in PPACP ............................................................ 5
- Future Models: Home Health and Community-Based Care ................................................................. 8
  - Care Coordination Support for ACOs and Medical Homes ................................................................. 8
  - Care Transitions Support for ACOs and Medical Homes ................................................................. 9
  - Collaborative Disease Management Support for ACOs and Medical Homes ............................... 10
- ACOs and Medical Homes: Partnering with Home Health ................................................................. 10
  - Quality Indicators ............................................................................................................................... 11
  - Cost Savings/Efficiency Indicators ...................................................................................................... 12
  - Customer Satisfaction Indicators ........................................................................................................ 13
  - Change Management/Adaptability ....................................................................................................... 13
  - Selecting Partners ............................................................................................................................... 13
- Summary ................................................................................................................................................ 14
- Bibliography ........................................................................................................................................... 155
ACOs, Medical Homes, and Home Health: A Collaborative Model

An Environment of Reform
“Reform” as defined by the Merriam-Webster Dictionary is “to put or change into an improved form or condition or to amend or improve by change of form or removal of faults or abuses.” (Merriam-Webster Dictionary) The two key terms in this definition are “improve” and “change.” Healthcare providers throughout the U.S. have begun to realize that “improvement” and “change” will touch their industries, practices, and organizations as a result of the health reform measures of the Patient Protection and Affordable Care Act (PPACA) (111th Congress of the United States of America, 2010). Most providers also realize that changes will occur before greater improvements will begin to be recognized, with the most significant changes occurring at the core of care provision: the models of care.

These changes and improvements are the foundation for the new models of care that are beginning to gain momentum as the result of the PPACA. Three themes in the PPACA relate to emerging models of care: 1) Accountable Care Organizations, 2) patient-centered medical homes, and 3) community-based care. It is imperative that leaders in every healthcare setting understand the features of these models as we move into an environment of not only reform, but of collaboration.

Our current independent silos of care are being replaced by interdependent, collaborative models in which all settings will not only work together, but will receive bundled payments and/or shared savings, and will be held to collaborative quality, utilization, and patient satisfaction standards.

Accountable Care Organizations (ACOs)
The first theme involving models of care in the PPACA is that of Accountable Care Organizations or ACOs. Accountable Care Organizations or arrangements are not a new concept as a means to fix our fragmented healthcare delivery system. The HMO (Health Maintenance Organization) movement of the 1970s-80s was an early attempt at accountable care by providing financial support and incentives to promote cost containment. ACOs in today’s times have gained momentum with their appearance in the PPACA as part of the Medicare Shared Savings Program; however ACO models are emerging for many payers, not just Medicare.

A general, all-payer definition of an ACO can be found in the ACO Toolkit from the Engelberg Center for Health Care Reform at the Dartmouth Institute. ACOs are:

- Collaborations of primary care professionals and other health service providers, such as other physicians and hospitals;

- Organized around the capacity to improve health outcomes and the quality of care while slowing the growth in overall costs for a population of patients cared for by a well-defined group of primary care professionals; and
ACOs, Medical Homes, and Home Health: A Collaborative Model

- Capable of measuring improvement in performance and receiving payments that increase when such improvements occur. (The Brookings Institution, 2011)

However, the ACO Proposed Rule from the Medicare Shared Savings Program has further defined ACOs in the Medicare model as a:

- Recognized legal entity under State law;
- Comprised of a group of ACO participants (providers of services and suppliers);
- That have established a mechanism for shared governance;
- Work together to coordinate care for Medicare fee-for-service beneficiaries; and
- Enter into a 3-year agreement with CMS to be accountable for the quality, cost, and overall care of traditional fee-for-service Medicare beneficiaries who may be assigned to it.

Under the proposed rule, Medicare would continue to pay individual providers and suppliers for specific items and services as it currently does under the fee-for-service payment systems. The proposed rule would require CMS to develop ACO-specific level of savings which need to be achieved by each ACO if the ACO is to receive shared savings, as well as a level of losses realized by an ACO if it is held liable for losses. Additionally, an ACO would be accountable for meeting or exceeding the quality performance standards to be eligible to receive any shared savings financial awards. (Centers for Medicare and Medicaid Services, 2011)

The ACO models for all payers builds upon the foundation of the HMO model combined with strong elements of the patient-centered medical home model. In many ways, patient-centered medical homes are a stepping stone to the foundation of ACOs as the medical home model contains the patient care supports necessary to create, implement, and sustain an ACO.

Patient-Centered Medical Homes (PCMH)

The second theme involving models of care in the PPACA is that of the Patient-Centered Medical Home (PCMH). The goals of Patient-Centered Medical Homes are in alignment with the goals of ACOs: to improve quality, decrease cost, and improve consumer satisfaction. The Patient-Centered Medical Home is an approach to providing comprehensive primary care for children, youth and adults. The PCMH is a health care setting that facilitates partnerships between individual patients and their personal physicians, and when appropriate, the patient’s family. (Patient Centered Primary Care Collaborative, 2011) The PCMH is not a place, but rather a model of care in which the patient’s primary care provider and their PCMH team assures that the patient receives care according to the PCMH principles. These principles are not only the foundation of the PCMH model, but are also the driving force behind health reform changes in the primary care setting.
ACOs, Medical Homes, and Home Health: A Collaborative Model

**PCMH Principles**
The following principles of PCMHs have been developed by the American Academy of Pediatrics (AAP), the American Academy of Family Physicians (AAFP), the American College of Physicians (ACP), and the American Osteopathic Physicians (AOA):

- **Personal Physician** - each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.

- **Physician Directed Medical Practice** – the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.

- **Whole Person Orientation** – the personal physician is responsible for providing for all the patient’s health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care, chronic care, preventive services, and end of life care.

- **Electronic Medical Records and Registries** - Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication. Care is facilitated by registries, information technology, health information exchange, and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

- **Patient Advocates** - Practices advocate for their patients to support the attainment of optimal, patient-centered outcomes that are defined by a care planning process driven by a compassionate, robust partnership between physicians, patients, and the patient’s family.

- **Evidence-Based Care** - Evidence-based medicine and clinical decision-support tools guide decision making.

- **Accountability for Quality** - Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement.

- **Patient Participation** - Patients actively participate in decision-making and feedback is sought to ensure patients’ expectations are being met.

- **Enhanced Access to Care** - Enhanced access to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff.
ACOs, Medical Homes, and Home Health: A Collaborative Model

- **Care Coordination** - Care is coordinated and/or integrated across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient’s community (e.g., family, public and private community-based services). (Patient Centered Primary Care Collaborative, 2011)

It has been said that these principles *should* already be in place within primary care practices, but in reality, due to our current payment structures and incentives, it is rare to find all principles upheld consistently outside the medical home model. Some principles are more challenging to achieve than others. In a recent study by the Medical Group Management Association (MGMA), coordinating care for high-risk patients was identified by over 40 percent of the practices surveyed as one of the top challenges in transforming to a PCMH. (Medical Group Practice Association, 2011) Other challenges include establishing care coordination agreements with referral physicians (more than 50 percent), financing the transformation to a PCMH (more than 40 percent), modifying or adopting an EHR system to support PCMH-related functions (almost 40 percent), and projecting financial effects of the transformation to PCMH (more than 35 percent). (Medical Group Practice Association, 2011) The principles and challenges of the PCMH model open the door for partnerships and collaboration across the continuum, especially with home health and community-based care providers that have proven expertise in care coordination, care transitions, and disease management.

**Community-Based Care**

The third theme involving models of care in the PPACA is that of community-based care. The PPACA has many references to community-based care in the forms of direct patient care, disease management, care coordination, health team support, and education. The following table outlines the most prevalent references in the PPACA to community-based services.

<table>
<thead>
<tr>
<th>PPACA Section</th>
<th>Medicare or Medicaid</th>
<th>Program</th>
<th>Summary</th>
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<tbody>
<tr>
<td>2401</td>
<td>Medicaid</td>
<td>Community First Choice Option</td>
<td>Availability of home and community-based attendant services and supports to eligible individuals, as needed, to assist in accomplishing activities of daily living, instrumental activities of daily living, and health-related tasks through hands on assistance, supervision, or cueing</td>
</tr>
<tr>
<td>2402</td>
<td>Medicaid</td>
<td>Removal of barriers to providing home and community-based services</td>
<td>All States develop service systems that are designed to— (1) allocate resources for services in a manner that is responsive to the changing needs and choices of beneficiaries receiving non-institutionally-based long-term services and supports (2) provide the support and coordination needed for a beneficiary in need of such services (and their family caregivers or representative, if applicable) to design an</td>
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# ACOs, Medical Homes, and Home Health: A Collaborative Model

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<td></td>
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<td>individualized, self-directed, community-supported life; and (3) improve coordination among, and the regulation of, all providers of such services under federally and State-funded programs</td>
</tr>
<tr>
<td>3026</td>
<td>Medicare</td>
<td>Community-Based Care Transitions Program</td>
<td>Creation of a Community-Based Care Transitions Program under which the Secretary provides funding to eligible entities that furnish improved care transition services to high-risk Medicare beneficiaries</td>
</tr>
<tr>
<td>3502</td>
<td>Medicaid</td>
<td>Establishing Community Health Teams to support the Patient-Centered Medical Home</td>
<td>Program to provide grants to or enter into contracts with eligible entities (states, state-designated entity, or Indian tribe or tribal organization) or to establish community-based interdisciplinary, inter-professional health teams to support primary care practices, including obstetrics and gynecology practices, within the hospital service areas served by the eligible entities. Grants or contracts shall be used to— (1) establish health teams to provide support services to primary care providers or other primary; and (2) provide capitated payments to primary care providers as determined by the Secretary</td>
</tr>
<tr>
<td>4202</td>
<td>Medicare</td>
<td>Healthy Aging, Living Well; Evaluation of Community-Based Prevention and Wellness Programs for Medicare Beneficiaries</td>
<td>Grants to State or local health departments and Indian tribes to carry out 5-year pilot programs to provide public health community interventions, screenings, and where necessary, clinical referrals for individuals who are between 55 and 64 years of age</td>
</tr>
<tr>
<td>5313</td>
<td>Medicare/Medicaid</td>
<td>Grants to Promote the Community Health Workforce</td>
<td>Grants to eligible entities to promote positive health behaviors and outcomes for populations in medically underserved communities through the use of community health workers. Grants shall be used to support community health workers— (1) to educate, guide, and provide outreach in a community setting regarding health problems prevalent in medically underserved communities, particularly racial and ethnic minority populations; (2) to educate and provide guidance regarding effective strategies to promote positive health behaviors and discourage risky health behaviors; (3) to educate and provide outreach regarding enrollment in health insurance including the Children’s Health Insurance Program under title XXI of the Social Security Act, Medicare under title XVIII of such Act and Medicaid under title XIX of such Act; (4) to identify, educate, refer, and enroll underserved</td>
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<td></td>
<td></td>
<td>Incentives for States to Offer Home and Community-Based Services as a Long-Term Care Alternative to Nursing Homes</td>
<td>populations to appropriate healthcare agencies and community based programs and organizations in order to increase access to quality healthcare services and to eliminate duplicative care; or (5) to educate, guide, and provide home visitation services regarding maternal health and prenatal care. The State submits an application to the Secretary that includes (1) a proposed budget that details the State’s plan to expand and diversify medical assistance for non-institutionally-based long-term services and supports under the State Medicaid program during the balancing incentive period and achieve the target spending percentage applicable to the State (2) including through structural changes to how the State furnishes such assistance, such as through the establishment of a “no wrong door—single entry point system”, optional presumptive eligibility, case management services, and the use of core standardized assessment instruments, and that includes a description of the new or expanded offerings of such services that the State will provide and the projected costs of such services; and (3) in the case of a State that proposes to expand the provision of home and community-based services under its State Medicaid program through a State plan, at the option of the State, an election to increase the income eligibility for such services from 150 percent of the poverty line to such higher percentage as the State may establish for such purpose, not to exceed 300 percent of the supplemental security income benefit rate (111th Congress of the United States of America, 2010).</td>
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Although not all community-based services referenced in the PPACA will directly impact all providers, all settings should note the clear shift in governmental support to community-based programs outside the framework of the typical long-standing home health model. Are these community-based services meant to replace home health? Not at all; but they will challenge home health for the limited financial resources from Medicare, Medicaid, and other payers.

The test for the home health industry is not in trying to get other provider settings to understand and support homecare (as is the current industry cries); the test is for home health to meet the needs of the other provider settings. This is the ultimate test for all providers at the individual patient level: Is this service (test, visit, admission, etc.) really necessary and if it is, is the provider performing it doing so at the best cost and highest quality? If not, the service, test, visit, admission, etc. could be eliminated or replaced. The answer to this test at the ACO, medical home, and payer...
ACOs, Medical Homes, and Home Health: A Collaborative Model

levels will be the catalyst for new partnerships, new care models, and possibly new provider settings. Old partnerships, old care models, and current provider settings could easily be replaced or significantly diminished for the ACOs, medical homes, and payers to achieve their low cost/high quality goals. Home health is at great risk for a significant overhaul.

Future Models: Home Health and Community-Based Care
The mandates of the PPACA clearly signify a paradigm shift in which collaboration and patient-level support across the care continuum are necessary to achieve clinical and financial goals and to attain financial rewards. As noted previously, the PPACA creates many opportunities for home health and community-based organizations to support ACOs and medical homes. These include, but are not limited to care coordination, care transitions, and disease management. Many physician practices striving to become a Patient-Centered Medical Home use national recognition or accreditation standards as their criteria for modeling their medical home. The gold standard in PCMHs is recognition or accreditation which can be achieved through National Committee for Quality Assurance (NCQA) or other accrediting bodies. (American Academy of Family Physicians (AAFP), American Academy of Pediatrics (AAP), American College of Physicians (ACP), American Osteopathic Association (AOA), 2011) Home health and community-based organizations striving to support ACOs or medical homes should understand the standards that PCMHs must achieve for recognition or accreditation and then mimic their community-based support services to assist the PCMHs in achieving these standards.

Care Coordination Support for ACOs and Medical Homes
As noted earlier, coordinating care for high-risk patients was identified as one of the top challenges in transforming to a PCMH by over 40 percent of the medical homes surveyed in recent study by the Medical Group Management Association. (Medical Group Practice Association, 2011) To explore this further, we must define care coordination in the PCMH model. Care Coordination is the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient’s care to facilitate the appropriate delivery of health care service. (Meyers D, 2010) Care coordination is one of the core functions of primary care, but the medical home model takes care coordination to a new level. It must be well-orchestrated, well-defined, with sufficient supporting resources, and of the highest caliber clinical skills.

The goals of care coordination are:

- To transfer information, such as medical history, medication lists, test results, and patient preferences, appropriately from one participant in a patient’s care to another. This includes transferring information to or from the patient; and
- To establish accountability by clarifying who is responsible for each aspect of a patient’s overall care. This includes specifying who is primarily responsible for key care delivery.
ACOs, Medical Homes, and Home Health: A Collaborative Model

activities, the extent of that responsibility, and when that responsibility will be transferred to other care participants.

In the Patient-Centered Medical Home Model, care coordination is inherently a responsibility of everyone on the PCMH team. Many PCMHs have a position or a team of “care coordinators” that are an integral part of the practice setting. For practices embarking on the PCMH model or in the early stages of PCMH development, the position of care coordinator may be either vacant or ill-defined. It is in these early stages of PCMH development that home health or community-based organizations can fill some of the voids in care coordination for patients that are shared between organizations or between payers (as some models are payer-specific). Another option is for the PCMH to have a contractual arrangement with a home health agency or community-based organization to provide care coordination for a subset of the PCMH population.

Regardless of the strategy, home health should play an important role in care coordination in medical home models at any stage of their development. Home health staff have a unique perspective on patient issues, home environment, and social support, all of which impact the patient quality of care and ultimate performance measures of the medical home. Care Transitions Support for ACOs and Medical Homes

Beyond general care coordination, ACOs and Patient Centered Medical Home models can benefit from care transitions interventions. Care transitions are the movement patients make between health care practitioners and settings as their condition and care needs change during the course of a chronic or acute illness. Transitional care (identified in this paper as care transitions interventions) is defined as a set of actions designed to ensure the coordination and continuity of health care as patients transfer between different locations or different levels of care within the same location. Representative locations include (but are not limited to) hospitals, sub-acute and post-acute nursing facilities, the patient's home, primary and specialty care offices, and long-term care facilities. (Care Transitions Program) As with general care coordination, care transitions interventions may not be a strategy in a new or emerging medical home. Again, there can be a benefit from home health or community-based organizations assuming the role of care transitions coaches to support patients shared by these programs.

Specific interventions by care transitions coaches that can be of value to a medical home include: coordination of hospitalization information between the hospital and medical home, medication reconciliation, initiation of self-management education, initiation of personal health records, assisting in scheduling and planning for post-hospitalization physician appointments, and meetings with the medical home team to assist in individualized patient care planning. Regardless of the specific care transitions interventions performed by the home health agency or community-based organization, coordination of care transitions interventions with the medical home would be a
ACOs, Medical Homes, and Home Health: A Collaborative Model

benefit to all settings and would be most beneficial to the patient and caregivers in assuring a seamless transition from hospital to home.

Collaborative Disease Management Support for ACOs and Medical Homes
Along with care coordination and care transitions interventions, disease/population management is an integral component of PCMHs and ACOs. Care coordination and care transitions touch upon interventions related to chronic disease management in that both care transitions and care coordination generally involve educating or motivating patients in self-management of their chronic conditions. However, for the purposes of this paper, we will explore disease management as separate from care coordination or care transitions interventions and will explore a model of collaborative management of chronic conditions.

Collaborative management is care that strengthens and supports self-care in chronic illness while assuring that effective medical, preventive, and health maintenance interventions take place. The essential elements of collaborative management are 1) collaborative definition of problems, in which patient-defined problems are identified along with medical problems diagnosed by physicians; 2) targeting, goal setting, and planning, in which patients and providers focus on a specific problem, set realistic objectives, and develop an action plan for attaining those objectives in the context of patient preferences and readiness; 3) creation of a continuum of self-management training and support services, in which patients have access to services that teach skills needed to carry out medical regimens, guide health behavior changes, and provide emotional support; and 4) active and sustained follow-up, in which patients are contacted at specified intervals to monitor health status, identify potential complications, and check and reinforce progress in implementing the care plan. (Michael Von Korff, Jessie Gruman, Judith Schaefer, & Susan J. Curry, 1997)

Collaborative management of chronic conditions is the responsibility of all providers caring for the patient. The role of home health or community-based organizations in supporting individual patient’s disease management can have a positive impact on the PCMH teams and on the patient outcomes. Home health and community-based organizations should work collaboratively with the PCMHs and ACOs to develop clear expectations for responsibilities related to communication, care planning, care coordination, care transitions, and disease management for all patients shared between the organizations. Home health and community-based organizations can position themselves as important players in future models of care by developing creative interventions within the scope of their practices to support medical homes and ACOs. ACOs and Medical Homes: Partnering with Home Health As many communities have a plethora of home health organizations, it can become a daunting task for a PCMH or ACO to determine which agencies are the best partners. Although currently, formal or informal relationships are now a deciding factor in many partnerships between home health and physicians or hospitals, the ACO and medical home models will require solid evidence of performance prior to embarking on a partnership with a home health
ACOs, Medical Homes, and Home Health: A Collaborative Model

agency. As incentives and regulations are rapidly changing, now is the time to proactively select partners and solidify those relationships.

In considering which home health agencies will make the best partners, an ACO or medical home should evaluate the following factors. Keep in mind that no one factor alone should be used to evaluate a home health agency’s performance; multiple factors should be considered that measure quality, cost savings/efficiency, customer satisfaction, and change management/adaptability. Note: All investigations should be HIPAA compliant using de-identified patient information.

Quality Indicators

- **Publicly Reported Data** – Currently home health agencies’ quality measures are available on the Home Health Compare website (www.medicare.gov). Home Health Compare provides a snapshot of individual’s agency quality measures and how an agency compares with other agencies and with statewide and national averages. However, this may not give a full or clear picture of the quality of care within the agency as data may be skewed by sample size and by characteristics of referral sources to the agency. Although the data reported is statistically significant, small agencies may have a small sample size which can distort how they are represented on the Home Health Compare website. In addition, some of the outcomes are related to issues or characteristics found with the referral sources (i.e. hospitals, physicians, nursing facilities, etc.) for that agency. As many agencies receive referrals from patients from somewhat predictable and often limited sources, some outcomes may be related to characteristics of the referral sources as well as characteristics of the agency. For example, if an agency received a large percentage of referral from a physician practice known to request patients be sent to the hospital for after-hours emergencies, this can impact the agency’s hospitalization rate.

- **Accreditation** - Accreditation by a certification body such as The Joint Commission, Community Health Accreditation Program (CHAP), or the Accreditation Commission for Health Care (ACHC) is an indicator of a home health agency’s commitment to quality and performance standards. However, accreditation is not be a lone indicator of quality or performance and should be used as only one consideration in selecting partnering agencies along with the other criteria listed.

- **Patient Occurrence Data** - Data on patient occurrence trends, such as falls, infections, medication errors, injuries, etc. will provide insight into issues within the organization. Data should be organized into monthly or quarterly summaries and be reviewed for a one to two year timeframe to be able to detect trends in improvement or decline in performance.

- **Complaint Data** – All home health agencies are required to investigate and document complaints made by a patient or the patient’s family or guardian regarding treatment or care
ACOs, Medical Homes, and Home Health: A Collaborative Model

that is (or fails to be) furnished, or regarding the lack of respect for the patient’s property by anyone furnishing services on behalf of the home health agency. The agency is required to document both the existence of the complaint and the resolution of the complaint. (Centers for Medicare & Medicaid Services, 2005) As with occurrence data, complaint trends are a strong indicator of improvement or decline in agency performance and should be viewed for a minimum one year timeframe.

Cost Savings/Efficiency Indicators

- **Re-Admission Rates per Hospital, Physician, and Payer** – As re-hospitalizations are one of the most costly expenses in healthcare and also an indicator of quality, partnering with an agency with low re-admission rates is essential to achieving quality and utilization goals in ACOs or PCMHs. Home health agency acute care hospitalization rates are publicly reported on the Home Health Compare website for all the Medicare, Medicare HMO, Medicaid, and Medicaid HMO patients served by the agency. This data is not an apples-to-apples comparison of the hospital re-admission data reported on Hospital Compare website (www.medicare.gov), as home health data is all hospital “admissions” and hospital data represents “re-admissions” within 30 days of hospital discharge. Agencies should be capturing this data in a like-comparison to the hospital data for all the hospitals, physicians, and payers that they serve, with a comparison to state and national averages per current Hospital Compare data.

- **Average cost per Visit** – Most agencies track average cost per patient as an indicator of profit. The GAO reported average costs per visit at $70-130/visit with the lower costs per visit indicating the potential for greater profit margins and efficiency of operations. (United States General Accounting Office, 2004)

- **Staff Turnover Rate** – Although turnover can also be viewed as a cultural or quality indicator, there is a significant cost to the agency associated with staff turnover. Analyzing turnover rates in provider and non-provider staff will give a snapshot into the culture and expenses of an organization.

- **Specialty Programs with Outcome Data** – As PCMHs and ACOs practices not only hinge upon providing superior patient-centered care to all patients, they must also be able to supply high-level care to the most chronic and needy in their patient population. As such, having a home health agency partner with certified/advance practice wound care specialists, disease management, telehealth, palliative care, and complex care teams in place is essential. In addition to the existence of the teams, each agency should be able to identify the impact of each program on their clinical and financial outcomes (number of patients served, re-hospitalization rate, average number of visits, average cost per visit, adverse events, etc.).
ACOs, Medical Homes, and Home Health: A Collaborative Model

Customer Satisfaction Indicators

- **Patient Satisfaction Data** - Home Health CAHPS (Consumer Assessment of Healthcare Providers and Systems) is now required for Medicare certified home health agencies. Although not all data will be publicly reported, agencies will receive robust reports from the CAHPS vendors. This data should be used to determine patient satisfaction with the agency under review.

- **Physician/Hospital Satisfaction Data** – Not all agencies survey their referrals sources to determine their level of satisfaction, but if this data is available, it should be evaluated.

- **Staff Satisfaction Data** – There are many tools an agency can use to determine the culture within the organization and the staff satisfaction, however these surveys are not mandatory and are often not performed within agencies. If available, these should be evaluated as an important factor in selecting a partner.

Change Management/Adaptability

- **Staff Education Plan** – Home health agencies that partner with ACOs or PCMHs should be able to demonstrate their ability to manage change rapidly and effectively. One indicator of an agency’s ability to handle change is to evaluate their education plan for the past year and for the upcoming year to determine if staff are: 1) exposed to new evidence-based materials, and 2) if staff are comfortable with both planned and unplanned education that is rather vigorous in nature.

- **Agency Communication Plan** - In addition to education, communication channels are also important to the adaptability of an organization. If an agency has no e-mail or EMR, will this meet the needs of the PCMH or ACO? How are changes communicated to staff? If communication cannot occur efficiently with messages sent simultaneously to multiple staff, will this hinder PCMH or ACH operations?

Selecting Partners

In selecting home health agencies as partners, it is important to remember that patients always have a choice of providers, regardless of partnerships. However, when partnerships are established, patients should be given the information about the relationship while they are selecting their agency of choice as this may impact their decision.

Another factor to consider in determining the best partner is the actual process for selecting the agency. Will one person be responsible for the selection? Will a team be responsible? Will there be a scoring mechanism to help determine the best partner by the best score? Will there be an application process or a required Request for Proposal (RFP) process?
Summary
Health reform and the changes brought about by the PPACA are creating new and exciting models of care with opportunities for home health and community-based organizations. To capitalize on these opportunities, agencies must have the flexibility and creativity to meet these challenges. The current relationships between hospitals, physicians, and home health or community-based organizations will often be replaced with formal partnerships in which an ACO or medical home selects the best partnering home health and/or community-based organization. Home health or community-based organizations demonstrating superior quality, cost savings/efficiency, customer satisfaction, and change management/adaptability will have the best opportunity for partnerships in our future care models.
ACOs, Medical Homes, and Home Health: A Collaborative Model

Bibliography


