NON-MEDICAL HOME CARE:
A Proven Resource to Reduce Hospital Readmissions

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TABLE OF CONTENTS

EXECUTIVE SUMMARY

About one out of every five U.S. seniors is readmitted to the hospital within 30 days of initially being discharged—a situation that annually costs the national healthcare system some $15 billion.[1] Thus, the "Patient Protection and Affordable Care Act" mandated that as of October 1, 2012, the Centers for Medicare & Medicaid Services (CMS) begin making the provision of full reimbursements to U.S. hospitals contingent upon their controlling readmissions of Medicare enrollees.[2]

In response, in May 2012, Henrico Doctors' Hospital of Richmond, VA, partnered with a local Home Instead Senior Care® franchise office ("Home Instead") providing non-medical in-home care services to launch a "Quality-Improvement Collaborative" designed to reduce the hospital's rate of readmissions for older patients with congestive heart failure (CHF)—a common diagnosis within this age group.

This "hospital-to-home" pilot project yielded positive results for the 48 participating CHF patients: the readmissions rate within the participant group was 12.5 percent, as compared to 14.5 percent in the project's control group.

Only six participants were readmitted, three of them for reasons unrelated to their primary diagnosis of CHF. Moreover, from a patient-satisfaction standpoint, after their project-related service periods expired, six of these older adults chose to continue using Home Instead's home-care services—doing so at their own expense.

By way of comparison: during the project period, the hospital's overall readmission rate for CHF patients was 16.9 percent. In addition, its parent organization, Hospital Corporation of America (HCA) experienced an overall CHF readmissions rate of 19.9 percent, while HCA's "Capital Division"—the hospital's regional subgroup—recorded a 19.8 percent mark. Finally, national CHF readmission rates for Medicare enrollees were reportedly as high as 24.6 percent.[3]

In short, then, this project demonstrated that in-home, non-medical caregivers can facilitate, coordinate and provide effective post-discharge care to older patients.

Consequently, it's time to offer this care modality a more-integral nationwide role in helping U.S. seniors avoid unnecessary hospital readmissions by allowing these patients to make safe, successful post-discharge transitions back to their own homes—where they want to be.

SECTION ONE

In Brief: Project Overview

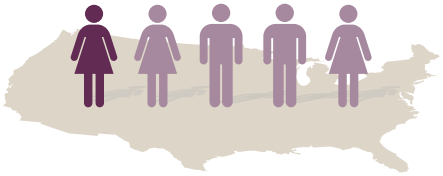
The "Why and How": Basic Background and Summary

Throughout the U.S., there are significant problems associated with the quality of transitional care for older adults moving from hospital to home. In fact, about one out of every five seniors is readmitted to the hospital within 30 days of initially being discharged—a situation that annually costs the national healthcare system some $15 billion.[4]

Evidence suggests that a large percentage of these readmissions should be preventable. In addition, within the U.S. healthcare community, addressing this problem has been a focus for several years. Nonetheless, national readmission rates have continued to rise.

Thus, the "Patient Protection and Affordable Care Act" included the "Hospital Readmissions Reduction Program," which mandated that as of October 1, 2012, the Centers for Medicare & Medicaid Services (CMS) begin making the provision of full reimbursements to U.S. hospitals contingent upon their controlling readmissions of Medicare enrollees.[5]

In response, in May 2012, Henrico Doctors' Hospital of Richmond, VA partnered with a local Home Instead Senior Care franchise office ("Home Instead") providing non-medical in-home care services to launch an 11-month "Quality-Improvement Collaborative" designed to reduce the hospital's rate of readmissions for patients with congestive heart failure (CHF)—one of the initial three diagnoses to be subject to CMS-imposed penalties (along with myocardial infarction and pneumonia).



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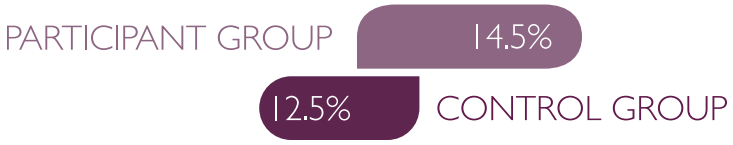
$15 BILLION.[4]

The goal of this project was to ensure smooth care transitions for these patients (who participated in this project voluntarily) during and after hospital discharge by using non-medical interventions to help prevent the deterioration in health status which often leads to unnecessary readmissions.

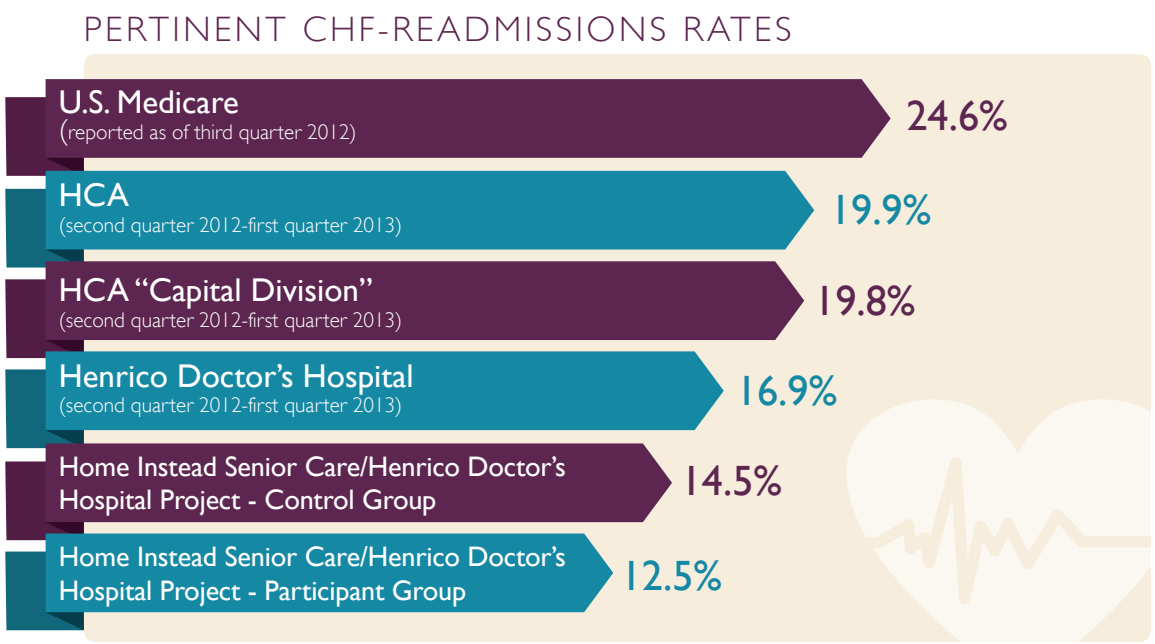
The "What": Project Results and Comparative Data

This "hospital-to-home" pilot project—which was funded entirely by Home Instead, Inc., franchisor of the Home Instead Senior Care franchise network—yielded positive results for the 48 participating CHF patients by identifying and implementing best practices to reduce readmission rates; improving the overall transitional-care process; and developing resources to assist these patients in better managing their conditions after discharge.

As can be seen in the data table at the end of this section, the readmissions rate within the participant group was 12.5 percent, as compared to 14.5 percent in the control group.



Furthermore, during the project period, the hospital's overall readmission rate for CHF patients was 16.9 percent. In addition, its 170-hospital parent organization, Hospital Corporation of America (HCA) experienced a CHF-readmissions rate of 19.9 percent, while HCA's "Capital Division"—the hospital's four-state regional subgroup—recorded a 19.8 percent mark. Finally, national CHF-readmissions rates for Medicare enrollees were reportedly as high as 24.6 percent.[6]



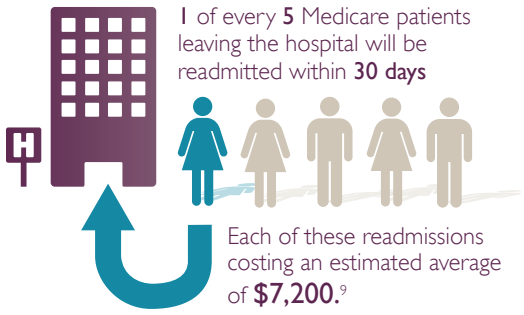
SECTION TWO

Rationale, Planning, and Methodology

The Impetus: CHF Patients at High Risk of Readmission

CHF affects some five million Americans, a number that could approach eight million by 2030 as the population ages.[7] Moreover, CHF patients who have been admitted to the hospital have a comparatively higher risk of subsequent readmission.[8]

Unfortunately, however, in spite of national efforts to reduce overall hospital readmissions, these rates actually have continued to rise. In fact, according to the U.S. Department of Health and Human Services, one of every five Medicare patients leaving the hospital will be readmitted within 30 days—with each of these readmissions costing an estimated average of $7,200.[9]



That said, it is estimated that up to 76 percent of these readmissions may be preventable.[10] These numbers are compelling, especially considering that some causes of readmission potentially could be minimized or even eliminated simply by employing low-cost, non-medical solutions.

Project Hypothesis and Goals

CHF is one of the most-common admission diagnoses for older patients admitted to Henrico Doctors' Hospital. For this reason, the hospital elected to collaborate with a local Home Instead Senior Care franchise office providing non-medical in-home care services to identify and target Medicare CHF patients, offering them the opportunity to participate in this project.

By working with Home Instead, the hospital was able to test the hypothesis that it could reduce readmissions for patients with CHF by ensuring smooth care transitions and providing basic non-medical in-home support services for these discharged patients—thus helping them to avoid deteriorations in health status that might trigger unanticipated returns to the hospital.

The project—which actually began while patients were still in the hospital and then continued for 30 days post-discharge—sought to achieve these outcomes by accomplishing two primary goals: 1) Ensuring smooth care transitions during and after discharge, and, 2) Identifying best practices to assist patients in their recoveries after leaving the hospital.

In fact, during the time when this project was running, the hospital's overall readmissions rate for CHF patients was 16.9 percent—which did compare favorably with national figures. However, the goal in participating in this

demonstration project was to bring down hospital-readmissions rates within this particular patient group by at least one full point, into the 15-percent range.

This project was initiated on May 1, 2012, and concluded on March 31, 2013. During the demonstration period, the hospital and Home Instead collaborated to care for 48 seniors with CHF, each of whom voluntarily participated in this project. The cost of these in-home-care interventions was funded by Home Instead, Inc., franchisor of the Home Instead Senior Care franchise network, and the project was jointly administered.

These non-medical-care services were provided by professional Home Instead CAREGivers[SM], selected with preference for those who were more experienced and more familiar with the patients' specific medical conditions (general knowledge of other chronic conditions was also deemed to be desirable). In addition, preference was given to CAREGivers with Certified Nursing Assistant (CNA) or Personal Caregiver Assistant (PCA) credentials.

Once these CAREGivers were selected, high priority was given to maintaining continuity of their pairings with patients throughout the 30-day service period.

Sampling Methodology and Data Collection

This "retrospective observational" pilot project compared the likelihood of hospital readmission within a group of the hospital's CHF patients receiving transitional, in-home care from Home Instead against a similar group of CHF patients receiving more-traditional post-discharge care.

Patients were deemed to be eligible for the program if they had these characteristics:

- Diagnoses of CHF;
- Status as Medicare payors; and,
- Plans for discharge directly to a home or assisted-living situation within the immediate Richmond geographic area.

In addition, the hospital's case-management team used a specially designed risk-assessment tool to certify patients for inclusion in this project.

Conversely, patients were declared ineligible if any/all of these disqualifiers pertained to them:

- The patients had been in "observation" status rather than being admitted;
- They were being discharged out of the hospital's aforementioned service area, to a skilled-nursing or intermediate-care facility, or to a long-term-acute-care hospital; and/or,
- They had a secondary psychiatric diagnosis.

These patients were categorized into two groups (both of which were selected during the same time period): an "intervention" group and a "control" group. The 48-member intervention group included those CHF patients who received non-medical services from Home Instead's professional home-care staff during their first 30 days post-discharge.

The 48-person control group (which was demographically very similar to the participant population) was randomly selected from a larger pool of candidates who met the inclusion criteria but declined to be part of the program. Typically, these patients refrained from participating because they believed that they had adequate in-home supports in place.

Data for the project were derived from the plan of care and from electronic medical records (EMRs), while outcomes data were collected by both the hospital's and Home Instead's case-management staff (this information is explained in greater detail later in this paper.)

The type of information assessed for patients included these variables:

- Selected demographic data;
- Related health conditions and co-morbidities; and,
- Whether (or not) patients were receiving care and support from family members, home-health-care, and/or hospice providers—or if they were residing in an assisted-living facility—while participating in this project.

The per-patient service-utilization characteristics that were examined comprised the following:

- The number of weekly caregiver visits;
- The hours of care required; and,
- The number of interventions used.

Of course, the primary outcome measure monitored was that of hospital readmissions within 30 days of initial patient discharge.

SECTION THREE

Interventions: Home-Care Services Provided

Home Instead offered each project participant the following array of professional, non-medical in-home transitional-care services for 30 days beginning immediately at the time of discharge.

Providing Transportation

This intervention was used by 83.3 percent of project participants:

- Immediately upon patient discharge, CAREGivers furnished transportation from hospital to home, if needed.
- Subsequently, the CAREGivers provided patients with transportation to doctors' offices and follow-up treatments, and to other essential locations such as pharmacies, grocery stores and churches.

Performing Home-Safety Evaluations

This intervention was used by 100 percent of project participants:

- Home Instead's Care Coordinator-type services provided patients with initial home-safety evaluations, and the CAREGivers subsequently provided light-housekeeping services to keep the participants' homes clean and safe.
- Home Instead's Care Coordinator also made recommendations regarding safety items, encouraged patients to utilize Lifeline, and, as appropriate, discussed with patients and their families the possibility of engaging other supportive services.

Educating Patients and Families About "Red Flags"

This intervention was used by 100 percent of project participants:

- Prior to this pilot, the nurse practitioner at the hospital's Heart-Failure Clinic provided training to the project team and to CAREGivers on recognizing "red flag" signs that might indicate problems with a patient's recovery.
- For CHF patients, these would include shortness of breath, edema, and rapid weight gain (thus, CAREGivers were shown how to perform daily patient weigh-ins, for example).
- Also, in conjunction with this project, educational materials on CHF and red-flag recognition were developed for CAREGivers to provide to patients and their families.

Providing Assistance in Managing Prescription Medications

This intervention was used by 71 percent of project participants:

- CAREGivers ensured that the medications on patients' discharge sheets were picked up from the pharmacy, and they would reconcile these new medications with those that were already in the patients' homes—subsequently notifying physicians and/or home-health workers if any discrepancies were identified.
- In addition, CAREGivers encouraged patients and their families to contact physicians and pharmacists to explore the option of using generic and/or lower-cost medications whenever possible.
- Finally, CAREGivers recommended that all patients have medication-management systems, or dispensers that the patients or families could fill weekly. The CAREGivers then encouraged patients' compliance with their post-discharge medication regimens.

Helping Patients Make and Keep Follow-Up Appointments

This intervention was used by 91.6 percent of project participants:

- Often, patients were unaware of the importance of making follow-up appointments with their physicians, and with allied healthcare providers such as physical therapists. Thus, these appointments frequently were made for participants by their CAREGivers (in many cases, even for patients with family members who were willing and able to do so).
- CAREGivers also transported and/or accompanied patients to these appointments as needed, and they subsequently assisted participants in complying with their healthcare providers' recommendations.

Preparing Meals and Offering Nutritional Support/Guidance

This intervention was used by 97.9 percent of project participants. In fact, since meeting these CHF patients' nutritional needs was deemed to be an important element of the program, this was one of the most-critical services offered:

- CAREGivers compared physician-recommended diets as outlined in patients' discharge instructions with participants' actual diets—and with the food that was already in their homes.
- CAREGivers also prepared healthy meals for participating patients and assisted them in the selection of healthy nutritional alternatives—for instance, recommending that during the project period, patients specifically select lower-salt and/or lower-fat foods, while avoiding canned- and processed-food items.
- From a longer-term perspective, CAREGivers made a point of teaching patients about proper nutrition; appropriate food selection and evaluation (for example, carefully reading packaging labels); and subsequent meal preparation.

Providing Personal-Care Services

This intervention was used by 100 percent of project participants:

- CAREGivers assisted patients with bathing, grooming (including oral hygiene), and/or dressing.
- As needed, they also helped participants with toileting, and, if necessary, provided support to patients who were dealing with incontinence problems.

Facilitating Communication and Reviewing Discharge Instructions

This intervention was used by 100 percent of project participants:

- CAREGivers helped facilitate and encourage regular, ongoing communication between/among patients, families and significant others.
- Particularly critical was the role the CAREGivers played in regularly reviewing the hospital-discharge instructions, and then educating patients and families about these instructions (though doing so could be difficult because these instructions occasionally proved difficult to locate in the patients' homes).
- In addition, the CAREGivers were responsible for keeping daily care-related records for each participant—documentation that helped ensure the provision of consistent, high-quality in-home services throughout the post-discharge care period.
- Finally, the CAREGivers intentionally looked beyond this defined 30-day stint to determine whether a longer-term-care plan also was in place for patients.

Coordinating Post-Discharge Care

This intervention was used by 100 percent of project participants:

- To ensure that patients received a coordinated array of post-discharge services from all providers, CAREGivers worked directly with physicians—primary-care doctors and specialists alike—and with home-health and hospice professionals.
- In addition, physical therapists worked with the CAREGivers to educate them on requisite patient therapies.
- CAREGivers also encouraged participant compliance with recommended exercise and therapy regimens.

SECTION FOUR

Patient Demographics and Participation

As can be seen in the table below, the mean patient age was 81 (more generally, participants were typically aged in their early- to mid-80s). **The gender mix of the participant group was 62.5 percent female and 37.5 percent male.**

In terms of race/ethnicity, more than two-thirds of participants (69 percent) described themselves as being "White/Non-Hispanic," with the remaining 31 percent self-described as being "African-American."

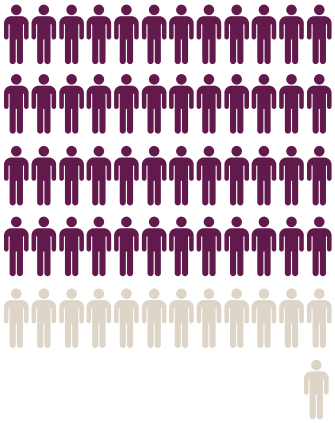
	INTERVENTION GROUP	CONTROL GROUP
Mean Age of Participants	81	77
Gender		
Male	18	22
Female	30	26
Race/Ethnicity		
White Non-Hispanic	33	35
African-American	15	12
Hispanic	0	1
Mean Co-Morbidities Per Participant	5	4.8

Finally, these patients averaged five co-morbidities—typically including diabetes, chronic obstructive pulmonary disease (COPD), and/or cancer—and 15 percent were deemed to have little or no family support available to them. Consequently, it perhaps is not surprising that 16.6 percent of these patients also were using skilled home-health-care services, and four percent each were in an assisted-living facility and/or they were under hospice care.

These patients averaged five co-morbidities—typically including:

- diabetes;
- chronic obstructive pulmonary disease (COPD);
- and/or cancer.

Completion Rates for Participants



Initially, 61 patients were accepted into this project, with 48 completing their 30-day service periods. This represents a 78.7 percent completion rate, with a 21.3 percent attrition mark.

Reasons for non-completion by the 13-patient "attrition" group were evenly distributed. Three participants each agreed to participate but canceled prior to joining; agreed to participate but died prior to joining; canceled soon after starting and did not rejoin; or died during the project period. The lone outlier here was a patient who participated for most of the project period (18 days) before leaving prior to completion.

Interventions: Frequency of Use

Over the 11-month duration of this project, most of the participating patients required all 10 of the interventions offered. The range was 5-10 interventions per patient, with the mean being 9.1.

The utilization of transitional-care interventions saw the following distribution:

In 100 percent of cases, Home Instead's Care Coordinator performed home-safety evaluations; educated patients and their families about "red flags"; provided personal-care services to patients; facilitated communication with/among patients and families, and reviewed post-discharge instructions with them; and coordinated care from post-acute providers.

In 97.9% of cases,
CAREGivers prepared meals and offered nutritional support.

In 91.6% of cases,
CAREGivers helped patients make follow-up appointments.

In 83.3% of cases,
CAREGivers provided patients with transportation services.

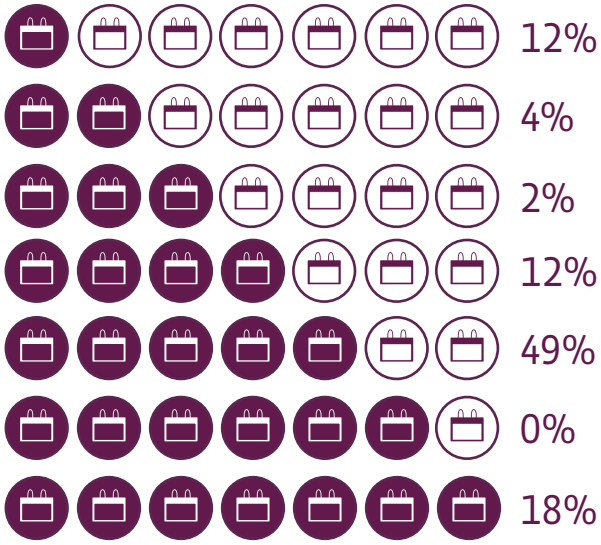
In 71% of cases,
CAREGivers assisted patients with management of prescription medications.

In addition, the CAREGivers provided program participants with regular companionship, offering them the emotional and social support that was integral to their recoveries.

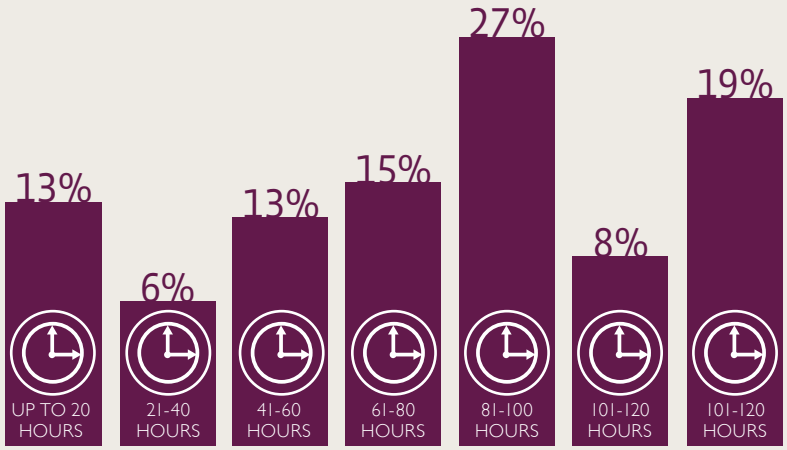
Interventions: Hours of Care Provided

On average, each patient received care on five days each week, totaling 103 hours of service from Home Instead over the 30-day project period.

However, these figures varied depending upon individual need. For example, the days-per-week totals for participants receiving services were distributed as follows:



Likewise, the hourly service totals over the 30-day service period varied widely, breaking down as follows:



Worth noting: one participant received 454 hours of service—by far, the highest individual instance of project-related-care usage.

[NOTE: Due to rounding, the figures in the above paragraphs may not total 100 percent.]

SECTION FIVE

The Results

Enhanced Post-Discharge Care Means Fewer Readmissions

Ultimately, this project resulted in a reduction in readmissions for the hospital's participating CHF patients to a 12.5 percent level, as compared with a 14.5 percent rate for those patients in the control group.

Only six project participants were readmitted, three of them for reasons unrelated to their primary diagnosis of CHF. Moreover, from a patient-satisfaction standpoint, after their 30-day service periods expired, six of these seniors chose to continue using Home Instead's home-care services (with all of these participants doing so at their own expense).

In Comparison: Notable Improvement Over local, Regional, and National Rates

Furthermore, these project results represent a 35-percent improvement upon the hospital's overall CHF readmissions rate (16.9 percent); 59- and 58-percent improvements over those of its parent company HCA and its geographic "Capital Division" within this organization (19.9 percent and 19.8 percent, respectively); and, finally, a 97-percent improvement upon recent, national readmission estimates for Medicare enrollees with CHF (24.6 percent).[11]

SECTION SIX

Lessons Learned: The Four "Core Protocols" of a Successful Transitional-Care Program

Through their collaboration on this project, the hospital and Home Instead demonstrated that four core protocols are essential to achieving favorable results in a transitional-care program:

A disciplined, consistent discharge process

Close, regular cooperation and communication between/among participating organizations

A strong emphasis upon effective CAREGiver selection and training

Dedicated supervision of care delivery

Following are detailed descriptions of each of these protocols.

Disciplined, Consistent Discharge Process

The hospital and Home Instead established the following process to transfer each patient successfully from hospital to home care (steps listed in order of occurrence):

Assessment of Each Client's Care History and Current Status

This was done by the hospital case manager to determine the program eligibility of each candidate—examining such variables as primary and secondary diagnoses; medical-risk profile; status as a Medicare payor; and plan for discharge to a qualified residential situation within the hospital's service area.

Development of an Individualized Care Plan

Each participant was expected to follow this personalized plan—which, ideally, had been issued with doctor's orders for home care as a prerequisite for discharge.

Personalized Briefing of the Home Instead Care Coordinator

The hospital's case-management director did this in order to familiarize Home Instead with the full patient-discharge plan.

Formulation of Recommendations Regarding Patient Medical/Nutritional Needs

The hospital's patient-care team formulated these patient-specific nutritional recommendations and then communicated them to the appropriate CAREGivers. Because it was deemed critical that each CHF patient follow the stipulated nutritional guidelines, this step in the discharge process was strongly emphasized.

Arrangement of In-Hospital Consultation with the Client and/or Family

Specific members of the care team—most typically, the Home Instead Care Coordinator—dealt with the family leading up to and then during the discharge into home care. In fact, this project showed that patient families could play important roles in helping to manage the transitional-care process (especially since many of the patients were not considered by their families to be healthy enough to be involved in their own care-related decisions).

The project also demonstrated an additional benefit to this very systematic discharge process: namely, in the time period that elapsed between the initial assignment of the patient to a CAREGiver and the delivery of care, necessary preparations could be made in the participant's home—for instance, doing a home-safety inspection and checking/restocking food stores.

Hospital and Home Instead: Close, Regular Cooperation and Communication

Substantial, regularly scheduled communication between the hospital and Home Instead was found to be essential not only at discharge, but for the entire 30-day duration of care for each patient. Throughout the 11-month period during which the project was operational, these two participating organizations typically had informal communications almost daily; in addition, care-management-team members met on a more-structured basis bi-weekly, bi-monthly, or at least monthly for the duration of the project.

Along with ensuring long-term, high-quality management of the relationship between these two care providers, reliable communication proved to be particularly critical during the development and design of this project, and then subsequently at three key points in the overall patient-care continuum: first, during the initial transfer of patients from hospital to home; second, in supporting the subsequent, ongoing client-specific care-review process; and third, as and when patient-related emergencies arose.

To facilitate this high level of communication, both participating organizations identified individuals who would be responsible for overseeing, managing and operating this project on a daily basis. In the case of the hospital, it was the inpatient case manager; likewise, Home Instead named one of its own organizational case managers to fulfill this role.

In addition—and very importantly—this program had "champions" within the hospital's administrative and case-management ranks, while high-level support within the Home Instead Senior Care franchise network came from local franchise ownership, as well as from the franchisor's corporate headquarters in Omaha, NE.

Emphasizing Effective CAREGiver Selection and Training

The CAREGivers utilized in this test were identified from the existing area Home Instead CAREGiver roster, with preference given to those who were more experienced—and, where possible, to those who were familiar with the medical conditions being dealt with by the patients.

The most-effective CAREGivers were knowledgeable not just about CHF, but also about diabetes, a common co-morbidity. More generally, familiarity with other chronic conditions also was deemed a plus; in addition, preference was given for those CAREGivers with credentials as Certified Nursing Assistants (CNAs) or as Personal Caregiver Assistants (PCAs).

Continuity of CAREGivers was found to be an important contributor to the provision of successful post-discharge service. As a result, special effort was made to ensure a consistent patient/CAREGiver experience throughout the 30-day care period (this also helped to prevent constant education of new CAREGivers.)

Ongoing CAREGiver training—an important element of this project—involved these components:

- Readmissions-specific instruction for CAREGivers as delivered by a registered nurse (RN), with a focus upon educating these CAREGivers regarding potential CHF-related issues and problems;
- Nutrition education from the hospital's heart-failure nurse practitioner, emphasizing the importance to CHF patients of following a proper diet, and highlighting the most-appropriate foods to be purchased and prepared for them;
- Instruction in recording and reporting daily observations of patients—to include performing patient weigh-ins every day;
- Familiarization with "red flag" warning signs related to other specific conditions; and,
- Ongoing review with CAREGivers of individual patient-care plans.

Dedicated Supervision of Care Delivery

Once the CAREGivers were selected and trained, in order to provide the most-effective outcomes, they were then closely supervised throughout the 30-day care period.

To ensure this continuity in care management, Home Instead dedicated a project manager/care coordinator for the duration of the 11-month project. This individual personally supervised all CAREGivers and their delivery of non-medical in-home care services to patients—thus providing overall consistency to this effort, and in individual care-related scenarios.

In addition, the project manager facilitated regular, effective communication between/among patients, families, CAREGivers, and Home Instead and hospital case-management personnel.

SECTION SEVEN

Discussion and Implications

Home Care Helps to Reduce Hospital Readmissions

In short, this project demonstrated that the provision of professional, in-home, non-medical care services to newly discharged CHF patients can diminish the likelihood that these seniors will be readmitted to the hospital.

This project saw the hospital's readmissions rate for participating CHF patients drop into the 12.5 percent range. This number represents a 35-percent improvement upon the hospital's overall CHF readmissions rate (16.9 percent); 59- and 58-percent improvements over those of its parent company HCA and its geographic "Capital Division" within this organization (19.9 percent and 19.8 percent, respectively); and, finally, a 97-percent improvement upon recent, national readmission estimates for Medicare enrollees with CHF (24.6 percent.)[12]

The aforementioned post-discharge offerings can include services such as providing patients with transportation; offering them home-safety assistance; watching for health-related "red flags" that could indicate problems with their recoveries; assisting them in managing medications; preparing their meals and providing them with nutritional support; and facilitating communication and coordination between/among these patients, their families, and other post-acute care providers.

Other Home-Care Research Supports These Findings

Moreover, Home Instead, Inc. has done additional independent, industry-wide studies on the quality and cost effectiveness of non-medical home care, with this other research lending credence to the positive results of this collaborative project. While these prior studies did not specifically look at the problem of preventable readmissions, they did suggest more generally that in-home, non-medical care can be a viable, cost-saving element of the overall care continuum for older adults.

For example, the "Value of Caregiving at Home" study found that on average, seniors using non-medical home care require about 25-percent fewer doctor's visits each year than do those older adults not using these services.[13] In addition, this research demonstrated that non-medical home-care providers can work very effectively alongside clinicians such as physicians and physicians' assistants, home-health nurses, and physical and occupational therapists.[14]

And a separate study done for Home Instead, Inc. by Dr. Frank Lichtenberg, a Columbia University economics professor, showed that home care can help save on national healthcare expenditures. According to his research, from 1998-2008, the length of U.S. hospital stays declined due to an

increased percentage of patients being discharged to home-health care and/or non-medical home care; in 2008 alone, this trend produced an estimated national savings of $14.9 billion.[15]

In Conclusion: Home Care Can Produce Savings by Improving Post-Discharge Care

The U.S. is at a critical juncture in the evolution—or perhaps even the reconfiguration—of its healthcare infrastructure.

A primary driver of this process is the financial unsustainability of this system in its present form. Consequently, a major consideration for all parties concerned—be they the government, healthcare providers, insurance companies, or patients and their families—will be finding ways to provide and/or arrange for the best-possible care, while also controlling related costs.

Thus, hospitals nationwide are looking for new ways to reduce expensive readmissions—particularly for Medicare enrollees.

Fortunately, then, this project has demonstrated that in-home, non-medical caregivers can facilitate, coordinate, and provide effective post-discharge care to older patients—thus helping them make successful transitions back to their homes, and, as a result, minimizing their chances of being readmitted.

On a local level, this could help relieve hospitals of myriad administrative and financial burdens associated with preventable patient readmissions. Nationwide, it has the potential to save the Medicare system vast sums of money that otherwise would be spent needlessly.

In conclusion: it's time to offer professional, non-medical in-home care a more-integral role in helping newly discharged U.S. seniors make safe, successful transitions back to their own homes—where they prefer to be—and thus avoid unnecessary, unwanted, and expensive return trips to the hospital.

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