

This paper is a distillation of the main themes from a series of verbal and written contributions by eleven panelists (listed at the end of the document) towards the close of 2010. While by no means exhaustive, the findings below were endorsed by this highly accomplished group of thought leaders for serious consideration by operators in the home care sector.

Six main themes evolved from this exercise:

1. Align – Prepare to become an active member of a seamless system of care.
2. Coordinate – Develop a specialization around care transitions, readmissions and re-hospitalizations.
3. Manage – Develop specialization around chronic disease management, care transitions management, medical home and/or wellness.
4. Support – Consider options to become a full service provider of both medical and supportive home services.
5. Invest – Make up-front investments in infrastructure and technology.
6. Scale – Investigate joint ventures, MSOs and virtual systems as a means of growth.

An outline of the key points discussed in each area follows.

- I. Align – Prepare to become an active member of a larger, seamless system of care.
 - a. There is clear movement by CMS towards breaking down silos and getting the entire health care system to work together in an aligned, coordinated system.
 - b. Independent providers must achieve alignment with larger systems of care (acute care systems, ACOs and medical homes) and integrate either actually or virtually.
 - c. Home care should prepare for partnerships with other providers (hospitals/physicians/payors) as ACOs – understanding that there will be several unique iterations of an ACO, all requiring high-quality, focused post-acute care.
 - d. Home care providers should focus specifically on close partnerships with physicians' groups/associations in order to become valued team members in the "medical neighborhood" of the future healthcare system.
- II. Coordinate – Develop a specialization around care transitions, readmissions and re-hospitalizations.
 - a. The home care industry is positioned to become the engine that coordinates the care provided at home by physicians/practices.
 - b. Home care should work towards becoming the convener – the master coordinator – of patient transitions and work in the front end of the care system as well as the post acute section.
 - c. The move toward Care Transition Models will position agencies to provide comprehensive coordinated chronic care management. Sustained improvement in patient quality outcomes will demonstrate real value to future Accountable Care Organizations. Home health organizations must be able to demonstrate their ability to improve and control avoidable readmissions to hospitals. Those organizations that can

- lower patient care costs by decreasing readmission rates will have a competitive advantage.
- d. Home health agencies should create and execute a new physician and provider communication strategy. The goal is to expand current relationships and cultivate new ones while acting as a catalyst using a team approach to connecting the patients' complicated system of care as well as to proactively present the home health value proposition to the health care community.
 - e. Develop and leverage expertise in:
 - i. Resource management
 - ii. Patient/family/caregiver satisfaction
 - iii. Defining realistic outcomes
 - iv. Patient advocacy
- III. Manage – Develop specialization around chronic disease management, care transitions management, medical home and/or wellness.
- a. Home health agencies (HHA) should excerpt and execute key concepts of population management models that allow care to be provided for a group of [chronically ill] patients pre, post and non-acute. The burden of cost should be shared with key constituents, IE, a multitude of payers and other providers. The HHA should formulate Service Under Arrangement agreements that fund services through risk shared outcomes. This can be done through a variety of service domains to include HH, Hospice, Private Duty, as well as traditional/non-tradition DM programming.
 - b. One focus should be on creating predictive models to identify at-risk patients while they are in acute care settings, and developing programs and incentives (potentially with the acute care provider) that reduce readmissions — leveraging call center and telemonitoring technologies.
 - c. Develop capabilities around wellness, “birth to grave”, and healthy consumers in order to be positioned for these needs.
 - d. Proactively direct involvement by all participants in the patient’s universe of care and catalyze communications among those participants.
 - e. Participate in community education programs.
- IV. Support – Consider options to become a full service provider of both medical and supportive home services.
- a. Because of the inter-dependencies of the two types of home care, medically oriented home health agencies should evaluate how to offer supportive services.
 - b. Agencies should consider alternative ownership arrangements that promote success in each of the operations, specifically: Preferred provider relationships, joint ventures, or two companies operating collaboratively but separately and bound together via a holding company.
- V. Invest – Make up-front investments in infrastructure and technology.
- a. Use of telehealth and EMR will be central to the future of aligned systems.

- b. Invest in hardware and software that provide virtual capabilities for delivering care. With home care reimbursement being minimized annually, home care entities need to re-define their care models and business models to produce excellence – clinically and financially.
 - c. Agencies should seek to find technology that is compatible with other health care segments, and continue to develop capabilities for sharing and managing data.
- VI. Scale – Investigate joint ventures, MSOs and virtual systems as a means of growth.
- a. Home health agencies with the capital and internal capability for growth and for operating as a Management Services Organization (MSO) should consider developing a Newco that achieves regional scale through joint ventures and an MSO relationship with small, independent home health agencies. The Newco provides the opportunity for small agencies to have the advantage of scale and immediate access to the same types of sophisticated IT, referral development, marketing, staff recruitment and training, etc. that competitors have. A management fee depending on how much value is being brought to the small agency would be established.
 - b. Home care operators generally speaking should be prepared for additional and more sophisticated contractual arrangements in the future, particularly as it relates to clinical integration. Operators that are able to embrace new arrangements will be more integral than, say, those with a fee for service mentality.

Panelists

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Erin Denholm, CEO, Centura Health

Bob Fazzi, President & Managing Partner, Fazzi & Associates

Dr. Michael Fleming, CMO, Amedisys Home Health

Kathleen Griffin, National Director - Post Acute and Senior Services, Health Dimensions Group

Ron Marshall, Vice President, Sutter Home Health

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