From Acute Care to Home Care: The Evolution of Hospital Responsibility and Rationale for Increased Vertical Integration

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EXECUTIVE SUMMARY

The responsibility of hospitals is changing. Those activities that were once confined within the walls of the medical facility have largely shifted outside them, yet the requirements for hospitals have only grown in scope. With the passage of the Patient Protection and Affordable Care Act (ACA) and the development of accountable care organizations, financial incentives are focused on care coordination, and a hospital’s responsibility now includes postdischarge outcomes. As a result, hospitals need to adjust their business model to accommodate their increased need to impact post–acute care settings.

A home care service line can fulfill this role for hospitals, serving as an effective conduit to the postdischarge realm—serving as both a potential profit center and a risk mitigation offering. An alliance between home care agencies and hospitals can help improve clinical outcomes, provide the necessary care for communities, and establish a potentially profitable product line.

For more information about the concepts in this essay, contact Mr. Dilwali at pdilwali@alum.mit.edu. Mr. Dilwali is the first-place winner of the graduate division of the 2013 ACHE Richard J. Stull Student Essay Competition in Health-care Management. For more information about this competition, contact Sheila T. Brown at (312) 424-9316.
INTRODUCTION

For years, the issue of patient handoffs has plagued hospitals. A search of the literature highlights many issues regarding the difficulty involved in ensuring high-quality care for patients when transitioning between providers. Forster, Murff, Peterson, Gandhi, & Bates (2003) found that one in five patients experiences an adverse event (defined as an injury resulting from medical management rather than from the underlying disease) in the transition from hospital to home. They also found that approximately 62% of adverse events could be either prevented or ameliorated.

A 2008 Commonwealth Fund study found that among eight industrialized nations, the United States had the highest rate of readmissions within 2 years to the hospital or patients visiting an emergency department (ED) as a result of complications that arose during recovery (Table 1).

Despite all the data reporting high postdischarge readmission rates, hospital discharge procedures have not been standardized (Greenwald, Denham, & Jack, 2007). This lack of consistency represents a large problem because systems to ensure that patient data are transferred to subsequent caregivers in an efficient and effective manner are inappropriate or ineffective (Moore, Wisnivesky, Williams, & McGinn, 2003; Wachter, 2004). For example, discharge summaries frequently lack critical data and are not sent to the patient’s primary care physician in a timely fashion (Kripalani et al., 2007; Van Walraven, Seth, Austing, & Laupacis, 2002). Roy et al. (2005) examined test results pending at the time of discharge and determined that posthospital providers were frequently unaware that results were pending, posing a potentially serious clinical threat. Specifically, delays in the reporting of test results are responsible for incomplete patient evaluations (Moore, McGinn, & Halm, 2007; Roy et al., 2005).

Furthermore, a meta-analysis revealed that only 12–34% of discharge summaries had reached aftercare providers by the time of the patient’s first posthospitalization appointment (Kripalani et al., 2007). In addition, patients were often left unprepared at discharge—many of those questioned did not understand their discharge medications and could not recall their chief diagnoses (Makaryus & Friedman, 2005).

A poor transition often leads to a poor understanding—on the part of both the patient and the caregivers—of health status, which can result in

| Table 1 |
| Readmission Rates by Country |
| Australia | Canada | France | Germany | Netherlands | New Zealand | United Kingdom | United States |
| 11% | 17% | 7% | 9% | 17% | 11% | 10% | 18% |

Source: Commonwealth Fund (2008).
negative consequences for the patient, including the following (Williams, Davis, Parker, & Weiss, 2002):

- Difficulties navigating the healthcare system
- Nonadherence to prescription medications and dosages
- Missed physician appointments

With more than 32 million adult discharges in the United States each year (Levit et al., 2007), these deficiencies in the transition of care can increase the rates of illness among them, lead to unnecessary hospital utilization, and incur unnecessarily high costs of care.

However, major structural changes are occurring within healthcare organizations to address the issues. These changes are finance driven, and home care is at the forefront of the shift.

In the 1990s, because home care was well reimbursed, hospitals frequently provided postdischarge care in the home. As costs were scrutinized and payments reevaluated, many hospitals did not see the financial benefit to providing these services and thus divested, resulting in a precipitous drop in home care services, which lasted into the 2000s (Horwitz, 2005). However, as the financial incentives are shifting once again—this time to pay for performance—providing these postdischarge services is reemerging as the industry standard. With hospital management focused on effective outcomes, entering the home care market is the logical move to ensure that hospitals achieve expected clinical results and maximize revenue opportunities.

**Home Care’s Reemergence**

The Joint Commission (2011) asserts that the best place for care is at home. Costs for care are lower, patients are more satisfied, and the environment is friendlier to the patient than in the hospital setting. Home care is defined by the Centers for Medicare & Medicaid Services (2013) as prescribed services delivered in the patient’s home, such as nursing care; physical, occupational, and speech–language therapy; and medical social services. The goals of home health care services are to help individuals improve function and live with greater independence; to promote the client’s optimal level of well-being; and to assist the patient to remain at home, avoiding hospitalization or admission to a long-term care institution (Shaughnessy et al. 2002).

In the late 1980s through the 1990s, hospital administrators considered integration with home care agencies essential, as home care was viewed as an important element of overall care. As Rumberg and Girard (1994) stated:

The typical compartmentalized approach, which divides service delivery systems and creates blind spots and inherent inefficiencies, can no longer be afforded in today’s cost-conscious health care market. Strategically integrating previously separate hospital and home care delivery systems is a key to enhanced service quality and economic efficiency.

Some of these blind spots were addressed by encouraging stronger hospital control postdischarge. During that time, home care was deemed a profitable endeavor—the effective delivery of home care could increase a hospital’s
income by up to $1 million (Rumberg & Girard, 1994).

However, as the reimbursement scheme changed to a prospective payment system and the profitability of home care decreased, numerous for-profit hospitals and health systems dropped the service, and home care became a cottage industry with many small companies providing local care. With the March 2010 enactment of the ACA, the symptoms of a splintered industry may be treated by encouraging coordination and collaboration among different groups of care providers. Hospitals are responding to financial incentives to ensure care continuity by monitoring their 30-day readmission rates. Because many patients are discharged home after hospitalization, home care in the hands of hospitals is a potential means by which to impose more control over postdischarge care, thereby controlling their quality-based reimbursement rates.

Still, according to the American Hospital Association (AHA, 2011), less than half of current community hospitals, both rural and urban, provide some sort of home care services (Figure 1). Data show that of the different types of patient care transitions, the hospital-to-home transition is associated with the most ED visits and preventable rehospitalizations (Figure 2) (Arbaje, 2010).

Numerous initiatives have been piloted to determine effective ways to discharge patients, including the patient-centered medical home model, the 11-step Reengineered Hospital Discharge method (Greenwald, Denham, & Jack, 2007), and the National Transitions of Care Coalition approach (NTOCC, 2008). Some of the

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**FIGURE 1**

Percentage of Hospitals Offering “Nonhospital” Services, by Location, 2009

<table>
<thead>
<tr>
<th>Service</th>
<th>Rural</th>
<th>Urban</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home health</td>
<td>41%</td>
<td>27%</td>
</tr>
<tr>
<td>Skilled nursing</td>
<td>38%</td>
<td>21%</td>
</tr>
<tr>
<td>Hospice</td>
<td>24%</td>
<td>24%</td>
</tr>
<tr>
<td>Assisted living</td>
<td>8%</td>
<td>3%</td>
</tr>
</tbody>
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Source: Data from AHA (2011).
interventions from these methods have been shown to reduce the rate of avoidable rehospitalization:

- Improved core discharge planning and transition processes out of the hospital
- Improved transitions and care coordination at the interfaces between care settings
- Enhanced coaching and education for the patient to support and encourage self-management

While educating the patient is important, forging a strong link between the hospital staff and the next set of providers has emerged as a priority. The Institute for Healthcare Improvement considers the execution of an effective transition from the hospital to post–acute care settings to be a high-leverage initiative, or one likely to be associated with significant improvement in outcomes, for reducing rehospitalizations (Sevin et al., 2012).

HOSPITALS’ FINANCIAL RATIONALE TO REENTER HOME CARE

Home care agencies are growing at a staggering rate. A report issued by the Medicare Payment Advisory Commission (MedPAC, 2012) shows that as of 2010, more than 11,000 for-profit and not-for-profit independent home care agencies were in operation—up from 7,000 in 2000. The number of total
beneficiaries using home health agencies has increased from 2.5 million in 2000 to 3.4 million in 2010. Home care agencies averaged nearly 18% margins during the period 2001–2009. Reimbursement rates are not going to stay as high as they have been, and with the ACA, organizations will feel downward pressure to reduce the market basket of payments to home care services. While margins will likely decline, they are still considerably higher than overall hospital margins, representing a significant financial opportunity for hospitals and independent agencies.

One home care chief financial officer (CFO) interviewed for this research noted that starting a home care company does not require a significant capital investment. Little physical infrastructure is needed, and the majority of the fixed costs are personnel. Hospitals are in a prime position to initiate or build a home care product line because they recruit healthcare professionals routinely in the course of its operations. Furthermore, the learning curve to achieve a functional system is relatively flat.

Hospital agencies will not be precluded from initiatives to prevent fraud and will have to abide by the new guidelines requiring specific interval assessments by medical personnel to ensure care is needed. Although abiding by the rules is important, this regulation should not have a significant impact on or delay utilization of services because the personnel are connected to the hospital directly. The prospective payment system that home care companies use is fair and creates a high-margin business with low startup and operating costs, thus presenting a large opportunity for hospitals to reap financial rewards.

**Organizational Changes**

On the organizational level, poor hospital discharge planning has been identified as a primary factor contributing to poor outcomes for seniors after hospitalizations (Graham, Ivey, & Neuhauser, 2009). The disjointed nature of postdischarge protocols results in readmissions with providers from each segment skirting responsibility. This vacuum of responsibility represents a major organizational issue, as the two groups do not share the same vision. However, with one group under an umbrella organization, a patient can be discharged to her home and use an in-home care service, and the hospital can provide a team-based approach through a controlled environment. Data show that a sense of camaraderie and loyalty indicates a significant positive relationship with quality of patient care (Khatri, Halbesleben, Petroski, & Meyer, 2007). If the two groups have a shared vision, the likelihood of effective outcomes is greater than without the shared vision. Further, with greater management oversight and a more centralized “command center,” doctors and home care providers will have access to each other and a strong need for effective communication. Such initiatives will prevent the breakdowns that occur in a fractured system of care. Encouraging a collaborative environment and a commitment-based approach to patient care has the potential to ensure enhanced outcomes and satisfy staff. Finally, this approach can help the team learn from mistakes
and encourage motivation between the different care providers.

**Proposed Plan**

A relationship with home care agencies is critical to ensure successful patient transitions. However, it is the opinion of the author that hospital executives should consider one of two approaches to potentially accomplish this task: complete integration or joint venture.

Success will rest on the establishment of a new position to facilitate the process: the chief transition officer (CTO). The main role of the CTO is to ensure effective discharge processes, including medical record handoffs, communication of discharge orders, and maintenance of medication lists. Also under the purview of the CTO will be the hospital home care agencies. The CTO will act as the facilitator, building strategic and operational relationships between the home care agencies and hospitals.

**Complete Integration**

In a complete integration model, the hospital buys the home care company directly or builds the capabilities in house, absorbing the initial costs and integrating the staff culturally. It establishes a credible business unit, similar to the radiology or surgical department. This action has numerous advantages. The hospital has complete control over the operations of the agency, allowing for an immediate assessment of any nonconformity from initial plans laid out by management. Information transfer and discussions between providers at both levels will be unhindered and transparent. Management oversight of the organizations can ensure compliance and a quick line of communication to monitor progress and outcomes. Because the objectives of the organization are aligned, the atmosphere encourages a team-based approach to caring for the patient. Revenues derived from application of the complete integration model support the hospital’s bottom line and increase potential market share in the local community as the hospital develops market power.

However, this course of action includes costs and risks. Investing in a home care company does not guarantee patient utilization, and the integrated company is not as scalable as an independent business. Staff will likely want to stay close to the hospital, but home care agencies may need to provide services to patients hundreds of miles away. Although the trained personnel required to staff home care companies are available within the hospital, this approach may strain the already high fixed costs that hospitals endure. This organizational structure provides the hospital with the most control and greatest financial benefit; however, few hospitals are currently entering the home care market in this manner.

Large organizations may be inclined, instead, to consider this type of decision. With greater capital and a more developed infrastructure, large systems are able to absorb startup costs and ensure that the revenue cycle management protocols are in place to properly administer the program.

**Joint Ventures**

An alternative, potentially stepwise, approach to entering the market is to
establish a joint venture or an exclusive agreement with a home care company. A joint venture does not require the capital start-up costs or the upkeep costs of running the organization. Building contracts revolving around utilization and referrals may suffice. A joint venture uses companies that are already established in the market and are potentially providing services to several counties. It provides flexibility for the hospital in the event that the home care agency relationship needs to be ended.

However, while effective, a joint venture poses serious concerns. Primarily, the care is still disjointed from the hospital. Hospital management and medical staff do not have direct communication with the home care aides. Financial incentives are not directly aligned, and the hospital does not establish a larger footprint in the community. The CTO, while an important liaison, has limited ability to exert control and influence over the home care organization. As indicated by the CFO interviewed for this research, however, this model is currently being used in numerous Texas facilities and could be applied nationally. Practically, joint ventures could make sense for smaller institutions as they decide how to effectively proceed and determine whether their involvement is attractive enough to create their own program.

**Conclusion**

Eventually, hospitals will be responsible for the entire continuum of care in a community. Engaging home care is one step that can be taken in the short term to reach that goal. Large health systems may be more financially suited than independent hospitals or small systems to embark on such initiatives on their own and be ready to take on the additional risk. However, it seems that smaller, community facilities may be able to implement home care initiatives at a local level more effectively for the population they serve. Culturally, they tend to be more agile than larger institutions and more knowledgeable about their specific community’s needs, and in responding to those needs by hiring personnel with understanding of their patients and providing services that are relevant. On the other hand, smaller institutions need to be willing to take the risk and recognize that their initiatives may not be suitably scalable.

Ideally, to hedge their risk, hospitals should consider a joint venture as an initial step to evaluate the effectiveness of the combined organization. Should the result be positive, executives may be inclined to consider a greater degree of collaboration and integration. Assessing both financial results and patient outcomes is necessary before expanding the relationship. A detailed management strategy and successful implementation plan for a joint venture could serve as the stepping-stone to a profitable relationship, with the ultimate goals of improved patient outcomes and solvency for the hospital.

Home care is a market with significant potential to positively affect care delivery within a community, encourage a managed approach to discharge procedures, and provide a high-margin business for the organization. Hospital leaders should recognize home care as both a profit center and a risk mitigation product that entails developing a strong
relationship crucial to patient outcomes, future market position, and financial rewards.

REFERENCES
transitions from the hospital to home health care to reduce avoidable rehospitalizations. Cambridge, MA: Institute for Healthcare Improvement.


