Effective Management of Heart Failure Population in Home Health Care

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Key components of the HF initiative:

- **Care teams**: Development of specialized HF care teams through the integration of evidence-based education and practice
- **Education**: Development of HF patient and caregiver self-management education
- **Continuous Care Model**: Making providers available to patients during and between home visits
- **Coordination across settings**: Efficient use of care transition specialists and clinical liaisons to coordinate patient care
- **Internal Policies and Procedures**: Align internal policies and procedures with evidence-based training and protocols
- **Clinical Pathways**: Integrate evidence-based care plan that details essential steps in the care of HF patients
- **Documentation Improvement**: Improve clinician skills to ensure accurate and timely clinical documentation which reflects the scope of services provided
- **Measurement**: Use measures across four pillars; track and report findings on consistent basis to promote transparency and accountability

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**Results**

**QUALITY**
- 15.9% decrease in hospitalizations (ACH)
- 16.9% decrease in readmissions (Re-ACH)
- 13.2% improvement in ambulation
- 11.2% improvement in pain interfering with activity
- 6.0% improvement in dyspnea

**PEOPLE**
- Recommendation rate of 98% or above for all three programs (HF clinical, non-clinical, and certification)
- 3,070 clinicians and non-clinicians completed mandatory HF training
- 461 BAYADA certified heart failure specialists across our practice

**FINANCE**
- PPS Revenue for HF program clients - $13,085,546
- GM% increased by 0.4%
- Average total visits decreased by 3.5%
- Average length of stay decreased by 17.9%

**GROWTH**
- 5.2% increase in admits per day

Pre-program measurement time period: Jan 1, 2014 to Nov 30, 2015
Post-program measurement time period: Dec 1, 2015 to Jan 31, 2017

Key outcome comparisons are based on % changes, thus time periods need not be the same

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**Background**

Heart Failure (HF) is a leading cause of hospitalization in people 65 and older and one of the top diagnoses of BAYADA Home Health Care’s Home Health Practice.

BAYADA’s home health practice provides customized home health services to nearly 10,000 patients in 22 US states. Home health care services are offered to Medicare beneficiaries who need skilled services for an intermittent period and require substantial effort to leave home (homebound).

Because of Medicare’s homebound requirements, home health care patients may represent as “sicker” HF patients. In January 2015, BAYADA designated Heart failure as a key strategic initiative for the Home Health Practice.

**Objective**

The aim of the HF initiative was to standardize evidence-based best practices, reduce variation in care, and improve performance practice-wide among 100 service offices in 22 states, with an overarching goal of reducing hospitalizations and keeping HF patients safe at home.

**Development and Implementation**

Development and Implementation: A multidisciplinary team developed evidence-based educational, clinical, and operational processes for team-based HF population management. The HF initiative was implemented on December 1, 2015 in 100 service offices across 22 states.

**Conclusions**

- Developing an organized system of care with specialized HF care teams improves the quality and consistency of care.
- Providing continuous support and effective care coordination to our patients, and aligning internal policies and procedures with evidence based guidelines, makes it possible to manage populations comprehensively and cost effectively.
- BAYADA’s HF initiative decreased hospitalizations and unnecessary utilization of health care services while improving key outcomes for this population.
- This initiative also helped forge meaningful relationships with external providers, community stakeholders, and payor groups to work collaboratively and address the needs of this population across the continuum of care.

**References**


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