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Home Care and Hospital Associations Applaud Senator Hannon's 'Hospital-Home Care-Physician Collaboration Program' in State Budget

ALBANY, NY – To promote health care system integration, State Senator Kemp Hannon (R-Nassau) has advanced an important new program in this year's state budget that supports home health care providers, hospitals and physicians as they work together on collaborative models.

The Home Care Association of New York State (HCA) and the Iroquois Healthcare Alliance (IHA) – which represent home care providers statewide and hospitals and health systems in the upstate region, respectively – applaud the Senator for his sponsorship of this vital initiative and look forward to continuing to work with the Senator on program implementation post-budget.

This initiative was previously introduced as standalone legislation (S.1110) and later adopted as a new program in the state budget, complementing related state health care policies. It specifically creates and devotes a statute within the Public Health Law to support "Hospital-Home Care-Physician Collaboration" programs. Such collaboratives could also include long term care facilities, behavioral health, supportive housing and other interdisciplinary providers.

"Collaboration among health care providers is essential to good care," said Senator Kemp Hannon (R-Nassau). "For patients who require care at home, collaboration must include the home health care providers as this program does."

"Virtually all health reform policies are aimed at provider collaboration and integration, making this legislation an important framework for tightening the loop among hospitals, home care agencies and physicians in their care management functions and deployment of staff on behalf of patients," said HCA President Joanne Cunningham.

She adds: "Home care providers, hospitals and physicians each have distinct roles in the health care system. But research shows that close collaboration, coordination and integration among these provider types leads to better care and lower costs. For instance, a home care provider may identify a change in a patient's condition at home, such as rapid weight gain or

difficulty breathing, to secure interventions by a physician or hospital, if needed, well before the condition worsens and requires higher-cost care or a longer hospital visit."

The new statute would specifically provide a foundation for programmatic, financial and regulatory support to facilitate: transitions in care; use of clinical pathways; application of telehealth/telemedicine services; facilitation of physician house calls; health home development; development and demonstration of new models of integrated or collaborative care; bundled payment demonstrations for hospital-to-post-acute-care; infrastructure support, such as recruitment, training, cross-training, retention and placement of essential direct care personnel; and other initiatives in the care and management of patients, through best practices, training and education of direct care practitioners and personnel.

Gary J. Fitzgerald, President and CEO of the Iroquois Healthcare Alliance, comments that "Collaboration is essential to the integration of care in our communities. By providing the opportunity for new models of care, especially between hospitals and home care with the physicians, we can innovate and improve the delivery system and continue towards the 'triple aim.'" The U.S. Centers for Medicare and Medicaid Services has identified the "triple aim" as lower costs, better population health and improved individual health.

The provision is compatible with other emerging health care policies, also supported in the state budget, including the Delivery System Reform Payment (DSRIP) program. Under DSRIP, the state is reinvesting over $6 billion in federal funding from Medicaid reform savings to promote new regional health networks, called Performing Provider Systems, aimed at bringing providers together.

The Hospital-Home Care-Physician Collaboration program is distinct from DSRIP in that it is more open and flexible, may be smaller or larger in scale, and may be developed and implemented by different configurations of collaborating providers. It would offer a flexible arrangement for any combination of provider groupings to participate in a collaborative program, further incentivizing cross-provider partnerships from the ground level on up. DSRIP projects, by contrast, are governed by a single lead institutional provider that drives all of the payment and program decisions and selects the partners allowed to be involved within a broad region. The two programs, however, are aligned in their objectives and are sure to feed mutual innovation and participation.

Indeed, a 2012 study by Simione Healthcare Consultants found that innovative care-transitions programs for a defined group of high-risk patients at just five Medicare-certified home health agencies saved $1.2 million in averted hospital expenses annually by reducing each agency's 30-day readmission rate, a key quality metric in federal health reform efforts. Duplicating these kinds of voluntary efforts statewide would lead to significant strides in improving patient care while reducing costs.

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