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HOME HEALTH CARE

Millenium Provides Winning Solution, Partnership Prevents Hospital Re-Admissions

Millenium Home Health Care offers a valuable solution in the continuum of care – an episodic, transitional option for patients who were discharged to their home, but are temporarily too sick to travel to their physicians' offices for medical treatment. This transition program bridges the gap, providing high-quality home health care from the time patients are discharged from the hospital or long-term care facility, until they are strong enough to go back to their physicians' offices.

This innovative transition program is a winning solution for patients, who receive high-quality medical assessments and treatment at home. Often, the programs' experienced Nurse Practitioners are able to diagnose, treat and manage patients' health conditions before the issues get worse, preventing the patients from needing re-hospitalization.

Additionally, this transition program is beneficial for physician practices, helping them fill the gap when their patients are too sick or weak to travel to their office. Physicians have peace of mind knowing that experienced, well-trained NPs are taking excellent care of their patients during this transition time, and helping to prevent hospital readmissions. This program does not replace primary care physicians as a long-term care solution, but instead provides an additional "safety net", working with home health care agencies, social workers, physical and occupational therapists, and other providers on a temporary basis to assess, treat and manage homebound patients.

In addition to benefiting physicians, the transition program is also financially beneficial to hospitals, as this approach has been shown to significantly reduce hospital readmissions. Since hospitals have to pay a hefty fee for certain re-admissions within 30 days, it's in the hospitals' best interests to reduce the Return to Hospital (RTH) rate. The higher the RTH rate at a facility, the greater the penalty they are required to pay.

Several years ago, Millenium Home Health Care entered into a successful collaboration with Post Acute Physician Partners, a nursing transition program. Pennie Savage, the lead NP at Post Acute Physician Partners, said that her team of NPs helps prevent many hospital readmissions – which she said can cost a hospital $13,500 or more for each readmission, if patients go back within 30 days.

To illustrate that point, Pennie's company has worked with one Baltimore-based hospital for the past six months. In that timeframe, they've helped cut readmissions for congestive heart failure (CHF) patients from 39% to just 6%.

According to Pennie, the statistics show that her homecare NPs helped keep 115 CHF patients from being readmitted to this particular hospital over the course of six months. Assuming that the hospital is fined $13,500 per readmission – which Pennie

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said is a low estimate – preventing 115 patients from being readmitted saved the hospital more than $1,500,000 in a six month timeframe. That could translate to a savings of more than $3 million – a noteworthy sum – over a year for this one hospital. Imagine the positive financial implications that other hospitals would experience if this model was replicated elsewhere.

"In no way are we trying replace patients' doctors. In this gap between being discharged from the hospital until they're strong enough to go back to their physician, we treat them at home. We help bridge that gap," Pennie explained. "We don't look at just one thing – we look at the whole patient."

According to Judy Bennett, Executive Director, at Millenium, partnering with transition programs like Post Acute Physician Partners offers benefits across the board.

"Patients enjoy increased convenience, with experienced NPs coming right to their home when they are too ill or weak to travel to offsite physicians' offices. The NPs collaborate with each patient's primary care physician, regularly communicating about the patients' care and progress. Physicians enjoy knowing that their patients are receiving extraordinary transitional care until they become strong enough to return to their practice. And hospitals benefit financially by decreasing their Return to Hospital rate – and the financial savings can be quite substantial," Judy explained.

"The benefit to Millenium is that transition program NPs provides another level of expertise and allows Millenium to enhance the services to the homebound patients we serve," Bennett continued.

Transition team NPs can evaluate, manage and treat homebound patients by adjusting medications, removing PICC lines, ordering lab work, checking blood pressure, and staying in touch with the patients' medical teams. They also provide quick, accurate turnaround times for paperwork, expediting billing and minimizing administrative hassles.

Millenium began working with Post Acute Physician Partners several years ago, and the collaboration has been a win for all involved. Now, they're celebrating an important milestone – successfully treating 300 patients together. As they commemorate this important occasion, both organizations agree that they will continue this valuable partnership, providing high-quality home health care for the patients and communities they serve.