

High-Value Home Health Care for Patients With Heart Failure

An Opportunity to Optimize Transitions From Hospital to Home

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Challenges and Opportunities With Home Health Care

In recent years, public reporting, targeted financial penalties, and incentives to develop alternative payment models that include the assumption of financial risk have compelled hospitals to focus on reducing readmission rates for high-cost conditions such as heart failure (HF). When older patients with multiple medical conditions including HF are discharged from the hospital, they are vulnerable to adverse events, which may result in recurrent hospitalization (the post-hospital syndrome).¹ In theory, providing home health nursing and therapy could promote recovery in vulnerable HF patients with post-hospital syndrome and potentially reduce readmissions.

Within the United States, home health care (HHC) referrals after acute care hospitalization increased by 65% to 3.7 million between 2001 and 2012.^{2,3} Patients discharged from US hospitals with a primary diagnosis of HF had the highest number of HHC referrals during this time, with ≈200 000 post-acute HHC referrals in 2012.² In addition, HHC surpassed skilled nursing facilities as the most frequently used post-acute care among Medicare beneficiaries with HF in 2012 (unpublished HCUPnet data). Such an increase in HHC use for patients with HF is likely related to multiple factors, including decreasing length of stay for patients with HF⁴ and more recent pressures to improve readmission rates for HF after adoption of the Affordable Care Act in 2010, which included the Hospital Readmissions Reduction Program that was implemented in 2012.^{5,6} Despite substantial growth in post-acute HHC referrals for patients with HF,² it is unclear whether HHC delivered in real-world settings consistently provides high-value care. Understanding the characteristics of effective post-acute HHC for patients with HF will inform best practices, optimal outcomes for cost, and ultimately high-value care.

Medicare Home Health Policy and Payment

Because most patients referred for skilled HHC are Medicare beneficiaries, Medicare eligibility and payment policies have

important implications for HHC. Patients who receive HHC reimbursable through Medicare must be under the care of a physician and are deemed to require skilled services (eg, nursing and physical therapy) and are certified as homebound, meaning that leaving home presents great difficulty because of medical/physical condition.

Changes to Medicare payment policies for HHC services have historically resulted in shifts in HHC utilization. One such change occurred after an Interim Payment System was implemented for HHC reimbursement in 1997, which capped reimbursement for HHC and resulted in a rapid decline in the use of HHC services.⁷ In 2000, Medicare changed to a prospective payment system for HHC services, in which HHC agencies are paid a predetermined amount adjusted to clinical complexity and functional impairment for HHC services for up to 60 days. After the change to prospective payment system, the number of HHC agencies and annual HHC episodes increased. Additionally, between 2001 and 2013 Medicare spending on HHC more than doubled to ≈18 billion annually.³

Although HHC costs for Medicare beneficiaries are substantial, the means of achieving ideal outcomes in post-acute HHC remain unclear. HHC agencies are required to publicly report process and outcome measures as a result of the Medicare Home Health Quality Initiative, which launched in 2003, and the Improving Medicare Post-Acute Care Transformation Act of 2014.^{8,9} HHC agency quality outcomes are publicly reported on the Home Health Compare website and include measures of managing daily activities, managing pain, treating wounds, preventing harm, and preventing unplanned hospital care (Table).⁸ Starting in 2018, a new measure of potentially preventable readmissions within 30 days of a post-acute HHC discharge will also be added to Home Health Compare.

Theoretically, publicly reported outcome data could incentivize HHC agencies to improve patient outcomes. Yet, public reporting alone has not historically been associated with substantial outcome improvements in other settings, such as with Medicare's Hospital Compare, which did not substantially

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Table. Home Health Compare Quality Outcome Measure Categories and Examples

Quality of Patient Care Measure Categories	Measure Examples
Managing daily activities	How often patients got better at walking or moving around
Managing pain and treating symptoms	How often patients' breathing improved
Treating wounds and preventing pressure	How often patients' wounds improved or healed after an operation
Preventing harm	How often the home health team taught patients (or their family caregivers) about their drugs
Preventing unplanned hospital care	How often home health patients had to be admitted to the hospital

impact mortality in key conditions beyond existing trends.¹⁰ On the contrary, linking reimbursement to clinical outcomes has been associated with improvements in readmissions to acute care hospitals for key conditions including HF through Medicare's Hospital Readmission Reduction Program.⁵

Although Medicare does not currently link reimbursement to clinical outcomes for HHC as a whole, an ongoing Home Health Value-Based Purchasing (VBP) model demonstration could inform whether such a model will incentivize high-value care. This Home Health VBP model was implemented in January 2016 within all HHC agencies in 9 states with the goal of incentivizing greater quality and efficiency in HHC and will continue through 2022.¹¹ Many of the performance measures in the Home Health VBP demonstration are the same as those publicly reported on the Home Health Compare website, examples of which are provided in the Table. Medicare may also adopt a MedPAC recommendation to implement readmission penalties for HHC agencies in coming years, in which case outcomes and payment in HHC are likely to become more closely aligned.¹² This overall shift toward improving the value of healthcare is unlikely to wane, even in the current political climate, as the Medicare Access and CHIP Reauthorization Act was developed and supported with bipartisan consensus.¹³

Alternative payment models (eg, bundled payments) that include financial risk to hospitals are likely to have important downstream effects on post-acute care. Historically, Medicare payment policies likely contributed to trends in utilization, including shorter hospital length of stay for patients with HF from the 1990s to 2000s,^{4,14} with concomitant increases in 30-day readmission rates and referrals to skilled nursing facilities.⁴ In a similar way, the pressures that alternative payment models place on hospitals to reduce costs for episodes of care that extend well beyond hospital discharge are likely to have downstream effects on post-acute care utilization. For example, patients who require post-acute care services may increasingly be referred for less costly post-acute care services such as HHC as a substitute more-costly skilled nursing facility care. Without an understanding of optimal HHC structure, it is not clear that such substitution will result in the objective of alternative payment models to provide better

and more coordinated care at lower costs.¹⁵ As The Centers for Medicare & Medicaid Services expands the reach of alternative payment models, it is inevitable that HF will become the focus of efforts to provide better care at lower costs.

Furthermore, as new HHC payment models, such as the Medicare Home Health VBP are implemented, it will be important to consider other potential unintended consequences. For example, safety-net hospitals that care for a higher proportion of medically complex and underserved patients were more likely to be disproportionately affected by financial penalties through Medicare VBP and Readmissions Reduction programs.¹⁶ Thus, HHC agencies seeking to avoid financial penalties may be less likely to provide services for underserved and complex patients under a VBP and readmissions reduction program. In addition, as the Medicare Home Health VBP model is evaluated, including measures to describe the resources and infrastructure that both Medicare and HHC agencies require to facilitate successful participation will be critical to inform future dissemination.

Evidence for HHC for Patients With HF

Home-based nursing interventions for patients with HF can improve health outcomes and healthcare value. In a systematic review, evidence from 14 randomized controlled trials comparing home nursing visits to usual care showed a reduction in hospital readmissions and mortality for up to 6 months for patients discharged after hospitalization for HF.¹⁷ The home nursing visit interventions in this systematic review included various educational components including recognition of HF symptoms with an action plan, dietary guidelines, medication management, and weight monitoring. Of interest, a few of the home nursing visit interventions included additional clinicians, such as pharmacists and physicians, in the home visits.^{18–20}

In a different observational study of national Medicare data, patients with HF who received a combination of early and intensive HHC combined with an outpatient clinician visit within the first 7 days after hospital discharge were significantly less likely to be readmitted to the hospital within 30 days.²¹ In this study, early and intensive HHC was defined as ≥ 1 HHC nursing visits within 1 day of hospital discharge for a total of ≥ 3 visits in the first week after discharge, described as frontloading of HHC visits.²² In another observational study, a group of 223 patients with HF who received transitional care including a combination of formalized communication between hospital, HHC, and outpatient clinicians; primary care follow-up within 7 days; and frontloading of HHC visits had a lower odds of 30-day hospital readmissions compared with a control group receiving usual care (adjusted odds ratio, 0.57 [95% confidence interval, 0.38–0.87]).²³ Thus, intensive HHC and outpatient clinician follow-up with structured communication between care settings is a promising approach to improve transitional care after discharge for patients with HF.

More Evidence Needed: HHC for Patients With HF

Despite these promising results, much is still unknown about how real-world HHC delivery might influence HF patient

outcomes such as satisfaction, hospital readmissions, and mortality or other outcomes such as healthcare cost. In a recent Institute of Medicine workshop *The Future of Home Health Care*, authors note that HHC agencies should be key partners that support patients transition home and facilitate high-quality care.²⁴ Yet, much work remains to determine (1) patients most likely to benefit from HHC, (2) how care can be efficiently coordinated between the hospital, HHC, and other settings, (3) elements of HHC, such as educational content, clinical personnel, and services, that improve patient outcomes after discharge, and (4) which payment models best align incentives for post-acute HHC across multiple stakeholders.

At present, decision making for post-acute HHC is often unstructured and at the discretion of individual case managers and physicians without use of an evidence-based approach to ensure that patients who are most likely to benefit are receiving HHC services on discharge.^{25,26} Patients who may benefit from HHC services may not be receiving them.²⁷ Furthermore, once a patient is referred for HHC at hospital discharge, communication between the hospital, HHC, and outpatient clinicians is often suboptimal so that HHC clinicians often lack critical information to provide optimal care for patients.²⁸ Finally, HHC clinicians may not have sufficient knowledge of HF management to provide evidence-based care for patients, and HF care provided across different HHC agencies may differ substantially because HF-specific education provided by HHC nurses has not been standardized on a national level.^{29,30}

Multiple promising approaches could begin to address the need for evidence and best practices for post-acute HHC for HF. For example, to reduce the variability in HHC referrals, clinical decision tools to guide clinicians with post-acute HHC referrals have been implemented effectively with reductions in 30- and 60-day readmissions.³¹ In addition, efforts to incorporate structured handoffs between clinicians in the hospital, HHC, and primary care settings could address communication barriers and help to establish clinician accountability for HHC orders and communication after discharge. Yet, studies of how to implement such handoffs effectively are needed.

The evaluation of standardized program content for HHC nurses to teach patients about HF self-care would also be informative to guide best practices. Educational content would likely include content about HF symptom recognition with an action plan, dietary guidelines, medication management, and weight monitoring, similar to the content included in randomized controlled trials of home nursing visits for HF.¹⁷ Such content would need to be literacy sensitive and individualized to different patient literacy levels.³² Standardizing content on a national level could ensure that patients and clinicians have the same goals for HF management across multiple care settings.

Additional work to identify which clinicians could contribute to effective HHC for patients with HF would be valuable. Although nurses have a key role in previous studies of post-acute HHC for HF, could HHC nurses collaborate with pharmacists to yield additional improvements in patient outcomes? A recent meta-analysis of pharmacist-led medication reconciliation at hospital transitions found reductions in 30-day drug-related readmissions (relative risk 0.33; 95% confidence interval, 0.20–0.53) and 30-day all-cause hospital readmissions (RR, 0.81; 95% confidence interval,

0.70–0.95).³³ Because 94% to 100% of HHC patients have at least 1 discrepancy between hospital discharge and HHC medication lists,^{34,35} HHC nurse collaboration with pharmacists to improve medication reconciliation could improve outcomes for patients with HF. Furthermore, because functional impairment increases the risk for hospital readmission in patients with HF,³⁶ physical therapists also likely have a central role in effective post-acute HHC.³⁷ In 1 pre-post study of a program that coordinated nurse and physical therapist home visits for patients discharged with HF, researchers found a 16% absolute reduction in hospital readmissions during the HHC episode of care.³⁸

Other disciplines could also have a role in post-acute HHC for patients with HF. Engaging community health workers or other nonclinicians could help address nonclinical and environmental factors that contribute to risk of readmission for patients with HF.³⁹ Optimally, evaluation of studies to improve post-acute HHC for HF should be assessed in the context of pragmatic trials that quantify both outcomes achieved and the associated costs.

Future Directions

As a growing proportion of hospitalized patients with HF are discharged with HHC, learning how HHC services can improve outcomes for patients will become increasingly important. A future research agenda to study post-acute HHC for HF should aim to (1) conduct pragmatic trials to determine key components in HHC referral and delivery that improve outcomes and value, (2) develop and implement scalable approaches to integrate evidence-based principles to HHC referral and delivery, and (3) seek optimal approaches to post-acute HHC for HF that will inform development of future payment models to incentivize high-value care. Ideally, such a research agenda would lead to evidence-based guidelines for HF care in HHC that could be broadly disseminated to improve patient outcomes and deliver high-value care incentivized through payment models. In addition, research would reach extend beyond discharge from acute care hospitals to include transitions from other settings, such as skilled nursing facilities to HHC, where evidence is also needed.

Reaching beyond traditionally siloed inpatient and outpatient settings to engage HHC presents a valuable opportunity for a national organization to develop best practice guidelines for HF in HHC to improve patient outcomes while supporting many patients' preferences to have the highest achievable quality of life at home. As hospitals, HHC agencies, and other stakeholders increasingly share accountability for patients across multiple care settings, collaborating to improve evidence and disseminate evidence-based strategies to reduce hospital readmissions from HHC will become increasingly important. Creating and following a deliberate research agenda will optimize the value of post-acute HHC for patients with HF, and the lessons learned are likely to have implications for patients with other chronic conditions for whom effective HHC would provide important benefits.

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References

- Krumholz HM. Post-hospital syndrome—an acquired, transient condition of generalized risk. *N Engl J Med*. 2013;368:100–102. doi: 10.1056/NEJMp1212324.
- Jones CD, Ginde AA, Burke RE, Wald HL, Masoudi FA, Boxer RS. Increasing Home Healthcare Referrals upon Discharge from U.S. Hospitals: 2001–2012. *J Am Geriatr Soc*. 2015;63:1265–1266. doi: 10.1111/jgs.13467.
- MedPAC. Report to the Congress: Medicare payment policy. 2015:213–231.
- Bueno H, Ross JS, Wang Y, Chen J, Vidán MT, Normand SL, Curtis JP, Drye EE, Lichtman JH, Keenan PS, Kosiborod M, Krumholz HM. Trends in length of stay and short-term outcomes among Medicare patients hospitalized for heart failure, 1993–2006. *JAMA*. 2010;303:2141–2147. doi: 10.1001/jama.2010.748.
- Zuckerman RB, Sheingold SH, Orav EJ, Ruhter J, Epstein AM. Readmissions, observation, and the hospital readmissions reduction program. *N Engl J Med*. 2016;374:1543–1551. doi: 10.1056/NEJMsal1513024.
- Centers for Medicare & Medicaid Services Readmissions Reduction Program. <https://www.cms.gov/medicare/medicare-fee-for-service-payment/acuteinpatientpps/readmissions-reduction-program.html>. Accessed December 21, 2016.
- Murtaugh CM, McCall N, Moore S, Meadow A. Trends in Medicare home health care use: 1997–2001. *Health Aff (Millwood)*. 2003;22:146–156.
- Centers for Medicare & Medicaid Services Home Health Compare. <https://www.medicare.gov/homehealthcompare/search.html>. Accessed January 4, 2017.
- Centers for Medicare & Medicaid Services. IMPACT Act of 2014 & Cross Setting Measures. <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/IMPACT-Act-of-2014/IMPACT-Act-of-2014-Data-Standardization-and-Cross-Setting-MeasuresMeasures.html>. Accessed October 21, 2016.
- Ryan AM, Nallamothu BK, Dimick JB. Medicare's public reporting initiative on hospital quality had modest or no impact on mortality from three key conditions. *Health Aff (Millwood)*. 2012;31:585–592. doi: 10.1377/hlthaff.2011.0719.
- Centers for Medicare & Medicaid Services. Home Health Value-Based Purchasing Model. <https://innovation.cms.gov/initiatives/home-health-value-based-purchasing-model>. Accessed February 2, 2017.
- MedPAC. Medicare Payment Advisory Commission Report to the Congress: Medicare Payment Policy, 2014, p. 215. http://www.medpac.gov/docs/default-source/reports/mar14_entirereport.pdf.
- Chazal RA. National election results: the potential impact on the ACC, its members, and our patients. *J Am Coll Cardiol*. 2017;69:592–593. doi: 10.1016/j.jacc.2017.01.001.
- Baker DW, Einstadter D, Husak SS, Cebul RD. Trends in postdischarge mortality and readmissions: has length of stay declined too far? *Arch Intern Med*. 2004;164:538–544. doi: 10.1001/archinte.164.5.538.
- Centers for Medicare & Medicaid Services. Bundled Payments for Care Improvement (BPCI) Initiative: General Information. Baltimore, MD. <https://innovation.cms.gov/initiatives/bundled-payments>. Accessed February 2, 2017.
- Gilman M, Hockenberry JM, Adams EK, Milstein AS, Wilson IB, Becker ER. The financial effect of value-based purchasing and the hospital readmissions reduction program on safety-net hospitals in 2014: a cohort study. *Ann Intern Med*. 2015;163:427–436. doi: 10.7326/M14-2813.
- Feltner C, Jones CD, Cené CW, Zheng ZJ, Sueta CA, Coker-Schwimmer EJ, Arvanitis M, Lohr KN, Middleton JC, Jonas DE. Transitional care interventions to prevent readmissions for persons with heart failure: a systematic review and meta-analysis. *Ann Intern Med*. 2014;160:774–784. doi: 10.7326/M14-0083.
- Stewart S, Pearson S, Horowitz JD. Effects of a home-based intervention among patients with congestive heart failure discharged from acute hospital care. *Arch Intern Med*. 1998;158:1067–1072.
- Aldamiz-Echevarría Iraúrgui B, Muñoz J, Rodríguez-Fernández JA, Vidán-Martínez L, Silva-César M, Lamelo-Alfonsín F, Díaz-Díaz JL, Ramos-Polledo V, Castro-Beiras A. Randomized controlled clinical trial of a home care unit intervention to reduce readmission and death rates in patients discharged from hospital following admission for heart failure. *Rev Esp Cardiol*. 2007;60:914–922.
- Holland R, Brooksby I, Lenaghan E, Ashton K, Hay L, Smith R, Shepstone L, Lipp A, Daly C, Howe A, Hall R, Harvey I. Effectiveness of visits from community pharmacists for patients with heart failure: HeartMed randomised controlled trial. *BMJ*. 2007;334:1098. doi: 10.1136/bmj.39164.568183.AE.
- Murtaugh CM, Deb P, Zhu C, Peng TR, Barron Y, Shah S, Moore SM, Bowles KH, Kalman J, Feldman PH, Siu AL. Reducing readmissions among heart failure patients discharged to home health care: effectiveness of early and intensive nursing services and early physician follow-up [published online ahead of print July 28, 2016]. *Health Serv Res*. doi: 10.1111/1475-6773.12537.
- O'Connor M, Bowles KH, Feldman PH, St Pierre M, Jarrín O, Shah S, Murtaugh CM. Frontloading and intensity of skilled home health visits: a state of the science. *Home Health Care Serv Q*. 2014;33:159–175. doi: 10.1080/01621424.2014.931768.
- Russell D, Rosati RJ, Sobolewski S, Marren J, Rosenfeld P. Implementing a transitional care program for high-risk heart failure patients: findings from a community-based partnership between a certified home healthcare agency and regional hospital. *J Healthc Qual*. 2011;33:17–23; quiz 23–24.
- Landers S, Madigan E, Leff B, Rosati RJ, McCann BA, Hornbake R, MacMillan R, Jones K, Bowles K, Dowding D, Lee T, Moorhead T, Rodriguez S, Breese E. The Future of Home Health Care: A Strategic Framework for Optimizing Value. *Home Health Care Manag Pract*. 2016;28:262–278. doi: 10.1177/1084822316666368.
- Bowles KH, Ratcliffe SJ, Holmes JH, Liberatore M, Nydick R, Naylor MD. Post-acute referral decisions made by multidisciplinary experts compared to hospital clinicians and the patients' 12-week outcomes. *Med Care*. 2008;46:158–166. doi: 10.1097/MLR.0b013e31815b9dc4.
- Bowles KH, Foust JB, Naylor MD. Hospital discharge referral decision making: a multidisciplinary perspective. *Appl Nurs Res*. 2003;16:134–143.
- Bowles KH, Naylor MD, Foust JB. Patient characteristics at hospital discharge and a comparison of home care referral decisions. *J Am Geriatr Soc*. 2002;50:336–342.
- Bowles KH, Pham, J, O'Connor M, Horowitz DA. Information deficits in home care: a barrier to evidence-based disease management. *Home Health Care Manag Pract*. 2010;22:278–285.
- Delaney C, Apostolidis B, Lachapelle L, Fortinsky R. Home care nurses' knowledge of evidence-based education topics for management of heart failure. *Heart Lung*. 2011;40:285–292. doi: 10.1016/j.hrtlung.2010.12.005.
- Topaz M, Shalom E, Masterson-Creber R, Rhadakrishnan K, Monsen KA, Bowles KH. Developing nursing computer interpretable guidelines: a feasibility study of heart failure guidelines in homecare. *AMIA Annu Symp Proc*. 2013;2013:1353–1361.
- Bowles KH, Chittams J, Heil E, Topaz M, Rickard K, Bhasker M, Tanzer M, Behta M, Hanlon AL. Successful electronic implementation of discharge referral decision support has a positive impact on 30- and 60-day readmissions. *Res Nurs Health*. 2015;38:102–114. doi: 10.1002/nur.21643.
- DeWalt DA, Schillinger D, Ruo B, Bibbins-Domingo K, Baker DW, Holmes GM, Weinberger M, Macabasco-O'Connell A, Brouckson K, Hawk V, Grady KL, Erman B, Sueta CA, Chang PP, Cene CW, Wu JR, Jones CD, Pignone M. Multisite randomized trial of a single-session versus multisession literacy-sensitive self-care intervention for patients with heart failure. *Circulation*. 2012;125:2854–2862. doi: 10.1161/CIRCULATIONAHA.111.081745.
- Mekonnen AB, McLachlan AJ, Brien JA. Effectiveness of pharmacist-led medication reconciliation programmes on clinical outcomes at hospital transitions: a systematic review and meta-analysis. *BMJ Open*. 2016;e010003. doi: 10.1136/bmjopen-2015-010003.
- Hale J, Neal EB, Myers A, Wright KH, Triplett J, Brown LB, Kripalani S, Mixon AS. Medication discrepancies and associated risk factors identified in home health patients. *Home Healthc Now*. 2015;33:493–499. doi: 10.1097/NHH.0000000000000290.
- Brody AA, Gibson B, Tresner-Kirsch D, Kramer H, Thraen I, Coarr ME, Rupper R. High prevalence of medication discrepancies between home health referrals and Centers for Medicare and Medicaid Services home health certification and plan of care and their potential to affect safety of

- vulnerable elderly adults. *J Am Geriatr Soc*. 2016;64:e166–e170. doi: 10.1111/jgs.14457.
36. Greysen SR, Stijacic Cenzer I, Auerbach AD, Covinsky KE. Functional impairment and hospital readmission in Medicare seniors. *JAMA Intern Med*. 2015;175:559–565. doi: 10.1001/jamainternmed.2014.7756.
37. Falvey JR, Burke RE, Malone D, Ridgeway KJ, McManus BM, Stevens-Lapsley JE. Role of physical therapists in reducing hospital readmissions: optimizing outcomes for older adults during care transitions from hospital to community. *Phys Ther*. 2016;96:1125–1134. doi: 10.2522/ptj.20150526.
38. Miller AME, Edenfield EE, Roberto J, Erb JK. Reduction in re-hospitalization rates utilizing physical therapists within a post-acute transitional care program for home care patients with heart failure. *Home Health Care Manag Pract*. 2017;29:7–12.
39. Hersh AM, Masoudi FA, Allen LA. Postdischarge environment following heart failure hospitalization: expanding the view of hospital readmission. *J Am Heart Assoc*. 2013;2:e000116. doi: 10.1161/JAHA.113.000116.

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