Closing Gaps in Home Health Care:

Current Challenges & The Path Forward

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Over the better part of the last decade, the healthcare continuum has come under greater scrutiny as providers have become increasingly incentivized by performance levels and outcomes. At the same time, the reimbursement model has transitioned from fee-for-service to fee-for-performance, fundamentally shifting focus for providers to two basic measures: quality of care and cost of care.

In today's value-based care scenario, hospitals must focus on patient experience metrics, clinical process of care measures and efficiency outcomes, as well as how well they close gaps in care during transitions to avoid unnecessary patient returns.

Unfortunately, rates of hospital readmissions continues to be an issue. According to recent data issued by the Centers for Medicare and Medicaid Services (CMS), 82% of the facilities participating in the Hospital Readmissions Reduction Program (HRRP) from 2016 to 2019 were penalized for readmitting too many patients. This represents 2,545 hospitals or about half of all hospitals in the U.S.

However, one in three hospital readmissions can be avoided simply by identifying key drivers –

- Lack of primary care follow up
- Insufficient care coordination
- Poor ownership of responsibility by patients

The home health care clinician plays a vital role in mitigating these factors throughout the patient's transition and during the home health period of care. Due to the effects of COVID-19, the industry's embrace of telemedicine and the diverse healthcare needs of a rapidly aging population, home health care is growing faster than any other healthcare setting. Because of the pandemic specifically, the demand for home health care and the likelihood of a patient's home becoming the center of care delivery has increased substantially.

As more individuals in the aging population prefer to receive care in the home, healthcare must adapt and ensure in-home care represents a safe, seamless and reliable long-term option for patients.

We have outlined the top three gaps in home health care and how to close them.

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01

Data Exchange & Transitions of Care

One of the biggest challenges when it comes to more harmonious transitions of care is closing the data exchange gap between a hospital or skilled nursing facility (SNF) and home health care.

According to a Patient Transition Study conducted by PointClickCare, 36% of acute care providers were still using manual-only strategies to coordinate patient transitions with the long-term and post-acute care (LTPAC) community in 2019. The same percentage of acute care providers did not track patients after they transferred to a post-acute care provider, and only 2% of acute care and LTPAC providers said they used IT-driven strategies to coordinate patient care and transfer data.

While many facilities have made strides in their digital data-sharing capabilities – especially during the pandemic – some healthcare providers still share essential patient information on paper, via fax or over the phone. Another hurdle? Providers reported only sharing what they believe to be the most critical patient data (rather than all patient data) due to perceived privacy concerns.

With the best of intentions, healthcare organizations are leaving out important patient information integral to a smooth transition of care to the home, such as measurement and observations, location, patient status and advanced planning information, as well as patient medication, diagnosis, allergy and demographic information.

Medication management, in particular, is one of the most common factors contributing to hospital readmissions. When handled properly, however, it can facilitate smooth transitions and allow caregivers to start delivering care quicker.

With home health care on the rise, providers must implement the necessary digital tools and systems that enable coordination and the seamless exchange of data between all partners along the care continuum. With a complete exchange of data, home health care providers can optimize the delivery of care, improve outcomes and ultimately reduce patient readmissions.

Acute care providers still using manual-only strategies to coordinate patient transitions with the LTPAC community

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02

Patient Engagement & Compliance

Outcomes-driven care necessitates a delivery model that encourages patient engagement and compliance. When patients are involved in their own healthcare decision-making, quality improves, costs go down and hospitalizations decrease.

The home health care clinician plays a vital role in raising the patient's level of awareness and education about the benefits of engagement and, ultimately, in activating it.

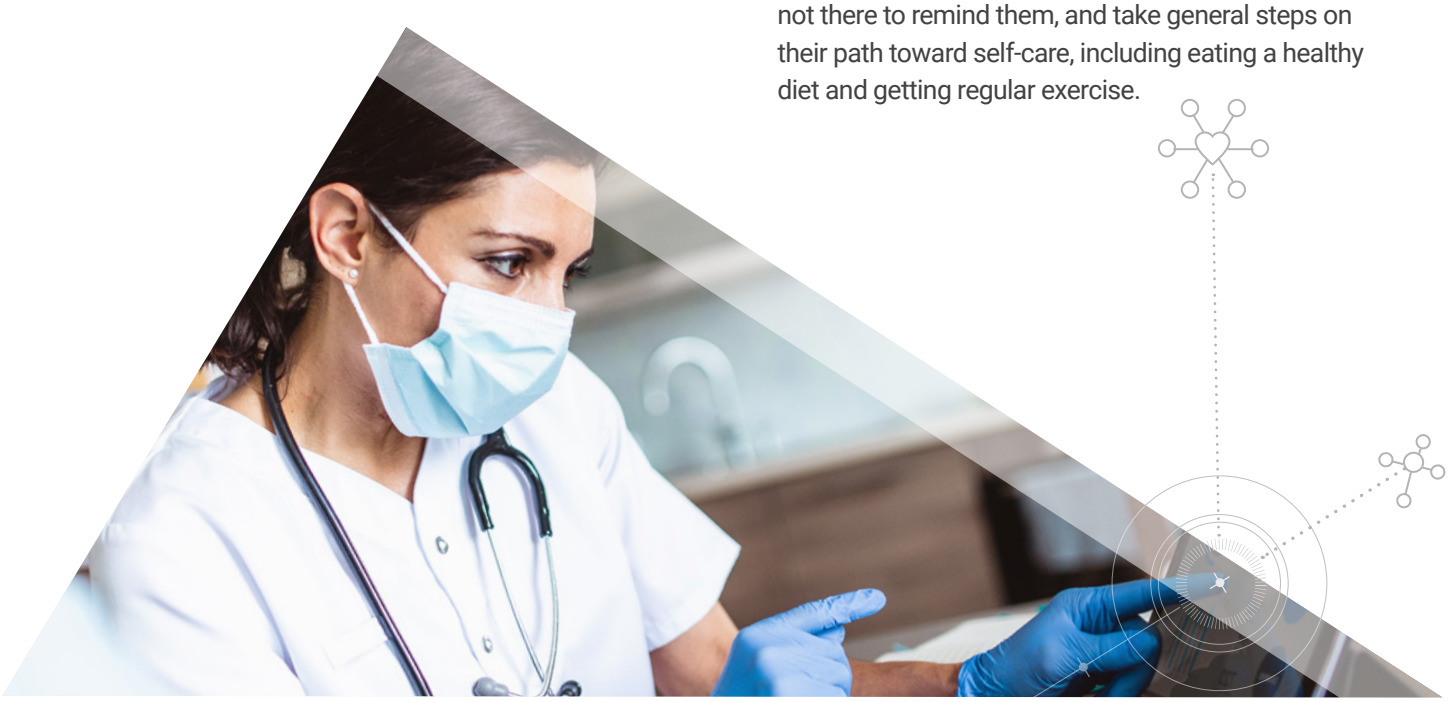
A patient-centered approach to care must involve seamless team communication, the development of a care plan related to the top drivers of hospital readmission and the important process of medication reconciliation.

Verifying patient medications for home health care versus what the previous care provider administered is critical to avoiding adverse effects or reactions. Moreover, empowering patients to be involved in their own care plan motivates them to adhere to it.

Achieving patient engagement not only requires compliance, but also a commitment to progress along a **four-step continuum**:

- Taking a role in self-management
- Building knowledge and confidence
- Taking action
- Maintaining behaviors agreed upon with the caregiver

By becoming an active participant in reaching the highest level of their own wellbeing, patients are more likely to engage in necessary measures, such as taking a nightly medication when the caregiver is not there to remind them, and take general steps on their path toward self-care, including eating a healthy diet and getting regular exercise.



03

Referral Management

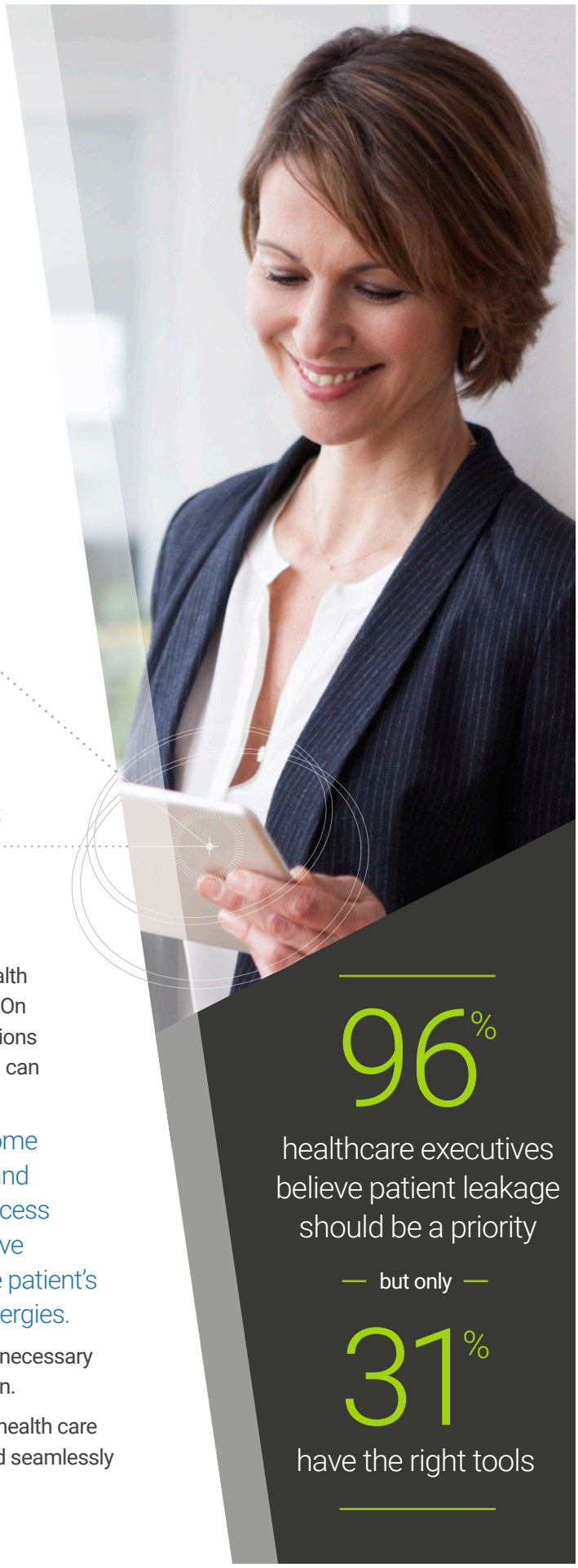
Referrals occur at a critical moment in a patient's journey: during transitions. Unfortunately, this also tends to be a time when information can get lost and gaps in care are greater. According to a recent survey, 96% of healthcare executives believe patient leakage should be a priority but only 31% have the right tools to accomplish their goals.

Providers must be in a position to orchestrate and navigate the flow of patients through the entire care continuum to help avoid cracks in the data. Without an interoperability framework in place for referrals and health information exchange, transitions are clunky and slow. On the flipside, a unified strategy to oversee patient transitions and hand-offs at different points of the care continuum can help bridge alliances and build referral bases.

With a strong referral management system, home health agencies can secure their own growth and financial health, while expediting the intake process and enabling home health care providers to have immediate access to important data about the patient's demographics, medications, diagnoses and allergies.

This also mitigates risks by minimizing the threat of unnecessary errors born out of simply not having enough information.

A holistic view of the patient upon intake allows home health care agencies to staff the clinician skill set appropriately and seamlessly bridge past care with present and future care.



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The Future of Connected Care

To avoid gaps in care resulting from the exchange of data, patient leakage and patient compliance, healthcare organizations must have access to digital tools that allow them to share data and collaborate seamlessly with other caregivers.

The PointClickCare Home Health Care solution is designed to think and perform like today's caregivers.

The solution transitions patient referrals through an integrated enterprise platform that digitally captures patient data at intake, at point of care and across care settings. This enables caregivers to quickly visualize patient insights, reduce manual errors and prevent delays in care plan follow-through.

Notably, it simplifies the important task of medication management. An embedded search technology within the tool enables clinicians to research, visualize and identify drugs based on manufacturer imprints, colors and shape.

With a holistic view of patient progress, performance, care schedules, case management and clear goals for staff, caregivers are empowered to deliver the highest possible level of care and improve outcomes for at-home patients.

Interested in learning more about how you can efficiently manage care transitions and reduce readmissions?

Click Here

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PointClickCare Technologies Inc., helps long-term and post-acute care (LTPAC) providers gain the confidence they need to navigate the new realities of value-based healthcare.

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