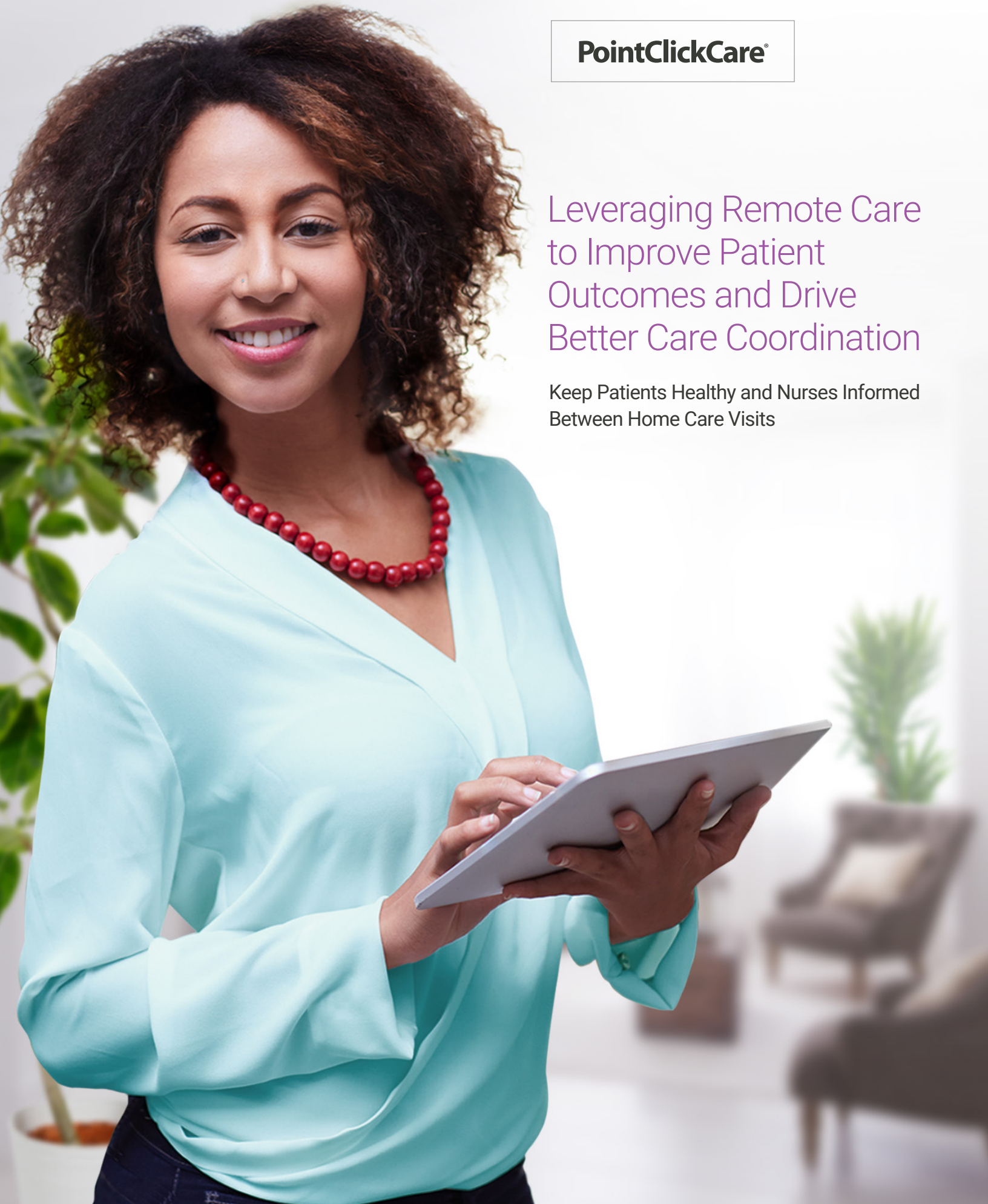
PointClickCare®

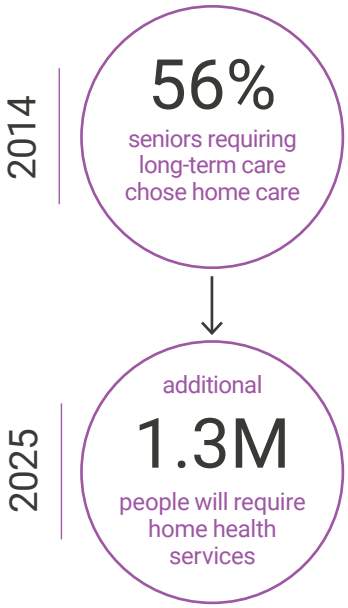
Leveraging Remote Care to Improve Patient Outcomes and Drive Better Care Coordination

Keep Patients Healthy and Nurses Informed Between Home Care Visits



As home health agencies (HHAs) are well aware, patients released from a hospital or skilled nursing facility (SNF) back to their homes are not always capable of following discharge plans. Even when an HHA is engaged to follow and assist in a patient's care at home, the visiting nurse cannot be on site 24x7 to ensure that the patient is taking all prescribed medications and sticking to their plan of care. If patients aren't compliant with their care plans, the risk of avoidable hospitalizations increases, and the HHA's performance record suffers. However, home health organizations can achieve better patient outcomes, while differentiating themselves in a very competitive environment, by introducing a remote patient monitoring program to their agency. Before considering this beneficial addition to a care portfolio, it's important to fully understand why it is more necessary than ever.

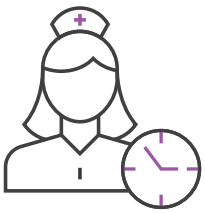
The Home Health Landscape Continues to Change



An astounding 90 percent of older Americans prefer to age in place rather than move to senior housing[1], due to financial circumstances, their strong attachment to a familiar long-time home, fear of losing their independence, or a combination of multiple factors. 50 percent of these people cope with two or more chronic and complex health conditions, making it highly likely that they will require home health assistance upon their return from a hospitalization.

While it is no surprise that seniors prefer to age in place, statistics prove there is demand. In 2014, 56 percent of seniors requiring long-term care chose home care. It is estimated that by 2025, an additional 1.3 million people will require home health services.

The types of services required have changed much over the years. Home care is no longer limited to custodial services; IVs and infusions, wound care, and chronic disease management are becoming commonplace and are enabling a greater number of seniors to live healthy and happily at home.



Nurses tend to manage a caseload of 25 to 30 patients at any given time, seeing 5 to 7 patients daily.

The growing demand for home care presents unique challenges to providers; ever-changing regulations put increasing pressure on them to maintain compliance. At the same time, payment reform is forcing agencies to operationalize new ways to cost-effectively support their patients, while still producing improved clinical outcomes. In 2017, CMS reduced $180 million in payments to HHAs. A simple challenge such as a patient who is geographically dispersed can hurt productivity and reduce billable hours, potentially shrinking caseloads and the HHA's bottom line. Even in urban areas, heavy traffic, limited parking, and inclement weather can affect visit schedules and cause inefficiencies. Nurses tend to manage a caseload of 25 to 30 patients at any given time, seeing 5 to 7 patients daily. Demanding caseloads and last-minute scheduling changes take a toll on clinicians, negatively influencing their satisfaction and morale.

[1]The National Aging in Place Council

Outcomes Suffer from Multiple Factors

Did you know?

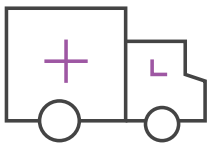
over a 60-day episode.

out of 1,440 hours!

During the typical Medicare 60-day home health episode, patients are seen by a nurse 9 to 12 times on average for about forty-five minutes to an hour. While the actual number of visits depends on the patient's functional status, the reality is that many patients are on their own most of the time. They must follow complex treatment plans to manage their health conditions, often with very little natural support. Also, the prevalence of comorbidities in the older adult population contributes to the complexity of these cases.

Half of the older adult population is living with two or more chronic health conditions and a third have three or more. In addition, a study published in 2013 found that almost 20 percent of patients discharged from the hospital had medical complications related to prescriptions during their first 45 days at home.[2]

Clinicians often rely on patient-reported data to gain visibility into a patient's condition. But the information recorded by the patients in logs is often incomplete or can even be inaccurate. Plus, health information trapped in a log book is generally not visible to a clinician until his or her next visit. These circumstances prevent nurses from gaining a clear picture of the patient's status between visits and may impact the clinician's ability to catch a potentially avoidable health event that could result in the patient needing to visit an emergency department or lead to the patient to becoming hospitalized. This is not only disruptive to the patient but also affects the HHA's quality measures.



Two out of ten home health patients in a Medicare episode visited a hospital emergency department at least once during their 60-day home health episode.[3]

The statistics on emergent care utilization during home health reinforces the importance of early detection and intervention. Two out of ten home health patients in a Medicare episode visited a hospital emergency department or were admitted to the hospital at least once during their 60-day home health episode.[3] Often these health events were precipitated by a lack of adherence to the self-care plan and could have been prevented had the care team known about the lapse or had early warning about the patient's change in condition.

So, what is the best way for HHAs to provide greater oversight of higher acuity patients without adding extra visits? How can they stay connected and detect small problems before they become a crisis? Being able to monitor patients remotely is a solution HHAs should consider providing more effective care and improve their clinical outcomes and reputation. Let's further explore how an HHA would incorporate remote monitoring into their standard of care.

[2]Journal of the American Geriatrics Society, "Adverse Drug Events After Hospital Discharge in Older Adults: Types, Severity, and Involvement of Beers Criteria Medications," Abir O. Kanaan, Pharm.D. et al., VOL. 61, NO. 11, November 2013.

[3]National Profile of Long-Term Care Services Users, U.S. Dept. of Health and Human Services, 2014.

Careful Planning and Implementation Will Ensure Remote Monitoring Success

The commitment to engage in remote patient monitoring must be made at the highest level of an HHA. That's where the vision for remote care begins, and how it will be driven to succeed. In considering remote patient monitoring, home health organizations must first determine their goals:

- What do we want to accomplish with remote monitoring?
- What does success mean for our organization?

Operational components are significant in adopting this solution. Someone in the HHA should be the designated point of contact for remote patient monitoring. That person will work with the proper staff members to set these goals. They will then develop policies and procedures, and seek remote monitoring champions within the organization. Once the agency chooses a remote patient monitoring solution, the staff must be thoroughly trained on how to use it – and how to encourage its use by patients.

An agency must then select patients to use the remote monitoring system. Does the agency have the correct assessment tools? If not, it will have to update them. Do the targeted patients meet the criteria the agency has set, in terms of age, cognitive abilities, diagnosis and experience with technology? Will remote monitoring help the patients recover or better manage their health? What might prompt the patients to refuse to use the system? And how would the agency overcome their objections? If an HHA answers these questions up front, it's more likely to have patients who engage with the remote monitoring system, adhere to their medications and avoid hospitalization.

Once the patients are selected, the system deployed, and training completed, the agency must look at implementation as a partnership. Create patient care plans that make the most of the new solution. Offer ongoing support to the patients as well as staff. This could be a process of trial-and-error in the beginning, but the agency's investment will be the better for it. HHAs should also introduce the solution to their patients' primary care physicians or group. It's important that agencies evaluate the patients' engagement with the system; compliance reports will be critical in measuring success and making adjustments.

Readmission Rates Plummeted Using Remote Monitoring

In fact, 92 % of patients using remote patient monitoring stayed out of the hospital in the 30 days post-discharge.

LB Homes of Fergus Falls, Minnesota is just one example of a company that has vastly improved its performance using remote patient monitoring. Offering a continuum of care, from hospice, independent living, assisted living, and enhanced assisted living, to transitional care, long-term care, and home care, LB Homes decided five years ago to add remote patient monitoring to its home care services. To date, it has seen a marked decrease in readmission rates in its home care population.

In addition to the positive outcomes generated, patient satisfaction is much greater than anticipated. As one patient put it, ***"I used it every morning. I was surprised that it worked that good!"*** LB Homes says its home care patients feel like it has more visibility into their care, checking on them every day rather than just when a nurse visits. Being able to intervene ahead of an issue, and avoid a rehospitalization, is a huge benefit to the both patients and the company.

"When we are able to catch a weight change even before we see any other physical symptom, we know to engage the doctor. We catch things early… we try to get the device out to all our Medicare patients!"

– LB Homes Official

Differentiate your Agency now with Remote Care

It's no secret that competition for home care patients is fierce. Superior outcomes are more important than ever to HHAs' narrowing referral network; physicians want to work with agencies that keep their patients healthier. At this point, providers must look for ***every opportunity*** to differentiate themselves from their competition – and remote care is a proven way to do so.

Remote monitoring provides meaningful value to patients: engagement, self-management, medication adherence, hospital avoidance, goal attainment, scheduling and improved quality of life. It allows them to participate in creating a self-care plan they can follow.

It increases their odds to successfully adapt to their homes after a hospitalization or SNF stay, so they can continue to age in place. HHA clinicians also benefit from the value of remote care. They can monitor their patients ***100 percent*** of the time during home care episodes with real-time information at their fingertips. By being better connected to their patients, they're more quickly informed of changes in their conditions. Nurses can detect problems remotely and take action, before a crisis leads to either an ED visit or another hospitalization. Both patients and staff are happier, knowing they have an easier system to support care coordination.

Ultimately, remote care systems are both a care decision and a business decision. SNFs and hospitals may begin to give preference to agencies with successful remote care programs. If an agency wants to be on these preferred lists for the long term – and generate greater patient engagement and satisfaction – a remote patient monitoring solution should be on its radar today.