REMINGTON REPORT®

Business Intelligence, Insights, and Trends

- Case Studies: Effective care transition models
- Team-Based Care: How to improve the patient care team experience
- ACOs: Decision-points to use home visits

remingtonreport.com ◆ November/December 2022

VOLUME 30 ◆ ISSUE 6

How Team-Based Care Engagement Improves Care Transitions

13 Core Principles Improving the Patient and Care Team Experience

NOVEMBER/DECEMBER 2022

Table of Contents

CONTINUES ON NEXT PAGE

KEY CHARACTERSTICS AND DECISION POINTS OF ACOs // PAGE 16 JUMP TO ARTICLE

Which Types of ACOs Use Home Visits the Most and Why?

By Lisa Remington, President and Publisher, The Remington Report

Home-based organizations eager to have partnerships with ACOs will learn in our discussion why certain ACOs engage in greater home visits and care transitions to manage complex patients. No two ACOs are alike. Get insights into the characteristics of ACOs and their decision points. We follow up with three key leadership discussion questions.

CASE STUDY: A 30-DAY POST-DISCHARGE CARE TRANSITION MODEL // PAGE 18 JUMP TO ARTICLE

Care Transitions Intervention Model to Manage Social Determinants of Health

By The Remington Report Editorial Team

The focus on social determinants of health is a hot topic in healthcare. Multidisciplinary teams and a care transition model in the case study resulted in reduced readmissions and improved outcomes. The model is scalable and a win-win for healthcare and the patient.

SPECIAL REPORT // PAGE 21 JUMP TO ARTICLE

36 Ways Your Investment in Technology Can Produce a Positive ROI Across Your Organization

In this special report, we provide 36 ways your investment in technology can produce a positive ROI across your organization. We identify the right technologies to get a positive return on your investment.

CONTINUES ON NEXT PAGE

GIVING THE ELDERLY THE CARE THEY WANT // PAGE 32 JUMP TO ARTICLE

Pre-Hospice Home-Based Care Transition Program

By Lisa Remington, President and Publisher, The Remington Report

Sharp found that emergency room visits and hospitalizations decreased from 85% in usual care to 35% in a new palliative model for cancer patients. It has seen a decrease in hospital mortality from 57% to 5% for cancer patients. It also has led to significantly reduced per-patient costs for cancer, COPD, heart failure, and dementia.

RESOURCES TO IMPROVE PERFORMANCE // PAGE 35 JUMP TO ARTICLE

Improving Real-Time Communications with Care Teams and Patients

By The Remington Report Editorial Team

In our extensive resource of special reports, you'll find actionable solutions to improving care transitions, real-time communications with team members, and what patients want for better communications. These complimentary resources offer solutions to workforce shortages, clinician burnout, and advancing solutions in home-based care.

PREPARE FOR THE FUTURE // PAGE 37 JUMP TO ARTICLE

7 Things Changing in Healthcare 2023 You Should Know About

By The Remington Report Editorial Team

Seven areas of healthcare are changing in 2023 in the areas of quality measures, bundled payments, the hospice benefit, and the expanded home health value-based purchasing model. For each, we provide details and resources to keep you in the know.

PRESIDENT AND PUBLISHER

Message From Lisa Remington

13 CORE PRINCIPLES IMPROVING THE PATIENT AND CARE TEAM EXPERIENCE

How Team-Based Care Engagement Improves Care Transitions

Healthcare is adopting integrated care approaches involving teams working across disciplines and sectors. We are seeing the transition to more team-based care because of the workforce shortage and the way providers are paid.

Team-based care allows healthcare practitioners to practice specific clinical skills at the "top of their licenses," which assists in evenly distributing workload among team members.

- A strategic redistribution of work among members of a practice team
- *Right person doing the right work at the right time*

The National Academy of Medicine defines team-based care as:

> "The provision of health services to individuals, families, and/or their communities by at least two health providers who collaborate with patients and their caregivers – to the extent preferred by each patient – to accomplish shared goals within and across settings to achieve coordinated, high-quality care."

In care delivery models such as hospital-at-home, skilled-nursing facility at home, value-based care, managing social determinants of health, behavioral health, palliative care, and home-based primary care, the team-based approach decreases the likelihood of duplication, reduces the risk for medication errors, and eases patient transitions between sites of care.

The Growing Recognition of Team-Based Care: What's Changing?

There is growing recognition of the importance of team-based care because of the shift from fee-for-service payments to value-based payment models. Because value-based payments reward providers for the quality of care provided, it highlights the importance of a team-based care approach to improve the health of individuals and populations, and to improve the safety, quality, and efficiency of healthcare delivery.

Many emerging value-based payment models facilitate closer integration and alignment of healthcare team members through coordinated payments and accountable care. A team-based approach is especially important when caring for patients with complex care needs.

Topics of Interest in the November/December Issue

In the November/December issue of The Remington Report, we tackle topics impacting team-based care, care transitions, case studies, and workforce improvement.

The Remington Report magazine is interactive, which means we have made it simple for you to click on links that will connect you to additional resources on each topic.

Quick Rundown on Articles in This Issue of The Remington Report

1. 5 Ways High-Functioning Team-Based Care Reduces Clinician Burnout
2. How Proactive Team-Based Care Engagement Improves Care Transitions
3. Which Types of ACOs Use Home Visits the Most and Why?
4. Care Transitions Intervention Model to Manage Social Determinants of Health
5. 36 Ways Your Investment in Technology Can Produce a Positive ROI Across Your Organization
6. Pre-Hospice Home-Based Care Transition Program
7. Improving Real-Time Communications with Care Teams and Patients
8. 7 Things Changing in Healthcare 2023 You Should Know About

The Remington Report

The Remington Report has been published since 1993 and is read by healthcare decision-makers across the United States. The magazine is a leading source of strategy, business insights, cross-continuum innovations, and future planning. The Remington Report provokes thought leadership and real-time solutions for executive decision-making to reach beyond the status quo.

The magazine offers insightful articles and real-world examples to provide you with information beyond the news headlines. We connect the headlines to the impact it has on your organization.

Get access to online resources for deeper insights; print the entire magazine in PDF format, read the articles online, or print each article; engage to find interactive decision-making resources beyond each article; and take the magazine with you anywhere.

SUBSCRIBE/RENEW

FEATURE STORY

5 Ways High-Functioning Team-Based Care Reduces Clinician Burnout

By Lisa Remington, President and Publisher, The Remington Report

Healthcare is adopting integrated care approaches involving teams working across disciplines and sectors. We are seeing the transition to more team-based care because of the workforce shortage. For example, hospitals are reevaluating their nurse-to-patient ratios model. Instead of assigning one nurse to oversee a small group of patients, a team-based approach of several staff members who work at the top of their license care for a larger group of patients.

In care delivery models such as hospital-at-home, skilled-nursing facility at home, value-based care, managing social determinants of health, behavioral health, palliative care, and home-based primary care, the team-based approach is based upon:

Members come together as a whole to discuss their individual assessments and develop a joint service plan for the patient. Practitioners may blur some disciplinary boundaries but still maintain a discipline-specific base (for instance, aspects of functional assessments may be shared across disciplines). Teams integrate closer to complete a shared goal. (Ellis & Sevdalis, 2019).

2 Different Approaches to Team-based Care

Though often used interchangeably, multidisciplinary and interdisciplinary care differ in their form and function.

Multidisciplinary Care Teams: A team composed of members from more than one discipline, offering patients a greater breadth of services. Team members work independently and in parallel, with each provider responsible for his or her own area. Communication between team members is formal, and team structure is often hierarchical with a designated leader overseeing the team.

Interdisciplinary Care Teams: A team of professionals from various disciplines participates in reaching a common goal, with each team member bringing his or her discipline's expertise to the team. Team members work formally and informally, and information is shared in a systemic way among team members. An interdisciplinary team is collaborative and integrates each profession's knowledge into the care plan.[1]

Each team member is encouraged to function to the fullest extent of their education, certification, and experience to reach optimal care outcomes.

How to Foster Effective Teams

The National Academy of Medicine identified five core principles to enable care providers to foster effective care teams.

1. **Shared Goals.** The team establishes shared goals that reflect the priorities of the patient and family. The goals are clearly articulated, understood, and supported by all team members.
2. **Clear Roles.** There are clear expectations for each team member's functions, responsibilities, and accountabilities.
3. **Mutual Trust**. Team members trust one another and feel safe to admit a mistake, ask a question, offer new data, or try a new skill without fear of embarrassment or punishment.
4. **Effective Communication**. The team prioritizes and continuously refines its communications skills and has consistent channels for efficient, bidirectional communication.
5. **Mutual Processes and Outcomes.** A reliable and ongoing assessment of team structure, function, and performance is provided as actionable feedback to all team members to improve performance.

How Team-Based Care Reduces Clinician Burnout

As workforce issues continue to pose very real challenges, team-based care not only offers solutions to the workforce shortage, but also has the potential to enhance patient care in terms of quality and safety, expanded productivity, and improved job satisfaction by reducing workloads and preventing burnout.

High-functioning clinical teams are essential for the delivery of high-value healthcare and have been associated with:

- Decreased workloads
- Increased efficiency
- Improved quality of care
- Improved patient outcomes
- Decreased clinician burnout/turnover

In Table 1, we see the relationship between the principles of team-based care and the impact of improving clinician burnout.

Table 1 | Principles of High-Performing Teams

Principle	Definition	Impact on Clinician Well-Being
Shared Goals	The team establishes shared goals that can be clearly articulated, understood, and supported by all members	
Clear Roles	Clear expectations for each team member's functions, responsibilities, and accountabilities to optimize team efficiency and effectiveness	Role clarity has been associated with improved clinician well-being A fully staffed team that is not over patient capacity is associated with decreased burnout
Mutual Trust (psychological safety)	Team members trust one another and feel safe enough within the team to admit a mistake, ask a question, offer new data, or try a new skill without fear of embarrassment or punishment	A strong team climate promotes clinician well-being and member retention
Effective Communication	The team prioritizes and continuously refines its communications skills and has consistent channels for efficient, bidirectional communication	Effective communication is associated with decreased clinician burnout Participatory decision making is associated with lower burnout scores
Measurable Processes and Outcomes	Reliable and ongoing assessment of team structure, function, and performance that is provided as actionable feedback to all team members to improve performance	Emotional exhaustion is associated with low personal accomplishment, so reiteration of accomplishments could decrease burnout

Source: National Academy of Medicine

The 4 Characteristics of Successful Teamwork

A team-based model of care strives to meet patient needs and preferences by actively engaging patients as full participants in their care while encouraging all healthcare professionals to function to the full extent of their education, certification, and experience.[2]

Successful Teamwork has 4 Key Characteristics

1. A clear and compelling purpose or goal,
2. An enabling social structure that facilitates teamwork,
3. A supportive organizational context, and
4. Expert teamwork coaching.[3]

Effective Teamwork Depends On:

1. the team member's psychological safety, defined as their ability to trust one another and feel safe enough within the team to admit a mistake, ask a question, offer new data, or try a new skill without fear of embarrassment or punishment, and

2. allows team members to learn, teach, communicate, reason, think together, and achieve shared goals, irrespective of their individual positions or status outside the team[4]

Key Features of High-Functioning Healthcare Teams

- Shared team identity, value, and goals
- Leadership
- Defined and complimentary roles
- Continuity and regular meetings
- Adequate staffing
- Shared physical space
- Psychological safety
- Task sharing and shifting
- Effective help among team members
- Team coordination
- Open communication and mutual trust
- Constructive conflict resolution
- Observation and feedback

Team-based healthcare has been linked to improved patient outcomes and may also be a means to improve clinician well-being.[5] The increasingly fragmented and complex healthcare landscape adds urgency to the need to foster effective team-based care to improve both the patient's and team's experience of care delivery.

Additional Insights to Combat Clinician Burnout

- 6 Ways to Recharge Clinical Engagement and Work-Life Balance

Footnotes

[1]ccnmtl.columbia.edu/projects/sl2/pdf/glossary.pdf.
[2]American College of Obstetricians and Gynecologists. 2016. *Collaboration in practice: Implementing team-based care.*
[3]Gordon, S., D. L. Feldman, and M. Leonard. 2014. *Collaborative caring: Stories and reflections on teamwork in health care.*
[4]Hackman, R. 2014. *What makes for a great team?* Washington, DC: American Psychological Association
[5]Welp, A., and T. Manser. 2016. Integrating teamwork, clinician occupational well-being, and patient safety—development of a conceptual framework based on a systematic review.

ALIGNING PATIENTS, FAMILIES, HOSPITALS, AND PHYSICIANS

How Proactive Team-Based Care Engagement Improves Care Transitions

By The Remington Report Editorial Team

Discharge destinations require established relationships with a network of high-quality post-acute providers, facilities, and home health resources in the community.

Sound Physicians is a national physician practice organization with a proven history of improving quality, satisfaction, and financial performance for its partners nationwide. Their whitepaper, "Planning the Next Site of Care as the Priority," promotes better care transitions and improved outcomes to bridge together discharge planning, home-based care, physicians, and hospitalists.

Proactive Engagement

Achieving a timely transition of care while simultaneously lowering the risk of readmission remains one of the toughest challenges in value-based outcomes. It's critical to start the hospital stay by keeping patients' best interests and goals for discharge at the top of the list of priorities.

It requires clear, proactive communication and alignment among all who engage in the acute episode of care – from the first day of an inpatient admission through the entire post-acute period. It's important to note that during this episode, on average, 38% of spending is related to skilled-nursing facility utilization and readmissions.

The Role of the Hospitalist

It is the hospitalist who is positioned to lead – from the start – the conversation and plan for transition to the appropriate next site of care.

Hospitalists' planning for the entire episode of care enables the primary care physician to see the benefits of what occurred in the hospital and supports them as they take over the seamless management of their patient back in the community setting.

Hospitalists need time to participate in multidisciplinary rounds and care team huddles and to proactively plan the transition with the care management team.

"Discharge destinations require established relationships with a network of high-quality post-acute providers, facilities, and home health resources in the community."

At the time of discharge, they need time to address questions and clearly document and create holistic plans of care. They can clarify how medications may have changed and anticipate other factors that may impact the patient post-discharge. Finally, they need time for a considered handoff of clinical care to the next provider and/or PCP or specialist.

When the hospitalist team starts with the end in mind, the path from admission to transition consistently leads to shorter stays and fewer unnecessary readmissions. Instead of frustration and confusion, the journey produces greater satisfaction for patients, their families, and the primary care physician

Engaging with Home-Based Care and Post-Acute Providers

Aligning patients, their families, the hospital, and physicians toward the goal of discharge to the right setting without unnecessary delays is key to delivering better care – and a better experience for the patient – at a lower cost. It's just the right thing to do.

Discharge destination decisions are reactive, based on the availability of beds or subject to referral patterns that may not be grounded in value or measurable outcomes. Overcoming this requires established relationships with a network of high-quality post-acute providers, facilities, and home health resources in the community. It is important to follow a transparent and rigorous process for evaluating facilities and then collaborating with them to plan for each patient's transition and treatment.

Key Leadership Discussions

- Is your organization having discussions with hospitalists and discharge planners to be a care transition team member?
- What real-time communications technology solutions are being utilized to involve all team members?
- What clinical and financial value is your organization bringing to team-based care? In other words, what separates your organization from others?

Additional Insights on Care Transition Solutions

- 4 Care Transition Challenges and How to Solve Them

KEY CHARACTERISTICS AND DECISION POINTS OF ACOs

Which Types of ACOs Use Home Visits the Most and Why?

By Lisa Remington, President and Publisher, The Remington Report

Accountable Care Organizations, which take on risk for patient populations, are more likely than other healthcare organizations to use home visits to support complex patients, including during care transitions and times when a patient is out of contact.

Under ACO contracts, providers are responsible for the quality and total costs of care of a patient population. There is a higher use of home visits among ACOs suggesting that alternative payment models are driving changes in care delivery approaches.

ACOs reported that home visits help them gain a greater understanding of a patient's home life, including any safety issues and barriers to health, while providing an opportunity to build relationships with patients and engage them in managing their health to reduce hospital and other care use. Challenges to the widescale adoption of home visits include their cost and the current lack of evidence-based best practices.

ACO: Motivations for Home Visits

ACOs reported three motivations for home visits.

1. To see the patient's home to identify unmet needs.
2. To reconnect patients perceived to be nonresponsive with office-based care.
3. To build relationships with patients.

ACOs that did not conduct home visits through a care management program were more likely to use home visits to locate a patient than as part of a care management program.

The study, published in *Health Affairs*, used 2017–2018 survey results as well as data obtained from interviews with 18 ACO leaders.

What the Study Found About Home Visit Decision Points

- ACO physician practices were more likely than non-ACO practices to conduct home visits for complex patients within 72 hours of hospital discharge (25.7% vs. 18.8%).
- ACOs using home visits tended to be larger (include a hospital or contract with more physicians) and more likely to be part of an integrated delivery system than ACOs that did not use home visits.
- More than 50% of ACOs that participated in risk-bearing payment arrangements, such as episode-based bundled payment, employed home visits. In comparison, only 30.2% of ACOs that did not have risk-bearing contracts used home visits.
- In addition to using home visits as part of a care management or care transitions program for complex patients, ACOs used home visits for patients who were non-compliant or non-responsive with office-based care.
- Post-discharge visits were common, but some ACOs also used home visits on an as-needed basis, such as when care teams sense something is not right with a patient or a patient cannot be reached by phone or other means.
- Care team members who conducted home visits included care management staff, nurses, social workers, health coaches, and pharmacists.
- Looking at only Medicare ACOs, the researchers saw no significant differences in quality scores or likelihood of achieving shared savings between ACOs that used care transition home visits and those that did not.

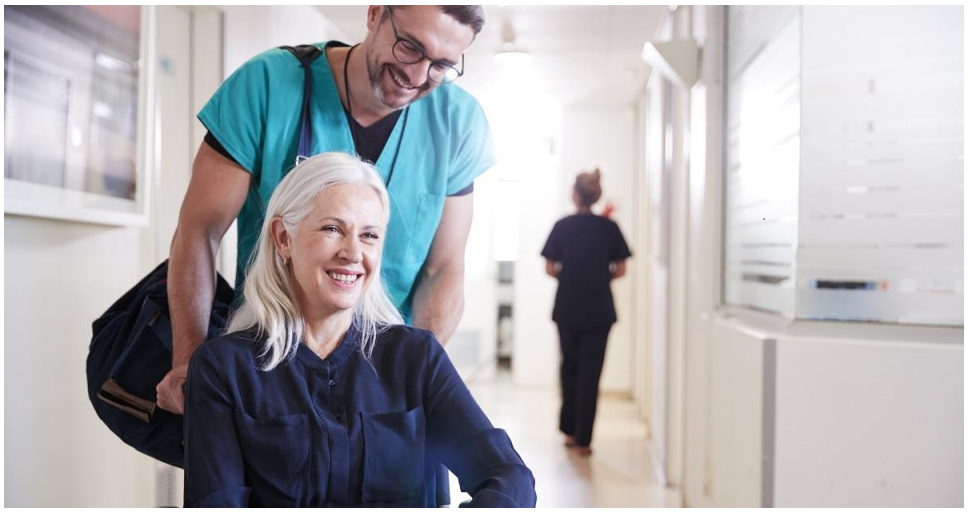
3 Key Discussions for Leaders

1. Does your organization evaluate different types of ACOs to determine the partnership value you bring?
2. As value-based contracting progresses, how do your organization's services fit into those models of care delivery? For example, in this article, we learned that ACOs in risk-based contracting are responsible for quality and total cost of care. How can you break down your value to meet the ACO's needs?
3. How is your organization able to engage communications in real-time to keep the care management team informed about their patients?

CASE STUDY: A 30-DAY POST-DISCHARGE CARE TRANSITION MODEL

Care Transitions Intervention Model to Manage Social Determinants of Health

By The Remington Report Editorial Team



The Care Transitions Intervention (CTI) program at Sharp Grossmont Hospital (SGH) provides 30-day post-discharge care transition coaching and community resources for underinsured or uninsured vulnerable patients (including homeless and refugee populations).

The CTI program involves a multidisciplinary team of healthcare professionals and is provided at no cost to patients by CTI "coaches" that include a registered nurse and medical social worker. Patients are identified as high-risk through SGH's comprehensive risk assessment tool that assesses for clinical as well as social risks.

Goals of the Model

The goals of the program are to improve quality of care, reduce readmission rates, and ensure patients have the resources to maintain their health and safety. In this program, collaborations with community organizations also connect patients to critical services such as access to fresh food, transportation, and social support. Through an innovative partnership with 2-1-1 San Diego, SGH can connect CTI patients with 2-1-1 health navigators to address both short- and long-term care needs and social determinants of health.

Results: Readmission Rates and Outcomes

From May 2014 to November 2016, 1,106 patients went through the program, with an overall average readmission rate of 13%. For patients who qualify for but do not accept CTI services, the average readmission rate is 22%.

The average readmission rate for calendar year (CY) 2016 (through November 2016) is only 9% among program participants. This notable decrease follows the implementation of 2-1-1 San Diego evaluation tool and connection services. In CY 2016, 62 CTI patients were referred to 2-1-1 San Diego's health navigation program. Of the patients that were referred to 2-1-1 and completed the program during CY 2016 (n=31):

- 24% decreased vulnerability regarding activities of daily living
- 38% decreased vulnerability regarding ambulance use
- 36% decreased vulnerability regarding health management
- 20% decreased vulnerability regarding housing
- 46% decreased vulnerability regarding income/employment
- 36% decreased vulnerability regarding nutrition
- 31% decreased vulnerability regarding primary care
- 44% decreased vulnerability regarding social support
- 16% decreased vulnerability regarding transportation

In addition, 95% of CTI patients referred to 2-1-1 San Diego felt confident in their ability and current plan to help them manage their health. This is a critical measure of patient self-efficacy that exemplifies the true goal of the CTI program – to maintain the health and well-being of community members after they have left SGH.

Lessons Learned

By tracking successful access to social supports (e.g., housing, medical homes, food distribution/CalFresh, and other community resources), in addition to readmission rates through 2-1-1 San Diego and Sharp's electronic medical records, respectively, the program's impact can be successfully evaluated by other hospitals interested in implementing this model.

It is this capability to track and measure program milestones that have communicated the positive impact of the CTI program for both patients and SGH, and these results have gained widespread recognition across Sharp HealthCare and in the community. Further, the partnership with 2-1-1 San Diego and the ability to evaluate the impact of specifically addressing social determinants of health as part

of whole-person care has presented this program as a successful practice in community health improvement.

Through root cause analysis of each readmission, the CTI team determined that lack of social supports (as opposed to disease process) is what truly brings patients back to the hospital. Thus, the health coaches have been central to identifying and connecting patients to the support services and community resources – particularly access to healthy food and 2-1-1 San Diego – that patients need to manage their care and maintain their health and safety. In addition, the development of a tool to understand patient needs, and the connection to critical community resources that address social determinants of health further contribute to the success of CTI.

The ancillary support for CTI has been critical to its success as well as its strong potential for expansion and the capacity to replicate the program in other hospitals. The intervention alone is not enough.

CTI has clinical specialists, pharmacy, community partnerships, and social connections in place, as well as hospital leadership support. Together, these elements result in a powerful collaborative impact. With strong leadership, a collaborative patient care team, and community partnerships to address social determinants of health, this program provides a successful model for hospitals to consider as they seek to measurably improve the health of their community.

Future Goals

Sharp Grossmont Hospital's CTI program is examining its current partnerships (both internal and external) for opportunities to improve access to community resources and help meet needs around social determinants of health, particularly access to healthy food and housing. These are complex challenges to community health, so leveraging current and growing new partnerships are essential to this component of the program, as well as to overall program maintenance and potential expansion.

Additional Insights on Social Determinants of Health

- 2023 Providers are Responsible for Social Determinants of Health Quality Measures

SPECIAL REPORT

36 Ways Your Investment in Technology Can Produce a Positive ROI Across Your Organization

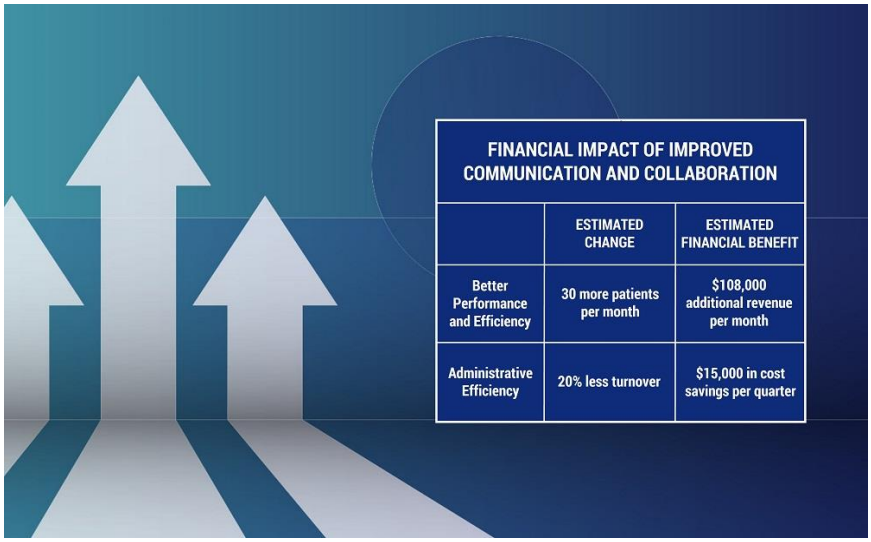
Identifying the Right Technologies to Get a Positive Return on Your Investment

- 5 ways communication and coordination technology can produce a positive ROI
- 7 technology investments aligned with patient needs
- 6 technology investments to increase your referral partner's experience
- 5 technologies that can maximize home health value-based purchasing measures
- 9 ROI benefits that improve overall efficiencies
- 4 benefits that justify return on investment

Examining Current ROI Challenges

When it comes to healthcare technology, return on investment (ROI) benefits much more than your bottom line. It can improve quality of care, patient satisfaction, and more.

In this special report, we examine current challenges in home-based care and provide specific examples for determining a technology ROI.



How Embracing Technology Can Produce a Financial Return

The home-based care landscape is expanding and changing. Moving forward, providers will be measured on performance related to patient outcomes, acute care utilization, and patient experiences. Tools that optimize efficiency, reduce the likelihood of human errors, increase patient satisfaction, and make staff more productive will be necessary to be competitive in this space.

Providers that can embrace the business case for technology may see the rewards – better outcomes and lower costs–reflected both in better patient care and a healthier bottom line. Investments in technology that supports communication and coordination are likely to produce a financial return for any organization.

5 Ways Communication Technology Can Produce a Positive ROI

RESULTS FROM BETTER COMMUNICATION	HOW THAT TRANSLATES TO DOLLARS
Lower likelihood of errors, adverse events, or hospitalizations	• Better performance on quality measures that influence reimbursement • Lower likelihood of penalties under HHVBP • More referrals from hospitals
Higher patient satisfaction	• Better performance on HHCAHPS
Increased patient activity	• Lower likelihood of hospitalization or ED utilization • Better patient functioning
Improved staff efficiency	• Lower costs • Higher volume of visits
Higher staff satisfaction	• Less staff turnover

7 Technology Investments Aligned with Patient Needs

A new Porter Research study of 300 patients and family caregivers who experienced home healthcare in the last 12 months reveals that home healthcare providers are falling short when it comes to what really matters to the consumer.

What do Home Healthcare Consumers Say?

- 95% of respondents said that communication responsiveness influenced their satisfaction with the home healthcare provider.
  Only about 40% of respondents reported being fully satisfied with their home healthcare provider when it comes to responsiveness on five communications-oriented categories on the HHCAHPS survey.
- Respondents reported that using phone, email and insecure text messages was four to five times more likely to fail to produce an immediate response than a mobile phone app.
- 96% of respondents reported that they would choose a home healthcare provider that uses real-time communication technology via smart phone, tablet, or computer, and they would give that provider better HHCAHPS survey scores.

The results indicate that outdated communications mechanisms used most frequently by home healthcare providers can negatively impact the Home Healthcare Consumer Assessment of Healthcare Providers and Systems (HHCAHPS) survey results and can heavily influence choice of home healthcare provider.

HHCAHPS Communications-Related Questions

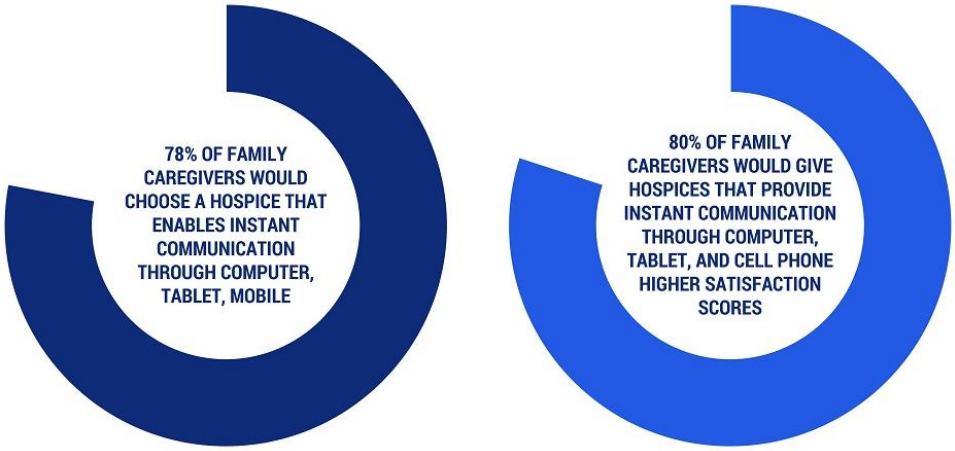
The Porter Research study identified seven consumer priorities for communicating in real time through a smart phone, tablet, or computer. Providers should use this information to prioritize investments that can have the greatest impact on patients and family caregivers.

Get this complimentary research report to learn more about what increases patient satisfaction: Impact of Home Healthcare Provider Communication on Consumer Satisfaction.

For the best solutions to better communications read this e-book: 12 Secrets to Patient and Family Caregiver Satisfaction in Home Health, Hospice, and Palliative Care.

How Hospice Provider Communication Impacts Patient Satisfaction

New research reveals that most hospice providers are falling short when it comes to what really matters to those who make the ultimate decision on choice of provider and serve up hospice satisfaction scores – the hospice consumer.



What Influences Family Caregiver Satisfaction?

Across all methods of communication, over 90% of family caregivers indicated that the method of communication influenced their overall satisfaction scores. If family caregivers are not receiving immediate responses, are forced to play phone tag, and send several communications to make their loved one comfortable during one of the most stressful times in life, they will respond with low satisfaction scores.

See this case study and get insights to improve patient communications: Consumer Research Reveals Hospice Communication Strategies Lag Consumer Expectations.

6 Technology Investments to Increase Your Referral Partner's Experience

Key frustrations among referring providers include unnecessary phone calls, lack of visibility into the patient care journey, delayed start of care, and reliance on fax.

Improving your technology tools can help you communicate seamlessly, see patients in a timely manner, and be more productive both in person and through virtual care – making you a more reliable home-based partner to your referral sources.

Up from 60% in 2019, 74% of referral sources say they would switch to a new home-based care provider if that organization was able to accept electronic referrals and interoperate with them effectively. With only half of post-acute care providers able to receive and use much of this critical data, serious frustrations between both sides of the referral equation are still very prominent.

How are Your Referral Source Expectations Shifting?

1. Referral sources care more about interoperability than ever before.
2. The pandemic has accelerated connected care trends.
3. More app-based care is helping organizations succeed across multiple care settings.
4. There's a gap between what referral sources want and what organizations are prepared to deliver.
5. Rehospitalizations need to be reduced.

6 Solutions to Respond to Your Referral Source's Engagement

Having the ability to communicate seamlessly, capture and send data electronically, and streamline workflows creates a better experience for referral partners – giving you a competitive edge and fostering stronger, long-term relationships.

1. Improved care coordination and collaboration.
2. Faster patient onboarding.
3. Enhanced remote clinical support and instant help.
4. Increased patient confidence with access to education.
5. Better clarity with visit scheduling and delivery coordination.
6. More patient and caregiver satisfaction with streamlined communication.
7.

Poor communication between nurses and physicians can be associated with an increased risk of hospital readmission among some patients.

For more details on improving referral engagement, read this e-book: 4 Greatest Challenges and How to Tackle Them with Technology.

5 Technologies That Can Maximize Home Health Value-Based Purchasing Measures

We're on the verge of a new era of reimbursement, where your old methods of communicating could significantly impact your measurement outcomes. Quality measure performance and an increased focus on patient experiences require more streamlined communication, planning, and documentation of care.

The right technology investments ensure your organization maximizes its HHVBP measures – including Home Health Consumer Assessment of Healthcare Providers and Systems (HHCAHPS) scores, Outcome and Assessment Information Set (OASIS) assessments, and claims-based measures – and maximizes reimbursements.

Examples to Maximize HHVBP Measures

1. Start of Care: A key measure derived from data collected in the OASIS, timely initiation of care is the percentage of home health quality episodes in which the start of care or resumption of care date was within two days of the referral date or inpatient discharge date, whichever is later.

Solution: When your team is communicating effectively, they know when a patient is ready to start care. Technology such as secure text messaging helps you maintain HIPAA compliance and allows your care team to communicate instantly, share photos, and start a dialogue about the patient care plan. Customizable digital forms and app-less eSignature capture allow your team to expedite any needed signatures required to start care through digital document workflows.

2. Data from claims-based measures including Acute Care Hospitalization During the First 60 Days of Home Health Use and Emergency Department Use without Hospitalization During the First 60 Days of Home Health are used to calculate performance.

Solution: Providers can help patients and family caregivers use instant messaging to get routed within a matter of minutes to a nurse on call. No more phone calls going through an answering service, emails sitting in inboxes, or messages waiting for responses from the next shift. When nurses are available instantly, patients and caregivers know you're there for them in an urgent situation.

3. In the HHCHAPS survey, patients are asked how well the home health team communicated with them throughout their care.

Solution: Multiple ways to communicate allows patients and caregivers to choose their preferred method of securely sending and receiving information. Secure instant messaging and video chat helps to maintain HIPAA compliance and gets patients answers from the care team faster than phone calls and emails. Making care teams easily and instantly accessible gives patients a sense of security knowing communication about their care is always at their fingertips.

4. In the Specific Care Issues section of the HHCAHPS survey, patients are asked whether the home health team discussed medicines, pain management, and home safety during their care.

Solutions: Technology can provide all training resources electronically and on-demand. Sharing is automated and it's all accessible 24/7. This allows you to tailor materials for staff and those they serve.

5. To measure their overall perception of your organization, the HHCHAPS survey asks patients how they would rate the overall care from your organization and whether they would recommend it to friends and family.

Solution: The HHCAHPS survey gives patients a voice. Solutions such as customer-facing platforms include education materials, access to plan of care, and the history of the services offered. This helps patients remember the things you did for them and the high-level of care provided.

See this important e-guide to advance HHVBP: 5 Ways You Should Be Modifying Your Communication Strategy Right Now in Advance of HHVBP.

9 ROI Benefits to Improve Overall Efficiencies

Read this white paper to learn the ROI technology benefits: Patient and family engagement technology can deliver ROI in home-based care.

1. **Reduced cost per patient: Repetitive activity like phone calls, paper use, scanning, copying and pasting progress notes, and sharing education and training materials can be automated, which decreases the cost of care for every patient.**
2. **Reduced held revenue: Held revenue can impact cash flow. By gathering referral information and prompting referral sources to provide key supporting documents, services can be billed quickly, and revenue can be released.**
3. **Reduced days service outstanding (DSO): When documentation is accurate and timely, the time it takes to go from care provided to billing and getting reimbursed decreases.**
4. **Reduced revenue at risk: Revenue can be at risk of needing to be repaid to a payer if documentation is missing or fails to support insurance claims.**
5. **Improved patient satisfaction: Satisfied patients lead to revenue retention, satisfied referral sources, and more referrals, which will help reach your organization's revenue goals.**
6. **Improved quality of care: Eliminating delays and interruptions in delivery of care can impact revenue and even accreditation.**
7. **Improved documentation: A more complete medical record supports billing and keeps care teams informed with the most up-to-date patient information.**
8. **Improved business contracts: Patient engagement features and onboarding processes have often led to an increase in the number of contracts awarded, ultimately resulting in more revenue.**
9. **Improved patient outcomes: Using multi-level solutions is important for clinical assessment information and tracking outcomes. Having timely information allows quick adjustments to a patient's plan of care, and trends in operational inefficiencies can create dynamic process improvement activity with positive impacts to care being provided.**

4 Benefits to Justify Return on Investment

When building a case for investing in technology, Melissa Kozak, RN, BSN, co-founder, and president of CitusHealth, said home health providers should consider four benefits to justify return on investment.

1. **Increased referrals and higher patient satisfaction.** Studies show patients will give higher ratings on patient satisfaction surveys to organizations that facilitate more real-time communication, which in turn can lead to increased referrals.
2. **Nurse retention and reduced staff turnover.** Using new technology reduces stress on nursing staff and allows them to have a better work-life balance.
3. **Creating more time for staff.** By automating as much of the nonclinical administrative work as possible, staff will have more time to focus on clinical duties.
4. **Improved patient outcomes.** Employing modern technology will allow staff to stay in closer touch and collaborate more with patients, which can potentially reduce the likelihood of hospital readmissions.

“We need to embrace the collaborative approach and agree that clinician-to-clinician and department-to-department communication is critical,” Kozak said.

Get the ROI White Paper

This white paper presents evidence found in clinical research and industry-specific studies that can help home-based care providers better understand why many of their successful peers are adopting modern communication and collaboration platforms.

Download Patient and family engagement technology can deliver ROI in home-based care.

CitusHealth, a wholly owned subsidiary of ResMed, is a digital health transformation leader that enables real-time, secure collaboration between patients, care teams, care partners, and family members to optimize the patient experience and positively impact the financial outcome of the care provider. Founded by a post-acute care nurse with domain expertise, and an internationally recognized digital health expert, CitusHealth delivers the only comprehensive on-demand digital and mobile platform that sets a new standard of patient, caregiver, family, and partner engagement. For more information, visit citushealth.com.

GIVING THE ELDERLY THE CARE THEY WANT

Pre-Hospice Home-Based Transition Program

By Lisa Remington, President and Publisher, The Remington Report

Sharp HealthCare, located in California, pre-hospice program called Transitions, is designed to give elderly patients the care they want at home and keep them out of the hospital.

Social workers and nurses from Sharp regularly visit patients in their homes to explain what they can expect in their final years, help them make end-of-life plans, and teach them how to better manage their diseases. Physicians track their health and discard unnecessary medications. Unlike hospice care, patients don't need to have a prognosis of six months or less, and they can continue getting curative treatment for their illnesses, not just for symptoms.

Before the Transitions program started, the only option for many patients in a health crisis was to call 911 and be rushed to the emergency room. Now, they have round-the-clock access to nurses, one phone call away.

"Transitions is for just that point where people are starting to realize they can see the end of the road," said San Diego physician Dan Hoefer, one of the creators of the program. "We are trying to help them through that process, so it's not filled with chaos."

The importance of programs like Transitions is likely to grow in coming years as 10,000 baby boomers – many with multiple chronic diseases – turn 65 every day. Transitions was among the first of its kind, but several such programs, formally known as home-based palliative care, have since opened around the country. They

are part of a broader push to improve people's health and reduce spending through better coordination of care and more treatment outside hospital walls.

Home-Based Palliative Care

Dan Hoefer's medical office is in the city of El Cajon, which sits in a valley in eastern San Diego County. Hoefer, a former hospice and home health medical director, and nursing home doctor, has spent years treating elderly patients. He learned an important lesson when seeing patients in his office: Despite the medical care they received, "they were far more likely to be admitted to the hospital than make it back to see me."

When his patients were hospitalized, many would decline quickly. Even if their immediate symptoms were treated successfully, they would sometimes leave the hospital less able to take care of themselves. They would get infections or suffer from delirium. Some would fall.

His patients were like cars with 300,000 miles on them, he said. They had a lot of broken parts. "You can't just fix one thing and think you have solved the problem," he said.

And trying to do so can be very costly. About a quarter of all Medicare spending for beneficiaries 65 or older is to treat people in their last year of life, according to a report by the Kaiser Family Foundation.

Hoefer's colleague, Suzi Johnson, a nurse and administrator in Sharp's hospice program, saw the opposite side of the equation. Patients admitted into hospice care would make surprising turnarounds once they started getting medical and social support at home and stopped going to the hospital. Some lived longer than doctors had expected.

In 2005, the pair hatched and honed a bold idea: What if they could design a home-based program for patients before they were eligible for hospice?

Thus, Transitions was born. They modeled their new program in part on the Kaiser experiment, then set out to persuade doctors, medical directors, and financial officers to try it. But they met resistance from physicians and hospital administrators who were used to getting paid for seeing patients.

"We were doing something that was really revolutionary, that really went against the culture of healthcare at the time," Johnson said. "We were inspired by the broken system and the opportunity we saw to fix something."

Despite the concerns, Sharp's foundation board gave the pair a $180,000 grant to test out Transitions. And in 2007, they started with heart failure patients and later expanded the program to those with advanced cancer, dementia, chronic obstructive pulmonary disease, and other progressive illnesses. They started to win over some doctors who appreciated having additional eyes on their patients, but they still encountered "some skepticism about whether it was really going to do any good for our patients," said Jeremy Hogan, a neurologist with Sharp. "It wasn't really clear to the group … what the purpose of providing a service like this was."

Nevertheless, Hogan referred some of his dementia patients to the program and quickly realized that the extra support for them and their families meant fewer panicked calls and emergency room trips.

Hoefer said doctors started realizing home-based care made sense for these patients — many of whom were too frail to get to a doctor's office regularly. "At this point in the patient's life, we should be bringing healthcare to the patient, not the other way around," he said.

In San Diego, Sharp's palliative care program has a strong incentive to reduce the cost of caring for its patients, who are all in Medicare-managed care. The non-profit health organization receives a fixed amount of money per member each month, so it can pocket what it doesn't spend on hospital stays and other costly medical interventions. Patients typically stay in Transitions about seven or eight months, but some last as long as two years before they stabilize and are discharged from the program. Others go directly yo hospice, and still others die while they are still in Transitions.

Sharp has found that emergency room visits and hospitalizations decreased from 85 percent in usual care to 35 percent in the new model for cancer patients. It has seen a decrease in hospital mortality from 57 percent to 5 percent for cancer patients. It also has led to significantly reduced per-patient costs for cancer, COPD, heart failure and dementia.

RESOURCES TO IMPROVE PERFORMANCE

Improving Real-Time Communications with Care Teams and Patients

Compiled by The Remington Report Editorial Team

In our extensive resource of special reports, you'll find actionable solutions to improving care transitions, real-time communications with team members, and what patients want for better communications.

SPECIAL REPORT

11 Strategic Actions to Improve Care Team Productivity

Get insights into advancing clinical communications with your referral partners, ways your care team always has real-time patient status, and how to improve the referral process. Don't miss the eight additional resources to dig even deeper into this topic.

SPECIAL REPORT

4 Care Transition Challenges and How to Solve Them

Learn about the challenges and solutions to effective care transitions, competitive tools, and shared peer actions.

SPECIAL REPORT

Seamless Care Transitions: Six Smart Ways to Stay in Communication with Your Referral Sources

Your referral partners increasingly expect robust communications to make patient transfers as seamless as possible, for both the patient and providers, which means you need strategies to create seamless transitions. Learn what leading home health and hospice agencies are doing.

SPECIAL REPORT

Strategic Priority: Facts Driving Why Family Caregivers Choose One Care-at-Home Organization Over the Other

Learn the seven family caregiver expectations to increase your competitive advantage.

SPECIAL REPORT

Empowering Your Clinical Team to Increase Patient and Family Engagement

Get multiple solutions to improve outcomes, patient engagement, and deeper conversations.

SPECIAL REPORT

Trends and Insights to Collaborate in Real-Time with Physicians, Care Teams, Patients, and Family Members

Insights, solutions, and resources to advance new ways to communicate in real-time and optimize the experience of patients, their families, and your care teams.

PREPARE FOR THE FUTURE

7 Things Changing in Healthcare 2023 You Should Know About

By The Remington Report Editorial Team

1

Hospitals: New Social Determinants of Health Quality Measure: Starts 2023

Hospitals will be required to report what portion of their population is screened for various social determinant of health (SDOH) and how many screen positive in each category. CMS's new SDOH quality measures were published in the 2023 Medicare Hospital Inpatient Prospective Payment System rule, released on August 1.

Hospitals will capture screening and identification of patient-level, health-related social needs—such as food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety. By screening for and identifying such unmet needs, hospitals will be in a better position to serve patients holistically by addressing and monitoring what are often key contributors to poor physical and mental health outcomes.

For greater insights into the SDOH quality measure, click here.

Health Plans: 2023 Social Determinants of Health Quality Measure Begin

The National Committee for Quality Assurance announced new and revised quality measures for health plans in the Healthcare Effectiveness Data and Information Set (HEDIS) for the measurement year 2023.

One of those measures is Social Need Screening and Intervention (SNS-E). The goal of this measure is to identify and address members' social determinants of health needs and to encourage health plans to assess and address the food, housing, and transportation needs of their patient populations. The screening looks at food, housing, and transportation needs. This measure helps health plans identify specific needs and connect members with resources necessary to address unmet social needs.

CMS Releases First-Ever Home- and Community-Based Services Quality Measure Set

CMS released the first-ever Home-and Community-Based Services (HCBS) quality measure set to promote consistent quality measurement within and across state Medicaid HCBS programs. The measure set is intended to provide insight into the quality of HCBS programs and enable states to measure and improve health outcomes for people relying on long-term services and support (LTSS) in Medicaid.

The release of this voluntary measure set is also a critical step to promoting health equity among the millions of older adults and people with disabilities who need LTSS because of disabling conditions and chronic illnesses.

Nationally, over 7 million people receive HCBS under Medicaid, and Medicaid-funded HCBS accounts for $125 billion annually in state and federal spending. Implementation of the HCBS quality measure set will create opportunities for CMS

and states to promote more consistent use, within and across states, of nationally standardized quality measures in HCBS programs to promote health equity and reduce disparities in health outcomes among this population.

To review the HCBS quality measure, click here.

Medicare Managed Care Organizations: Federal and State Regulations for SDOH Screening and Technology Usage

States are increasingly requiring MCOs to incorporate methods to identify SDOH needs in screenings, covering areas such as housing, employment status, food insecurity, physical safety, and transportation needs. Additionally, some states are contractually requiring MCOs to either encourage or require their provider networks to incorporate SDOH needs screening into their practices. Louisiana and Ohio require MCOs to reimburse providers for SDOH screening and submitting applicable diagnosis codes (Z codes) on claims.

Main Trends in SDOH State Requirements

- Many states are requiring MCOs or provider networks to screen enrollees for SDOH needs.
- States are increasingly requiring MCO care management programs to incorporate SDOH, to coordinate with community-based organizations and to ensure referrals to social services and supports.
- Recent RFPs have included requirements that MCOs incorporate SDOH into their quality assessment and performance improvement (QAPI) programs and that MCOs provide SDOH training for staff.

The Bundled Payment Pilot Extended By 2 years

On October 13, 2022, CMS announced that the Bundled Payments for Care Improvement Advanced (BPCI Advanced) Model will be extended for two years. The BPCI Advanced Model, which launched on October 1, 2018, was set to end on December 31, 2023, and will now conclude on December 31, 2025.

A bundled payment methodology involves combining the payments for physician, hospital, and other healthcare provider services into a single bundled payment amount.

BPCI Advanced is an Advanced Alternative Payment Model (Advanced APM) under the Quality Payment Program and tests whether linking payments for an episode of care will incentivize healthcare providers to invest in practice innovation and care redesign to improve care coordination and reduce expenditures while maintaining or improving the quality of care for Medicare beneficiaries

As of December 31, 2021, more than 1.2 million Medicare beneficiaries have received care from Participants in the BPCI Advanced Model, and over 1,800 Acute Care Hospitals (ACHs) in coordination with 69,867 physicians have engaged in care redesign activities because of participation in the BPCI Advanced Model.

Overall, in the first two model years, Medicare providers and suppliers in the BPCI Advanced Model have lowered healthcare spending without reducing quality.

For more details on the Bundled Payment Initiative, click here.

Medicare Advantage Value-Based Insurance Design Model VBID Hospice Benefit in 2023

The Medicare Advantage (MA) Value-Based Insurance Design (VBID) Model tests a broad number of complementary MA health plan innovations designed to reduce Medicare program expenditures.

For the plan year 2023, the VBID Model has 52 participating Medicare Advantage Organizations (MAOs) with a total of 9.3 million enrollees projected to be enrolled in participating plan benefit packages (PBPs). More than six million of these enrollees are projected to receive additional Model benefits and/or rewards and incentives as part of the Model test in 2023.

Of the 52 MAOs participating in 2023, 15 are participating in the Hospice Benefit Component, six more than in 2021 and two more than in 2022. These 15 organizations will test the inclusion of the Part A hospice benefit in MA benefits through 119 PBPs (up from 53 PBPs in 2021 and 115 PBPs in 2022) and in 806 counties (up from 206 counties in 2021 and 461 counties in 2022).

In participating in this voluntary Model component, MAOs are incorporating the Medicare hospice benefit into MA-covered benefits while offering comprehensive palliative care services outside the hospice benefit for enrollees with serious illness.

In addition, participating MAOs can provide individualized, clinically appropriate transitional concurrent care through in-network providers and offer hospice-specific supplemental benefits. Each participating MAO prepared health equity plans on how they will address potential inequities and disparities in access, outcomes, and/or enrollee experience of care as it relates to their participation in the Hospice Benefit Component.

For additional information on the VBID model, click here.

The Expanded HHVBP Model

The expanded HHVBP Model began on January 1, 2022, and includes Medicare-certified HHAs in all 50 states, District of Columbia, and the U.S. territories. Calendar Year 2022 is the pre-implementation year.

The first full performance year for the expanded HHVBP Model is CY 2023, beginning January 1, 2023. Calendar Year 2025 will be the first payment year, with payment adjustment amounts determined on CY 2023 performance.

Data from the Outcome and Assessment Information Set, completed Home Health Consumer Assessment of Healthcare Providers and Systems surveys and, claims-based measures are used to calculate HHAs' performance.

For additional information on HHVBP, click here.

A Trusted Advisor to More Than 10,000 Organizations

For more than three decades, **The Remington Report** and its growth advisory division, has been providing **Big Ideas** for new growth opportunities, expanded partnership relationships, and transformation.

Recognized across the care continuum, we **Think Boldly** to bridge together the care continuum to advance care delivery transformation.

Learn more at: https://remingtonreport.com/about-us

REMINGTON REPORT®