POST-ACUTE CARE

Are you delivering person-centered care?

Consider these 4 crucial elements

Person-centered care is more than just how a healthcare professional treats an individual.

Ask any post-acute care provider to define person-centered care, and you'll likely hear phrases such as "care centered around the patient or family," "resident-focused" or "relationship-centered approach."

Despite its frequent buzzword reference today, person-centered care – defined as "care that is respectful of, and responsive to, individual patient preferences, needs and values" – is rooted firmly and deeply in long term and post-acute care.

It's important to note that person-centered care is more than just how a healthcare professional treats an individual. It is also about how payers, providers and government create and support policies to put healthcare users at the center of care.

In 1987, person-centered care appeared in the Omnibus Budget Reconciliation Act (OBRA), also known as the Nursing Home Reform Act (NHRA). NHRA was established to ensure that nursing home residents receive the "highest practicable mental, physical and psychosocial wellbeing."[1]

In the Institute of Medicine's 2001 seminal report Crossing the Quality Chasm, person-centered care was identified as an essential foundation for healthcare quality and has remained a high priority for the delivery of healthcare services across the industry.[2]

1 National Library of Medicine, National Institutes of Health, https://www.ncbi.nlm.nih.gov/pubmed/2671955

2 Institute of Medicine, http://www.nationalacademies.org/hmd/~/media/Files/Report%20Files/2001/Crossing-the-Quality-Chasm/Quality%20Chasm%202001%20%20report%20brief.pdf"Crossing the Quality Chasm: A New Health System for the 21st Century"

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When outcomes are prioritized, data becomes king. Without data, it's impossible to prove your value.

Clearing the way to value-based reimbursement

As the Centers of Medicare & Medicaid Services (CMS) barrels down the road to make person-centered, value-based care a reality for consumers, the question becomes clear: What must post-acute care organizations (skilled nursing, home health and hospice agencies) do to best implement person-centered care in their systems, workflows and cultures?

They must arm themselves with technology that enables true **care coordination**, **interoperability**, **analytics** and **virtual care.**

Equally important, post-acute care providers need to be able to prove their value to payers and hospital partners or they may not be in the game at all.

As payers narrow their networks and hospitals become more selective in those they partner with, post-acute providers must ask themselves: Do I have the data analytics capabilities to prove my value to referral partners and payers?

When implemented systematically and effectively, a person-centered, value-driven approach has the potential to better meet an individual's needs, improve clinical outcomes, reduce costs and increase staff satisfaction.

Person-centered care is dependent on outcomes

First and foremost, person-centered care is dependent on outcomes. Delivering person-centered care begs the questions: Did the individual achieve his/her goals? How did I help the individual achieve them? Can I prove it? Quality care is no longer about how much care and services were provided to the person, but rather how did the care and services meet the person's needs.

When outcomes are prioritized, data becomes king. Without data, it's impossible to prove your value. The data – and more importantly, the insights that come with it – is your linchpin to succeeding in an outcomes-based healthcare environment.

Value over volume

To move from an operating model rewarded on volume of care to a model rewarded on value requires post-acute leaders to rethink their approach to healthcare delivery. They must bring new attention to active collaboration, an open exchange of information and shared decision-making with all parties including healthcare consumers, acute-care partners and payers.

The right technology becomes the foundation for organizations to prove outcomes and showcase value. Person-centered operations is a tall order made impossible without the proper technology investments.

Accelerate the use of person-centered technology

Post-acute leaders must accelerate the use of person-centered health information technology to be successful in the new environment.

Today, many post-acute providers are using health information technology designed for fee-for-service not fee-for-outcomes. Adding to the provider's burden is that most software companies designed their electronic health record (EHR) systems for a single care setting, which prevents an individual's information to travel with them when they transition care settings.

As a result, when an older adult with multiple chronic conditions moves from an assisted living facility to a skilled nursing facility, for example, their information ceases to move with them, creating poor "handoffs" and breakdowns in care, medication errors, low satisfaction with care and high rehospitalization rates.

When an EHR system is designed around the individual, seamless transitions between multiple care settings become the norm. And when your health information technology allows you to collect, analyze and share relevant data with other stakeholders, true care coordination is achieved.

Let's dive deeper into the first essential element of delivering person-centered care: care coordination.

Care coordination

For a person to receive the right care at the right time in the right setting, caregivers need to be able to find and share critical information. Without access to complete information, it becomes difficult to capture a holistic view of an individual, including their medical care, social determinants of health and their general well-being.

What's more, older adults are often seen by multiple providers across separate health systems, which demands that providers be able to collaborate and coordinate a person's care across all systems and settings.

Powerful interoperability, coupled with a unified platform, enables automated electronic referral management, streamlined admissions, efficient billing and access to view and manage a person's care journey across multiple care settings. Most importantly, you improve the consumer experience by keeping them healthy longer in the lowest acuity care setting.

Only **41%** of skilled nursing facilities and **52%** of home health agencies can send patient information to other providers.

RELATED: Success in long-term care through care coordination

When providers use a person-centered EHR, rather than a setting-centered EHR, they can expect to gain:

- **Integrated care transitions**

  Risk is highest when an individual transitions between care settings.

  With a person-centered EHR, you can reduce this risk by keeping the individual's information centralized, while the care settings change around them. Your care teams will be able to provide more informed and timely care, which in turn maximizes outcomes for the people in your care.

- **Positive experience**

  Individuals and their families put their trust in your organization to provide the best care possible.

  By having all relevant information in a centralized place, your caregivers can spend less time searching through paper charts or computer files and more time focused on the individuals in their care.

- **Clinician satisfaction**

  Clinicians chose their profession to care for and help people.

  It's important to remove one of the biggest burdens in a clinician's day: duplicate data entry. By decreasing documentation time and easing click fatigue, your clinicians can spend more time with people in their care and less time on computers.

More than ever, value-based reimbursements will require strong partnerships across care settings and across a person's continuum of care.

Hospitals and post-acute providers are forming partnerships to institute seamless transitions and true coordination of care. Health systems are recruiting preferred partner organizations who can take on these new population health management opportunities and make it easy to connect with other systems and networks.

RELATED: How to manage care for multiple conditions [video]

A second essential element to delivering person-centered care is interoperability.

2 Seamless interoperability

Interoperability, one of health IT's biggest buzzwords, can be confusing because it means different things depending on whom you ask.

Defined by Healthcare Information and Management Systems Society (HIMSS), interoperability is the ability of different information systems, devices or applications to connect, in a coordinated manner, within and across organizational boundaries to access, exchange and cooperatively use data amongst stakeholders.

Only **53%** of home health agencies and **41%** of skilled nursing facilities are integrated to receive patient information

RELATED: What is true interoperability?

Interoperability is the engine to access and share information. In no other industry is access to critical information more vital than in healthcare. A health event that triggers a change in medication but is not communicated to the right provider at the right time can be the difference between life and death.

That is why The United States Department of Health & Human Services (HHS) in its annual report to Congress stated that the future state of healthcare must be "seamlessly interoperable in order to support sophisticated data analytics and patient/provider access to complete data."

RELATED: Interoperability: Going Beyond the Standards

Person-centered care requires providers to leverage the four domains of interoperability (send, receive, query and integrate) to understand the full health picture of an individual.

A successful interoperability strategy should include the ability to:

- **Send**

  Not all care happens inside your organization, so sending patient information to other providers is critical to minimizing the risk of readmission. Only 41% of skilled nursing facilities (SNFs) and 52% of home health agencies can send patient information to other providers.[3]

- **Receive**

  When your organization receives a new patient from a referral partner, can you electronically receive the referral information into your EHR? Many organizations are still managing this process through printing, scanning and manually inputting this information. Only 53% of home health agencies and 41% of skilled nursing facilities are integrated to receive patient information.[4]

- **Query**

  It's common for a referral or a Continuity of Care Document (CCD) to have limited or incomplete patient information. In order to prevent readmissions or negative patient experiences, providers need interoperability to search national health information exchanges and frameworks, like Carequality, to pull complete patient information directly from other providers.

  By electronically consolidating missing patient information into the EHR, providers can create a longitudinal view of the individual and their needs. Only 27% of skilled nursing providers and 42% of home health agencies are able to search for missing information.[5]

3 https://www.healthit.gov/sites/default/files/page/2018-11/Electronic-Health-Record-Adoption-and-Interoperability-among-U.S.-Skilled-Nursing-Facilities-and-Home-Health-Agencies-in-2017.pdf

4 Ibid.

5 Ibid.

Only **27%** of skilled nursing providers and **42%** of home health agencies are able to search for missing information.

- **Integrate**

  Your EHR should be able to electronically receive, send, query and integrate patient information from outside sources. A Stratis survey found that in a disconnected model without interoperability, it can take a skilled nursing facility as much as 9.75 hours to reconcile medications versus 1 hour when the SNF is integrated with the referring partner.

  Currently, 18% of skilled nursing providers and 36% of home health agencies can integrate patient information from outside sources.[6]

Without true interoperability, "very soon hospitals, ACOs and MCOs are highly unlikely to partner with any post-acute providers incapable of sharing patient data electronically," said Tim Rowan in a recent Healthcare at Home: The Rowan Report.

Along with strong care coordination and interoperability, a robust analytics ecosystem is a major component to achieving the goals of person-centered care.

3 A robust analytics ecosystem

A Black Book Market Research survey of more than 2,000 long-term and post-acute care facilities showed that just 3% of long-term care providers have the data analytics capabilities to reduce healthcare costs and unnecessary hospital readmissions while ensuring the organization receives proper reimbursement for care.

Value-based care requires data aggregation, provider communications and analytics. As a post-acute provider, you must be able to transform data into actionable insights.

You must also be able to view data that allows for a total understanding of your business (i.e. total cost of care, risk, regulatory compliance, competitive strengths/weaknesses) so you can gather insights to make necessary changes.

Data insights and analytics will help you understand the potential risk of an individual in your care, so you can act proactively, not reactively. Health IT and EHRs built to address episodic, fee-for-service reimbursement models won't serve you well in value-based reimbursement models.

"Achieving the goals of person-centered care will depend on seamless interoperability, broad access to data, and a robust analytics ecosystem," HHS says.

The fourth essential component to delivering person-centered care includes virtual care.

6 https://www.healthit.gov/sites/default/files/page/2018-11/Electronic-Health-Record-Adoption-and-Interoperability-among-U.S.-Skilled-Nursing-Facilities-and-Home-Health-Agencies-in-2017.pdf

4 Virtual care

A crucial step to designing care around the person means improving access, so individuals can get care where they want and when they want it. Telehealth gives patients and providers what they want most – more time with each other.

With a telehealth visit, 95% of the patient's time is spent face-to-face with the clinician, compared to less than 20% of a traditional visit,[7] where most time is spent traveling and waiting for an appointment.

Timely access to care

Telehealth gives consumers on-demand access to high valued providers, which helps ensure the right care is delivered at the right time. Doing so reduces costs and improves consumer satisfaction. What's more, by using technology to monitor patients at home, providers can quickly identify risk and intervene before an issue escalates, thus reducing hospital re-admissions.

> RELATED: Telehealth software that connects to a network of more than 600,000 providers and 25,000+ organizations.

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With the rise of aging in place – 87% percent of seniors age 65 and older and 71% of those between 50 and 64 want to age in place[8] – healthcare mobility solutions must be established so organizations can leverage mobile technology at the point of care to treat patients quickly and accurately.

> RELATED: Tidewell Hospice boosts staff satisfaction and patient care with mobile solution

Closing thoughts

If improving a person's health and well-being is healthcare's ultimate goal, then we all must embrace outcomes-based healthcare. Without question, the beneficiaries of an outcomes-based system are the people who are served.

To make person-centered care a reality, you need a technology partner that goes far beyond just the EHR, equipping you with the right tools to integrate care, to share information and to make the most informed decisions.

7 https://patientengagementhit.com/news/patient-satisfaction-of-telehealth-hinges-on-convenience-quality

8 https://press.aarp.org/2014-04-25-New-AARP-Report-Outlines-What-Older-Americans-Want-In-Their-Communities-How-Many-Are-Thinking-of-Moving https://www.reuters.com/brandfeatures/venture-capital/article?id=112522

With the post-acute care market expected to hit $481 billion by 2025, demand for services will continue to skyrocket.

With the post-acute care market expected to hit $481 billion by 2025, demand for services will continue to skyrocket.[9] Meeting this huge demand will require much more than an EHR that simply digitizes information. It will require an EHR that truly provides care coordination, seamless interoperability, data analytics and virtual care.

As CMS Administrator Seema Verma emphasized at this year's HIMSS conference in Orlando, "The healthcare system needs greater technical efficiency so we don't repeat expensive tests, run the risk of adverse drug interactions, and compromise patient safety – all things that drive up healthcare costs."

Are you set up for success?

Without effective, open data sharing, delivering optimal care is difficult. And without data to track patient progress, payers cannot tie payment to outcomes. As you transition from fee-for-service to fee-for-outcomes, you will need to ask yourself:

1) Does my business model support person-centered, outcomes-driven care, so I can succeed with risk-based contracts?
2) Can my EHR adapt and scale to meet the fast-changing regulatory requirements?
3) Are my revenue cycle processes positioned to meet new payment designs, like the Patient-Driven Groupings Model for home health agencies and Patient-Driven Payment Model for skilled nursing facilities?

These new payment designs are only the beginning. More will come, like a falling row of dominos, as CMS pushes our healthcare system to a person-centered, value-based model.

Those who have implemented the right technology to deliver person-centered, outcomes-based care will transform the healthcare system and come out winners.

Let's talk. Contact us.

Only Netsmart has a proven track record of delivering the solutions required to meet outcomes-based care models.

Let's get started. Fill out this simple form. A Netsmart expert will contact you to listen to your needs and discuss a strategy to meet your goals.

Netsmart helps more than 30,000 health and human services and post-acute care organizations improve the health and well-being of the individuals they serve.

We can do the same for you.

9 https://www.reuters.com/brandfeatures/venture-capital/article?id=112522

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