HOMECARE & HOSPICE
National Association for Home Care & Hospice

Adopting Information Technologies for Post-Acute and Long-Term Care: Achieving Care Continuity a.k.a. Longitudinal Coordination of Care

Home Health Agencies in New Models of Care

- Accountable Care Organizations (ACOs) = 18.7%
- Bundled Payment Partnerships = 6.4%
- Patient-Centered Medical Homes = 12.3%
- Transitional Care Programs = 20.3%
- Other Models = 1.9%

Source [2013 National State of the Home Care Industry Study]. Over 1,100 home health agency leaders were interviewed. The focus of the study was on the present and future use of key technology and clinical practices.

Economies of Health Care in LTPAC

- Each year approximately 15 million medically complex and/or functionally impaired individuals receive long-term and post-acute care (LTPAC) services in nursing facilities (SNFs), home health agencies (HHAs), and other settings.
- Many of these individuals are the top 10% of patients that account for 70% of Medicare health care spending.

Source: S&I Framework Longitudinal Coordination of Care White Paper.

LTPAC Providers Receive 40% of Acute-Care Hospital Discharges

	LONG-TERM ACUTE CARE HOSPITAL	INPATIENT REHAB	SKILLED NURSING FACILITIY	OUTPATIENT REHAB	HOME HEALTH
Patients' ***first*** site of discharge after acute care hospital stay	2%	10%	41%	9%	37%
Patients' use of site during a ***90 day*** episode	2%	11%	52%	21%	61%

- "Clean" care transitions are critical to reducing rehospitalizations and unplanned ER visits
- Aging-in-place is as important to controlling cost as reducing rehospitalizations and unplanned ER visits
- The average per day cost to Medicare (90 day episode) is $58 home health, $453 SNF, $2,178 hospital

Health IT Adoption: Home Health Care

- 78.1% of home health agencies (HHAs) use electronic medical record systems
- 57.8% of HHAs use point of care (POC) systems
- 28.7% of HHAs use telehealth/remote patient monitoring systems

Source [2013 National State of the Home Care Industry Study]. Over 1,100 home health agency leaders were interviewed. The focus of the study was on the present and future use of key technology and clinical practices.

Clinicians' Use of Point of Care Systems (POC)

- 80.5% of all HHAs require clinical documentation via POC in the patient's home
- 58.6% of clinicians that use POC document onsite fifty percent or more of the time
- 31.2% of HHAs achieving the highest 25% score in quality use POC systems

Source 2013 National State of the Home Care Industry Study.

Telehealth's Impact on Care Delivery

- 72.9% increase in overall quality
- 64.4% increase in care coordination
- 64.2% increase in patient satisfaction
- 56.1% increase in patient self-care
- 69.8% lower unplanned hospitalizations
- 65.1% lower emergent care admissions

Source 2013 National State of the Home Care Industry Study.

Path Toward Longitudinal Coordination of Care

- Home Health Plan of Care (HHPOC)
- IMPACT Transition of Care (ToC)
- Electronic Submission of Medical Documentation (esMD) Digital Signature
- KeyHIE Transform™
- Electronic Long Term Support Services (eLTSS) and Advance Directives
- esMD Face-to-Face Clinical Template
- HL7 Fast Healthcare Interoperability Resources (FHIR™)

Recommendations for the Advancement of Health IT

- HHS should focus on high-value deliverables shared by doctors, hospitals and LTPAC providers – such as the exchange of transitions of care summaries and interoperable care plans.
- Congress should consider legislation to advance the use of interoperable health IT to all settings and authorize the reimbursement for telehealth and remote patient monitoring technologies in Medicare.

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"Health IT that enables patient-centered longitudinal coordination of care is paramount so people are engaged and healthcare is delivered in the right place, at the right time, with the most appropriate interventions, therapies and resources available in their communities."

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