Excel Health™
Bringing Transparency to Healthcare

AUG 2017

HOME HEALTHCARE ADHERENCE | OVERVIEW

TRANSPARENCY IN THE MARKET IS HERE

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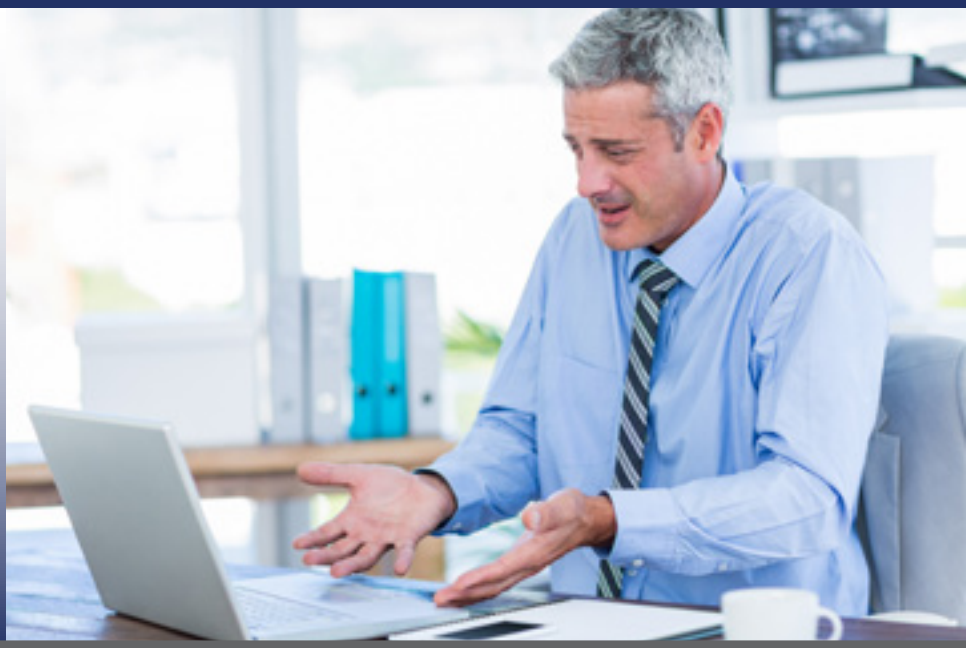
THE CURIOUS CASE OF THE DISAPPEARING HOME HEALTH PATIENT

AND THE $2.5 BILLION HE TOOK WITH HIM



It is a well-accepted fact that the not all home healthcare appropriate patients get the care they need. Would it surprise you to know that on average, nearly 40% of patients that were referred from hospitals to home healthcare last year were not actually admitted into home healthcare? And that those patients represent nearly $2.5 Billion in lost revenue annually for home health agencies? Not to mention the impact on these patients, who without skilled care have a greater risk of negative outcomes, including readmission.

Patients that are not admitted to home health represent $2.5 billion in lost revenue

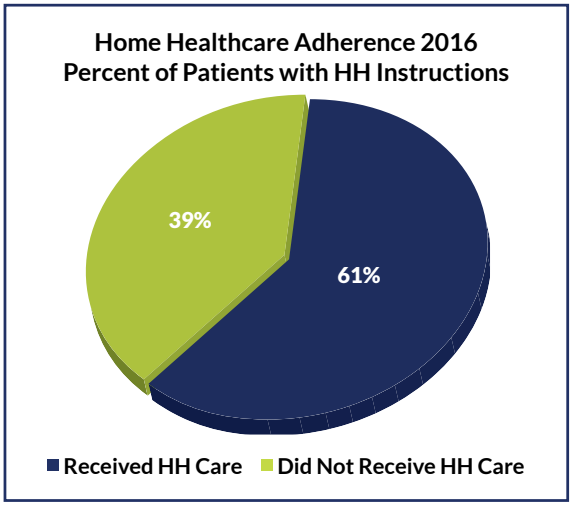
UNDERSTANDING THE NEED FOR HOME HEALTH SERVICES

The reality is that many patients (and their primary caregivers) leave the hospital without understanding their need for and access to home health services. This is to the detriment of all involved – patients who lose their ability to optimize functional improvement with home health care, hospitals that are saddled with avoidable readmissions and home health agencies that are not able to serve patients who most need care.

Recent Studies Prove it

A recent study by the University of Pittsburgh, published in the Journal of the American Geriatrics Society, suggests that improved discharge planning processes, particularly with better involvement and understanding of discharge plans by patients and their caregivers, would significantly reduce hospital readmission rates. Across 15 separate studies involving more than 4,300 patients, the conclusion was that more effective discharge planning would yield a 25% improvement in readmission rates. And, it isn't just discharge planning gaps that contribute to the problem.

A recent round table report sponsored by the Alliance for Home Health Quality and Innovation and United Hospital Fund points out that patient refusals of home health services, albeit for a variety of reasons, also contribute to gaps in care and boost avoidable readmissions. In fact, hospital patients who refuse home health care upon discharge are likely to be younger and seemingly healthier than others who receive care at home; however, this group is also twice as likely to be readmitted to the hospital within 30 to 60 days.



Optimizing PAC

With hospital value-based purchasing, the increase in bundling initiatives and the growth in Medicare Advantage enrollments, hospitals are increasingly focused on improving patient outcomes through an integrated approach to optimizing post-acute care (PAC). Hospitals clearly recognize that it is in their best interests to cultivate top-performing PAC networks. For home health providers the challenge is two-fold: Not only demonstrate an ongoing commitment to high quality patient outcomes, but also become a strategically valuable partner. And that translates to collaboration–the sharing of information and expertise as the essential vehicles for creating mutual advantage. Healthcare is increasingly data-driven, and the information that your agency's hospital partners need right now is available to you.

The question is, how can your agency help with that need? The answer is by providing data that can be used for the mutual advantage of the agency and its potential hospital partners to improve patient outcomes and hospital performance. Strengthening the discharge planning process and providing physician and patient education about the long term benefits of skilled home care post discharge will benefit your hospital partners and improve their performance. That effort will pay dividends for your agency, especially when one considers the true extent of the problem hospitals are facing:

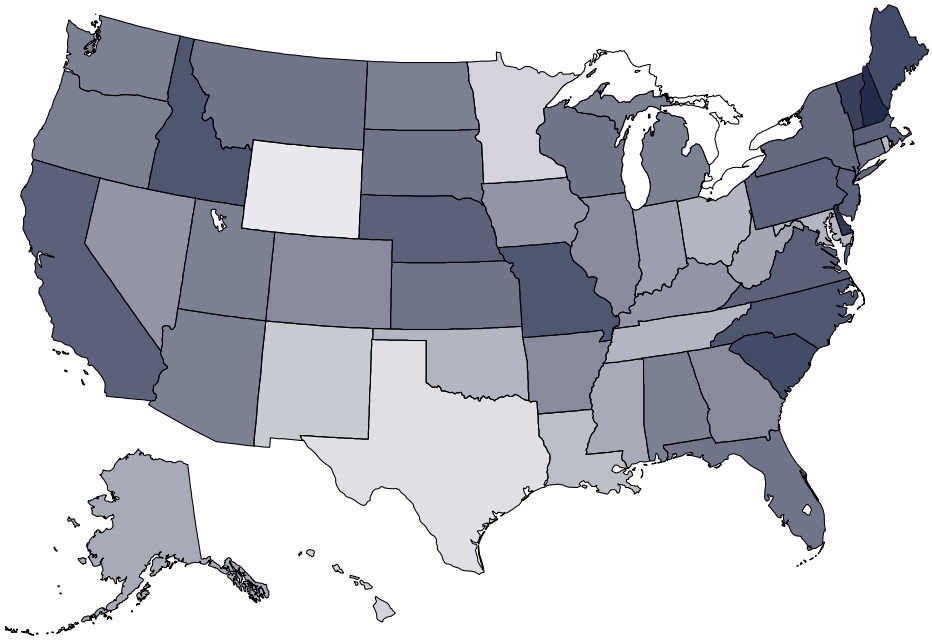
NUMBERS TALK

- Approximately 20% of discharged hospital patients are indicated as appropriate for home health care as they leave the hospital. On average, only 60% of those patients receive skilled home care.
- It has been estimated that as many as 28% of caregivers are not consulted with respect to discharge planning options and are unaware of assistance that may be available for the care of their family member following his/her hospital discharge.
- States where the issues and opportunities for improvement are most pronounced include TX, CA, FL, NY and PA, where the largest agencies are typically found and where the foregone opportunity for home health agencies exceeds $866 Million a year. The opportunity in these states alone is immense. Of the 49 hospitals that will face the maximum readmission penalty in 2017—18 are in one of these five states.

Source: *Patients Who Refuse Home Health More Likely to be Readmitted*

Even in states with the best performance, we guarantee that a look at the Excel Health data will be eye-opening.

Home Healthcare Adherance By State 2016



CLICK HERE TO DOWNLOAD THE FULL 50 STATE REPORT

In our next white paper, we will examine the impact of these lost patients. What is the impact on outcomes and performance of this non-adherence? In the meantime, download the full 50 state report now to see how your state measures up, available by clicking the button above or schedule a demo today to realize the growth potential that exists today in your market!

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