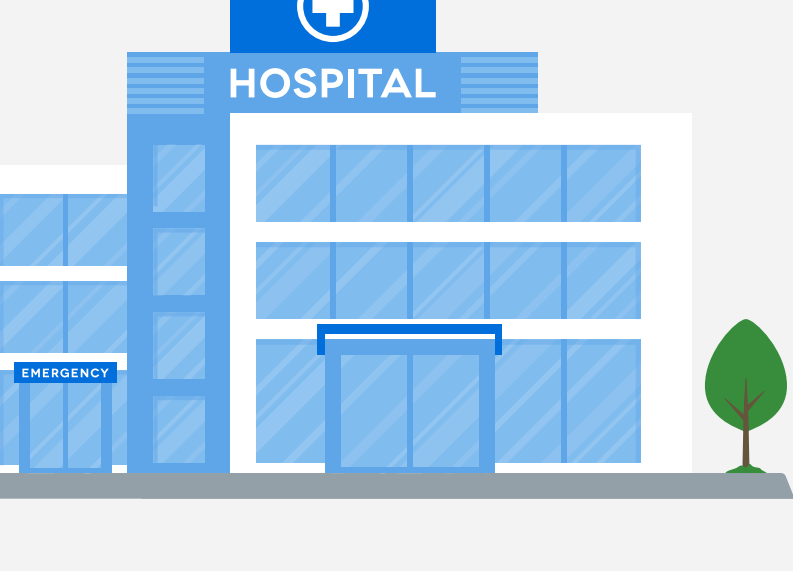


HOME HEALTH AGENCIES

Reducing Acute Care & ED Visits with Digital Care

For many home health agencies, acute care hospitalizations and emergency department (ED) utilization is an ongoing challenge that causes a variety of negative impacts, from low patient satisfaction to Medicare penalties and poor star ratings. Yet many acute care and ED visits can be prevented with the right training and tools. Let's take a look at what causes these visits and what your agency can do about it.



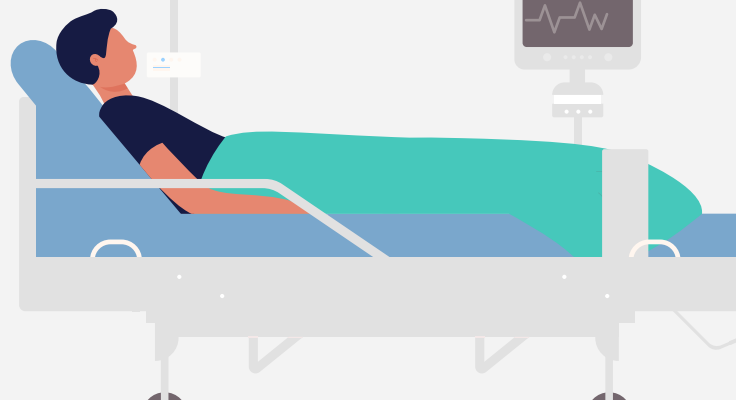
Acute Care and ED Visits at a Glance

- ▶ CMS penalties occur when acute care hospitalizations and ED utilization occur within **60 days of start of care**.
- ▶ Over half of hospitalizations from home health occur **within the first 14–21 days of start of care**.¹
- ▶ An estimated **40% of ED visits from long-term care are potentially preventable**.²

Why Do Acute Care and ED Visits Occur?

The top reasons for acute care hospitalizations and ED visits from home health patients include:

- ▶ **Complications from chronic and non-chronic conditions** like heart failure, acute myocardial infarction, COPD, pneumonia, and kidney disease.
- ▶ **Medication errors.**
- ▶ **Poor patient engagement and compliance.**
- ▶ **Inadequate transitions of care.**
- ▶ **Incomplete or missing patient education** leading to misunderstandings about discharge instructions and care plans.



Congestive heart failure (CHF) is the most common cause of rehospitalization in the U.S. for people older than 65 years of age, but proper patient management can reduce the instance by half.³

How Digital Care Can Help

For home health agencies tasked with improving care quality and clinician competence while minimizing costs, digital care is an effective strategy for reducing acute care and ED visits. With a digital care solution that combines **patient education, patient engagement, and clinical education tools**, agencies can:

Help Patients Better Manage Their Chronic Conditions

According to the World Health Organization (WHO), **outcomes for patients with chronic conditions are significantly higher when patients (and their families) take an active role in their care**.⁴ Yet many patients with chronic diseases don't have the skills or knowledge they need to effectively manage their condition.

In order to properly manage their disease and even slow its progression, patients need engaging, easy-to-understand information on topics such as:

- ✔ The name of the diagnosed condition, along with symptoms, anticipated tests and treatments, prognosis, and complications.
- ✔ Required medications, schedules, and treatment timeframes.
- ✔ Dietary restrictions, allowances, and recommended menus.
- ✔ Required follow-up, such as doctor's visits, therapist visits, blood tests, and x-rays.
- ✔ When a regular doctor appointment is appropriate versus the emergency room.
- ✔ Home care instructions on skills such as hygiene practices, using medical equipment, testing glucose, and measuring blood pressure.
- ✔ Behaviors that improve health such as stopping smoking, reducing alcohol, and managing weight.



Relevant digital care tools:

- ▶ Digital patient education
- ▶ Online clinical training
- ▶ Online soft skills training
- ▶ Remote digital monitoring
- ▶ Risk stratification



Ensure that Nurses Can Identify Signs and Symptoms

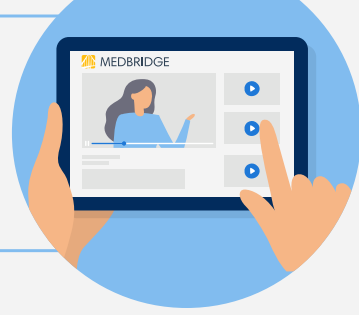
To prevent chronic conditions from progressing, home health nurses must recognize warning signs as soon as they arise and ensure that patients are following their prescribed care regimen, regardless of how they're feeling from day to day.

How proper training can prevent acute care and ED visits



A heart failure patient begins to experience increased coughing and swelling in her legs.

Her home health nurse has recently completed training on preventing heart failure exacerbation and notices these warning signs.



After asking some targeted questions, the nurse discovers that the patient has stopped taking her water pill because it causes her to visit the restroom more often.

The nurse helps the patient understand why it's so important to take her medication every day and uses active listening skills to address her concerns.



The patient returns to her prescribed medication regimen and her symptoms subside.



Relevant digital care tools:

- ▶ Online clinical training
- ▶ Online soft skills training

Keep Patients Engaged and Activated Between Visits

Did you know that **engaged patients are less likely to visit the emergency room and 30% less likely to be readmitted to the hospital following discharge**?⁵

A good digital care program will include a strong patient engagement component that allows agencies to:

- ✔ Create condition-focused templates within an engaging home exercise program.
- ✔ Assign templates based on patient type and condition, from chronic conditions like HF and COPD to falls, TJR, and pressure wounds.
- ✔ Efficiently progress patients by updating their program throughout the episode of care to support timely outcomes and patient satisfaction.
- ✔ Leverage telehealth, patient feedback, and messaging to support the patient throughout their care plan.



Relevant digital care tools:

- ▶ Home exercise program
- ▶ Patient adherence tracking
- ▶ Telehealth
- ▶ Patient mobile app or an easy-to-access web portal
- ▶ Remote digital monitoring

How MedBridge Can Help

Home Exercise Program (HEP)

Engage patients with an easily accessible and customizable library with thousands of video exercises developed by industry professionals.

Patient Insights

Capture patient insights like pain, difficulty, and perceived progress with surveys and monitoring tools to help build a patient-inspired culture.

Telehealth Virtual Visits

Replace or supplement in-person visits for low-risk patients with effective, user-friendly telehealth tools.

Patient Education

Help patients understand their diagnosis and rehabilitation plan with engaging education to encourage them to effectively manage their care.

MedBridge GO Mobile App

Engage patients and promote adherence by prescribing home exercises in easy daily doses and allowing patients to reach out with questions or concerns via two-way messaging.

About MedBridge

MedBridge has over 10 years of experience helping more than 2,500 healthcare organizations grow their business, elevate their workforce, and deliver exceptional patient experiences.

Contact MedBridge to see what we can do for you.



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1. Rosati RJ, Huang L. Development and testing of an analytic model to identify home healthcare patients at risk for a hospitalization within the first 60 days of care. Home Health Care Serv Q. 2007;26:21–36.
2. Caffrey C. Potentially preventable emergency department visits by nursing home residents: United States, 2004. NCHS Data Brief. 2010 Apr;(33):1–8.
3. Nair R, Lak H, Hasan S, Gunasekaran D, Babar A, Gopalakrishna KV. Reducing All-cause 30-day Hospital Readmissions for Patients Presenting with Acute Heart Failure Exacerbations: A Quality Improvement Initiative. Cureus. 2020 Mar 25.
4. https://apps.who.int/iris/bitstream/handle/10665/252269/9789241511629-eng.pdf
5. Jack BW, Chetty VK, Anthony D, Greenwald JL, Sanchez GM, Johnson AE, Forsythe SR, O'Donnell JK, Paasche-Orlow MK, Manasseh C, Martin S, Culppepper L. A reengineered hospital discharge program to decrease rehospitalization: a randomized trial. Ann Intern Med. 2009 Feb 3;150(2):178–87.