5 Keys

to Becoming a Preferred Home Health Referral Partner

CipherHealth

Home Health Care News

Operating in the home health care space can be challenging, from the largest providers to the single-site independent operators. As the healthcare landscape continues to shift toward value-based reimbursement, competition is also rising, leading to a two-pronged challenge of championing new regulations and thriving as provider networks narrow.

But there are several ways for home health care providers to position themselves as preferred partners to their referral sources, leading to a steady stream of business in light of an uncertain economic climate. By developing a strategy around partnerships, home health operators not only can withstand today's business challenges, but also grow and thrive in the current environment.

Here are 5 keys to becoming a preferred home health referral partner:

01 Reduce hospital readmission rates

02 Increase patient satisfaction

03 Improve efficiency

04 Build strong networks and information sharing

05 Define health care specialties

01

Reduce hospital readmission rates

When it comes to hospitals and health systems, home health providers can prove their value in the care continuum by demonstrating their ability to improve one specific measure: ***readmission rates.***

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As a result of new payment models stemming from the Affordable Care Act (ACA) and other payor initiatives, hospitals and other providers are focused on reducing readmission rates.

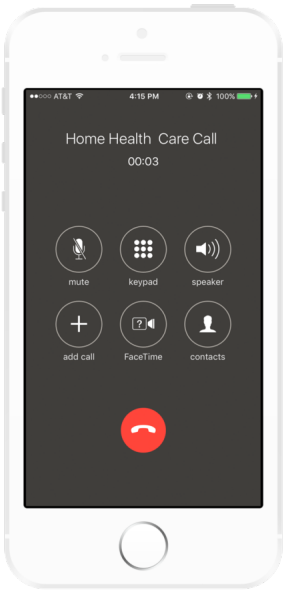
Specifically, hospitals are penalized if patients are readmitted within 30 days of discharge, giving home health care providers a perfect opportunity to help patients make the safe transition home and avoid adverse events. To prove value as a partner in this process, home health agencies can harness technology to support their readmission reduction strategies.

Penn Home Care & Hospice, based in Philadelphia, began using new technology in late 2015 to better manage patients at home and collect feedback from patients via the telephone. At the same time, the agency launched other initiatives to improve care outcomes and patient satisfaction. Penn Home Care & Hospice and its palliative care division, Caring Way, have a census of roughly 2,000 patients between the three divisions. The agency is also affiliated with three hospitals in Pennsylvania: Presbyterian Medical Center, University of Pennsylvania Health System and Penn Hospital. More than half of referrals come from these sources, making their partnerships essential to continued business.

To ensure patients had what they needed outside of home visits, the provider began using CipherHealth's Voice Follow-Up Platform, which calls 100% of patients multiple times throughout their episodes of care to ask a series of questions regarding patient's health.

"Before we started with CipherHealth, our metrics were really, really low," says Katherine Major, director of Caring Way at University of Pennsylvania Health System Home Care and Hospice Services. "We figured we had to do something. We had a very high readmission rate and very low patient satisfaction scores. We decided we would use any and all technology we could to help us with our patient population."

After integrating CipherHealth's Voice platform, [Penn Home Care & Hospice] was able to touch more patients, more often. What would have once been "impossible," ... was achievable.



After integrating CipherHealth's Voice platform, the agency was able to touch more patients, more often. What would have once been "impossible," according to Major, was achievable. Voice automatically calls all patients on census and asks questions related to both their care experience and recovery. Should an issue arise, Caring Way staff is prompted with a real-time alert to call the patient back and resolve the concern. Additionally, a patient can also press a button to receive a call from a nurse. By using this type of technology, Penn Home Care And Hospice is able to reach out to more patients, resolve issues quickly and receive a wealth of data to improve transparency.

Although text messages are a possibility, patients are more likely to engage with calls, as they have been shown to be more effective at influencing patient behavior, according to one recent study supported by a grant from the National Institutes of Health.

The calls focus on two lines of questioning related to scheduling and any issues with a patient's plan of care. For example, the automated call would ask a patient if they knew when their nurse was next coming and if they needed to reschedule. The calls also ask patients if they were involved in their plan of care.

The feedback from the calls has helped the agency stay in contact with patients and ensure that care staff can follow up with more information, two things critical to improving outcomes and the patients' experiences. Since integrating the technology, coupled with other initiatives like telehealth and intensive care conferencing with nurses, Caring Way has seen its readmission rate drop, according to Major. Beyond the technology, the additional information has helped nurses better respond to patient needs, and will likely continue to improve care and patient outcomes.

02

Increase patient satisfaction

Beyond readmission rates, health care partners—and the greater health care system—are also paying attention to patient preferences, which means home health agencies need to keep track of and improve ***satisfaction scores.***

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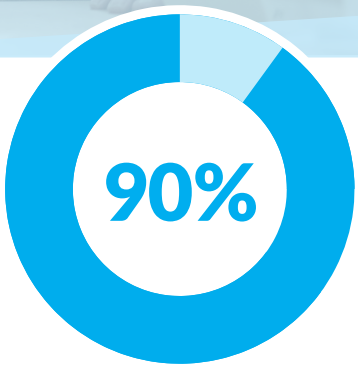
Similar to patient outcomes, patient satisfaction plays a role in the financial health of a home health care agency. Home Health Consumer Assessment of Healthcare Providers and Systems (HHCAHPS) scores and star ratings by the Centers for Medicare & Medicaid Services (CMS) play a role in both census volumes and reimbursements.

These ratings are visible on CMS' Home Health Compare website, where consumers can look at star ratings for Medicare-certified home health agencies. This year, under value-based purchasing models, satisfaction scores can determine a gain or loss of 3% in reimbursements in certain states. By 2022, the stakes will be even higher, as reimbursements tied to HHCAHPS scores will vary by up to +/- 8%.

Fortunately, home health is a natural fit for high patient satisfaction, as most patients would prefer to receive care at home versus institutional care. In fact, nearly 90% of people over age 65 want to stay in their home as long as possible as they get older, according to AARP. And technology is helping home health agencies improve patient satisfaction, resulting in higher HHCAHPS scores and increasing the agencies' capacity to gain preferred provider status among referral partners.

CipherHealth recently partnered with the Visiting Nurse Services in Westchester (VNSW) in White Plains, New York to leverage its Voice technology for VNSW patients, of whom 80% are 65 and over.

"We knew our patients were getting great care, we knew our patients were stabilizing at home, " says Mary Gadomski, Director of Business Development & Community Relations with VNSW. "With data gleaned from the CipherHealth technology platform, we are able to gain further insight into our patients' health status and behaviors, enabling us to intervene early as problems arise. Ultimately this is leading to reduced instances of hospital readmissions. Early indicators show a high patient engagement rate with the Voice calls, significantly higher than the national average." Gadomski noted.



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Source: AARP

VSNW has only recently begun to use the technology and is already determining how the technology is positively impacting patient satisfaction levels along with other metrics..

"We anticipate that the continued use of Voice will result in increases in patient satisfaction and show that patient needs were met," Gadomski says. "These calls help to reinforce patient education and engage them in their own care. This empowers the patient, leading to increased satisfaction and a positive care experience. We think this type of telephonic outreach also increases satisfaction with home care in general because patients know they can contact us immediately to address their health concerns, reducing anxiety and stress."

With telephonic check-ins, such as those Voice provides, home health agencies can collect pertinent information that helps to address short-term patient satisfaction issues, and help plan for long-term improvements.

03

Improve efficiency

While providing essential quality metrics with data is important, health care partners also want to see which home health care providers can have better patient outcomes with the greatest ***efficiency.***

While quality and data are important, home health referral sources also want to see which home health care providers drive better patient outcomes while maintaining high levels of efficiency. For instance, agencies that can streamline some services, such as checking in with patients over the phone, can lower their costs and allocate more resources where they are needed. Some agencies might even be able to reduce the total number of home visits in a care episode for certain patient groups, resulting in a higher quality of care at a lower overall cost.

"We are seeing a rapidly changing dynamic between post-acute and acute providers. What used to be seen as two independent care siloes are now being viewed as an integrated continuum of care—both by the patient and by payors. In order to succeed under these new care models, home health care providers must be proactive in responding to new regulations by finding ways to lower the cost of care without sacrificing quality," says JB Powell, VP of Post-Acute Care Strategies at CipherHealth.

Home health care providers would agree that technology alone doesn't make patients healthier, but better technology enables care staff to provide more services without having to go into the home for every change in status or question from a patient. Instead, some issues can be resolved remotely using a technology that today's population of patients on home health services are comfortable with using, the telephone.

"Without this technology, it would be impossible to call every patient a few times per week to check in with them," Major says. "It helps us be more nimble in our response to what patients need because we are catching them and asking them about their point of care. The technology is very helpful, but it's only as good as the people behind it, answering calls and responding to patients' requests and needs."

"In the future, data is going to be even more critical. We want to be prepared for that so we can say: 'Here is the data about us, here are the metrics that support our reputation for quality of care.'"

Mary Gadomski
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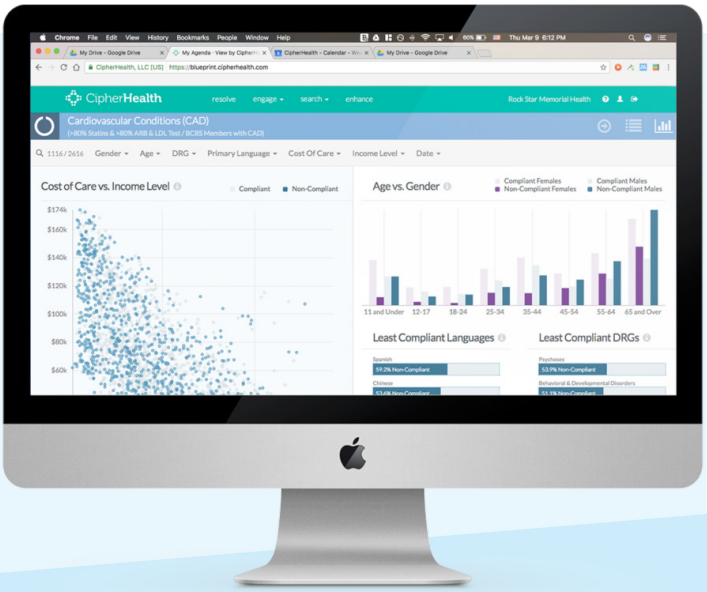

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Build strong networks and information sharing

The goal of becoming a partner with other health care providers, like hospital systems, physician groups or ACOs, starts with ***networking.***

The goal of becoming a partner with other health care providers, like hospital systems, physician groups or ACOs, starts with networking. Home health care partners who are already working with other care organizations are much more attractive to the bigger health care players.

Networks cannot be successful without open communication and information sharing. This has been highlighted in the recently revised CMS Conditions of Participation, which require a new level of communication between home health agencies and the patient's physician. "In the future, data is going to be even more critical," Gadomski says. "We want to be prepared for that so we can say: 'Here is the data about us, here are the metrics that support our reputation for quality of care'. In the face of growing competition, we want to do all we can to be the best partner out there."

As home health care providers begin the process of implementing new technologies that drive efficiencies and improves outcomes, collecting and analyzing data should be a key driver in new initiatives. Understanding where opportunity areas lie can help drive success for all providers across the continuum.

05

Define health care specialties

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More and more, health care regulations are targeting specific diseases and are tying payment models to certain patient groups. In the past few years, home health providers have become an integral part of bundled payment initiatives, which tie reimbursement to the total cost of a care episode.

As more of these initiatives continue down the pike, agencies that have specialty care programs for specific diseases—and the data to back up better outcomes—will be better suited to handle these targeted patient groups and make themselves more attractive to referral partners. Technology and data can help an agency determine where they are experts and where to improve. Plus, they can share those metrics with partners, patients, and other invested parties.

Most of these critical solutions can be realized through technology. Home health agencies that utilize effective tools to facilitate care coordination and prove better patient outcomes will find themselves in a better position to become preferred partners with referral sources.

Proving value through data, patient engagement, care coordination and outcomes is crucial for home health partners to align themselves with other health care providers. A shifting system that is more demanding can be a challenge, but there are ways for home health agencies to view this challenge as an opportunity by becoming attractive partners for other providers across the health care continuum.

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