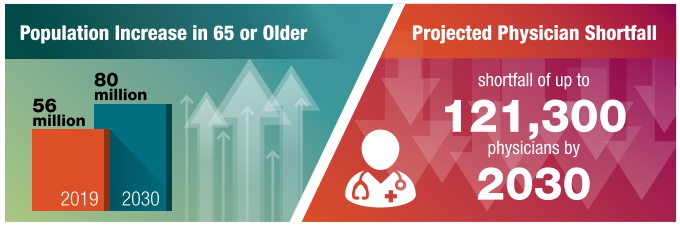
# Improving Patient Outcomes through Postdischarge Virtual Care

**By Sean Muldoon, MD, MPH, FCCP**

New approaches to care management are required as our nation faces a wave of aging Americans with new and increasing healthcare needs. Adding headwinds to this scenario are the anticipated physician shortage and continued push toward value-based care.

In this whitepaper, learn the benefits of virtual care and the strategies providers should be considering to take advantage of the growing technology.




## The Need for Virtual Care

The demographic numbers are quite striking: by 2030, there will be more than 80 million Americans 65 years or older, up from 56 million today. Not only is there a larger aging population, they are also sicker, with more than 66% of Medicare beneficiaries having 2 or more chronic conditions that are difficult and costly to treat. A recent report by the nonpartisan Congressional Budget Office stated that "while the sheer number of older adults is rising, so too is the cost of their healthcare as individuals are more frequently living with multiple chronic and complex medical conditions."

This comes at the same time that our nation is looking at an impending physician shortage. According to the Association of American Medical Colleges, the United States is projected to have a shortfall of up to 121,300 physicians by 2030. Additionally, when the need for geriatric care is rapidly growing, data from the National Resident Matching Program shows that only 35 of the 139 geriatric fellowship programs were filled in 2018.

This "perfect storm" of the growing number of older patients needing care solutions with fewer specialized physicians to meet their needs also comes when the Medicare program and other payers are increasingly demanding value-based care.

To drive value and a positive patient experience with fewer resources, providers are increasingly turning to "virtual care" solutions. Earlier in the year, Modern Healthcare predicted that a significant growth in virtual care was a top trend for 2019. Virtual care programs will become increasingly important, particularly for chronic care management.

## Encouraging Virtual Care

Over the past several years, the Centers for Medicare & Medicaid Services has recognized the value of telemedicine and other forms of virtual care. For several years, including in the 2019 payment rule, the agency has added CPT and Healthcare Common Procedure Coding System (HCPCS) physician payment codes for Medicare to encourage adoption of activities including virtual check-ins, remote evaluation, and interprofessional internet consultation. It is anticipated that Medicare and other payers will continue to incentivize adoption of virtual care.

**What defines virtual care?** "Virtual care is a broad term that encompasses all the ways healthcare providers interact with their patients without seeing them in person. In addition to treating patients using telemedicine, doctors will use live video, audio, and instant messaging to communicate with their patients in a variety of ways. This may include checking in with patients after an in-person visit, monitoring their vitals after surgery, or responding to patient questions. Simply put, the term virtual care is a way of talking about all the ways patients and doctors can use digital tools to communicate in real-time, regardless of whether the doctor is using this technology to treat a patient. While telemedicine refers to long-distance patient care, virtual care is a much broader term that refers to a variety of digital healthcare services." InTouchHealth

Physicians agree that virtual care programs are invaluable to patient care going forward. In the Deloitte 2018 Survey of US Physicians, the top benefits were reported by participating doctors as being:

- Improved access to care
- Improved patient satisfaction
- Staying connected with patients and caregivers

## Challenges to Adoption

Despite predictions for major growth in virtual care and telemedicine, there are still significant barriers to adoption. According to the Deloitte 2018 Survey of US Physicians, only 14% of physicians have video visit capability and only 18% of the rest plan to add the ability in the next 1–2 years.

Physicians cited the top challenges to telemedicine and virtual care as lack of reimbursement, complex licensing requirements, and the high cost of technologies. Not to mention the security measures needed to protect patient privacy.

One way providers can bridge these obstacles is to partner with postacute providers or other entities who already offer virtual care solutions, thereby gaining access to existing resources and infrastructure.

# **Case Study:** Kindred Hospital's AfterCare Program Success

## Opportunity

We saw an opportunity to enhance the patient experience as well as offer continued clinical support to our patients to prevent a decline in their health status, especially in those that were transitioning directly home. Recognizing this need and the role of virtual care, we developed an ongoing care management and patient engagement service called *AfterCare*, a program that is offered by and facilitated through our Kindred Contact Center.

## Solution

As part of this virtual care solution, the AfterCare program features registered nurses telephonically reaching out to patients, on a scheduled timeline, to identify and manage clinical gaps and medication management to prevent patient decline or hospitalizations.

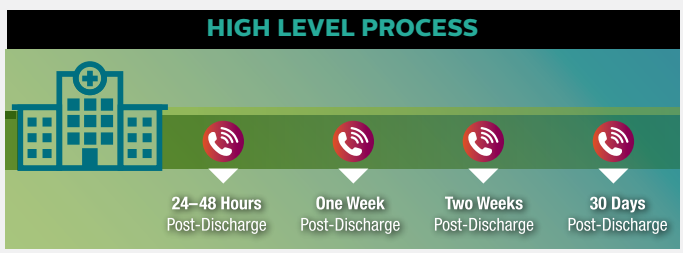
## Decrease Your Patient's Risk for Rehospitalization with Our AfterCare Program

Recovery does not end with a transition—neither should care management. Our AfterCare Program is designed to help recovering patients heal and provide the support they need once they have discharged from our transitional care hospitals to their home.

*What Does This Mean for My Patients?* Our program helps your patients on their healthcare journey recover. Our registered nurses connect with patients to:

- Prevent hospital readmission
- Assess progress
- Identify unmet or new needs
- Determine if continued care is needed
- Ensure physician appointments are made and kept
- If applicable, connect patient with appropriate healthcare provider

*How Does It Work?* Our patients receive calls at 24–48 hours, 1 week, 2 weeks, and 30 days postdischarge from a Kindred Hospital to assess their progress and to ask about identified needs.




We break down these identified needs into 4 groups:

- *Durable medical equipment:* Did they receive it and do they understand it?
- *Medications:* Were they able to get their prescription medications filled? Do they understand them? Do they have enough "critical" medications to last them until their scheduled follow-up appointment with their primary care provider?
- *Primary care provider appointment:* Is it scheduled in an appropriate time frame?
- *Postdischarge services:* Have they been initiated and is the patient/caregiver satisfied?

In addition to telephone support, our case managers are proactively seeking and addressing identified needs before discharge. If an identified need arises through a follow-up call postdischarge, we will begin the intervention process.

*Why Is This Beneficial?*
The needs we identify are communicated to the hospital and can help provide the patient with the appropriate services to continue to recover.

## Results

The first year of this pilot program proved incredibly successful for Kindred Hospitals and our patients. For patients within the AfterCare program, from July 2016 through May 2017, the program realized the following benefits[1]:

- The rehospitalization rate decreased from 7% to 2%
- The percentage of patients who are discharged with an identified need decreased from 21% to 6%

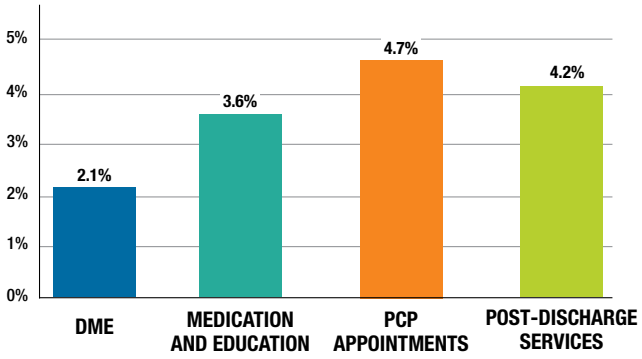
Results in 2018 were even stronger for Kindred patients in the AfterCare program:

- The rehospitalization rate within the first 30 days was down to 0.6%[2]
- The percentage of patients with an ongoing satisfaction concern was also <1%

The success of this program can be tapped into by and shared with our referral partners as it is offered to all Kindred Hospital patients who are transitioning home.

**TYPES OF IDENTIFIED NEED**

**Percentage of AfterCare calls related to a specific need for a three-month period of calls to 3,253 patients**




**Abbreviations:** DME, durable medical equipment PCP, primary care physician.

**Discharge Data:** Patient Population: 3,253

- Durable medical equipment needs – 70
- Medication and education – 118
- Primary care physician appointments – 155
- Postdischarge services – 137

**Dates for Discharge:** 10/1/2018–12/31/2018

# Patient Success Story and Nurse Testimonial:
## Nurse Works with Case Manager to Aid Discharged Brain Injury Patient

Sheila Walter is one of the registered nurse advocates who spearhead the Kindred Contact Center's AfterCare program, one of the many virtual care platforms provided by the Kindred Contact Center. Each day, Sheila makes up to 60 calls to recently discharged hospital patients or their caregivers as a means to identify and manage clinical gaps and help prevent patient decline or rehospitalizations.

AfterCare program registered nurse advocates like Sheila typically inquire about the patient's medications and any necessary medical equipment, make sure each patient has an appointment with a primary care physician soon after discharge, and also ensure that outpatient services or home health are arranged. They take a general assessment over the phone based on the patient's diagnosis; for example, they might ask an individual with chronic obstructive pulmonary disease about breathing or swelling. The nurses also ask the patients to offer their evaluation of their Kindred Hospital experience, and the registered nurses share the feedback—good and bad—with the hospital.

Calls are scheduled between 24 and 48 hours after discharge, then continue at 1 week, 2 weeks, and 30 days after discharge. Most are routine and appreciated, like helping an elderly couple without transportation access community resources to have medications delivered. Others can be lifesaving.

Sheila, who had been a hospital-based nurse for 33 years before joining the Kindred Contact Center, recalls calling the mother and caregiver of a patient who had been hospitalized as a result of a traumatic brain injury.

He had a tracheostomy and a feeding tube, but some of the equipment vital to suctioning his airway and giving him nutrients had not arrived home due to a delay in the insurance process that wasn't communicated by the insurer to the hospital or the patient.

"The mother was very fretful," Sheila said. "She didn't know who to reach out to or what to do and just by happenstance it was our call that came through that started fixing things."

Because the missing equipment could threaten the patient's health and safety, Sheila immediately called Kindred Hospital's case manager. The case manager coordinated with the patient's home health agency to get a nurse at the home within an hour and have the necessary equipment—including suction catheters and tube-feeding supplies—delivered an hour later.

At the end of the day, Sheila went above and beyond by calling the mother back to make sure the patient was doing fine, to double check that the mother was comfortable with her caregiver training, and to ensure that they had the equipment and supplies needed to tide them over until additional equipment and supplies arrived via mail. Everything was in order, thanks to Sheila's call and the follow-up efforts of the case manager.

"In a hospital setting, I always felt like a case manager was the nurse's right-hand person because a lot of the things that the patients have to be prepared for when they go home or go to rehab facility could not be done without the determination of the case manager," Sheila said. "They always have the best interest of the patient and family in mind. We couldn't do our job without them."

Today, specially trained registered nurse advocates like Sheila help the Kindred Contact Center engage with patients and their families to ensure smooth transitions and bridge gaps in care. The role isn't as hands-on as being a bedside nurse, says Sheila, but it is rewarding in its own way.

"It's always rewarding at the end of the call to at least be able to allow them to share what their loved one might have gone through or themselves, if they are the patient—just being a sounding board sometimes," said Sheila. "And it really is gratifying when you are meeting a need, when the patient or loved one just doesn't know where to turn to get the medicines, to get the equipment, to make the appointments." ■

## References

1. Kindred Internal Survey data.

2. Patient-reported data.