Goodbye, post-acute care

‘Heavy-lifting’ will shift to community-based care

Healthcare providers know that one of the principal challenges facing our society is caring for the vast number of older Americans requiring healthcare. More than 10,000 people a year reach Medicare age, some of whom will develop multiple chronic conditions and account for a large share of Medicare spending. The strain will financially overwhelm an unchanged healthcare delivery system.

In response, many healthcare providers are re-engineering their pathways of care to promote alternatives to repeated hospitalizations. These alternatives—including greater use of palliative-care specialists, geriatric nurse practitioners, expanded roles for pharmacists and social workers and patient navigators in patient- and family-centered home-based and community programs.

In short, “post-acute care” has become an anachronism. In the future, a greater portion of the heavy-lifting of healthcare will be performed in many nonhospital settings, post-acute and beyond. Because of that shift, we call it community-based care.

Hospitals can no longer live in a four-walls, brick-and-mortar world. Community-based care will be the future metric against which providers will be measured. That is, their reimbursement will be based on performance of care rendered in multiple provider sites by various types of caregivers, including in-home settings.

Many services are already more appropriately and affordably performed in the home. The trend is being encouraged by telemedicine and new biogenetic devices. Indeed, with increased electronic connectivity, we will be able to reduce over time much of today’s unnecessary procedures and acute-care stays, error-prone medication ordering practices and patient noncompliance.

More services must move out to settings where both patient and family members can be enlisted to treat and prevent illness and services are typically less expensive. Healthcare providers cannot alter behavior without the active participation of patients and their families. Community-based care programs are demonstrating that participation is best achieved in the residential setting. In the home, patients and family members are more relaxed and able to remember what they are taught.

While there are exceptions, the home is the preferred setting to discuss disease management, prevention counseling, lifestyle changes and end-of-life care. Sending providers to the home also enables a social assessment of the environment and evaluation for referral of other services such as custodial support.

Two relatively new services in Southern California are showing positive results using a community-based approach. One is the Outreach Care Network in Pasadena. OCN started as an outpatient palliative-care service but has evolved to serve patients with multiple chronic or life-limiting illnesses, most of whom have had multiple trips to the emergency department or numerous hospitalizations.

Through hands-on assessments, nursing support, coordination of care, rapid interventions and the palliative control of pain and symptoms, OCN has reduced avoidable admissions and ED visits. In the home setting, OCN caregivers are able to give focused education and, when appropriate, have delicate discussions regarding prognosis and end-of-life options.

The second program, offered by hospice pharmacy advisory company CareRx, sends a pharmacist into the home setting for face-to-face meetings with patients and family members. A typical patient has multiple chronic and progressive diseases, nine-plus medications, two or more prescribing physicians, medication adherence problems and is likely to be noncompliant with the medication regimen. Studies indicate that up to 35% of hospital readmissions are caused by some type of medication-related problem. Consultation referrals come from case managers, hospitalists, palliative-care physicians and increasingly from primary-care physicians.

In many situations, home-visiting pharmacists improve care transitions by conducting medication reconciliations at home rather than in the hospital. Unlike nurses and other types of clinicians, pharmacists are viewed as experts on medications, and patients tend to openly communicate with them, especially in the home setting. Also, they can actually see patients’ medications and dosage information, which patients often fail to recall or mention while in the hospital.

As a result, pharmacists can develop comprehensive medication plans and convey the relevant information. Pharmacists have found and resolved duplicative medications, unrecognized side effects, self- or past clinically prescribed medications not relevant to current conditions, misunderstandings of the prescriptions and other limitations to medication compliance.

With home-visiting pharmacists as part of the care team of case managers, other caregivers and primary-care physicians, CareRx’s results to date have been impressive. The 30-day readmission rate is less than 2%, and the 90-day readmission rate is 23% versus more than 34% nationally for all Medicare patients.

As hospitals and their physician partners move to develop accountable care organizations, these provider networks will need to demonstrate that their evolving systems are connecting the dots. They can best do that by creating organizations capable of delivering the compassionate care our patients deserve in community settings.

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