BRIDGING LAPSES IN CARE

An Integrated Model for the Care Continuum

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OUR OBJECTIVES

1. To identify gaps and pitfalls in the care continuum.
2. To understand how the care continuum includes everything that happens between care visits and outside the clinical setting.
3. To promote a more sustainable health care for our health systems partners.
4. To enable home-based care providers to pursue concrete, meaningful change.

INTRODUCTION

Continuity of care throughout our healthcare system is essential to support safety, ensure quality of care, decrease costs, and provide positive experiences in difficult times.

This process is meant to follow patients through a path of preventive care.

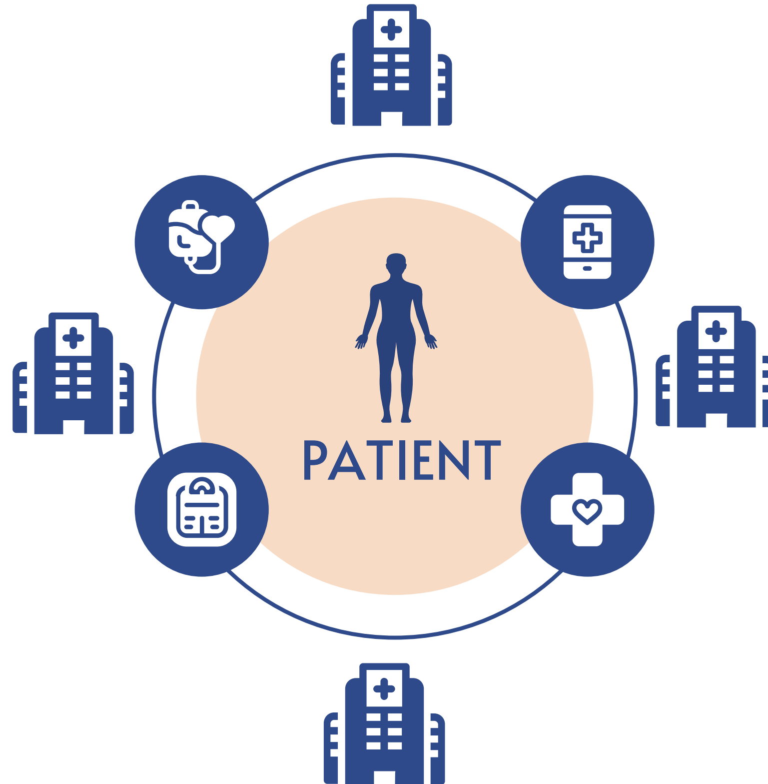
THE CONTINUUM OF CARE

ACUTE CARE

- Specialty clinic
- Hospital
- ICU

HOME CARE

- Independent living
- Chronic disease management
- Community clinic
- Doctor's office



RESIDENTIAL CARE

- Assisted living
- Skilled Nursing Facility

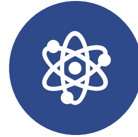
NONMEDICAL SUPPORTS

- Social services
- Case management
- Transportation

DRAMATIC SHIFTS IN…

DEMOGRAPHICS

People are living longer.



CONSUMERISM

Consumers are driving care. Patient satisfaction is a key measure of performance.

HEALTHCARE LANDSCAPE

Shifting to a Community- and Home-Based Model for Health Care

THE GAPS AND PITFALLS

Accessing care outside of the hospital is a complex process involving multiple persons and multiple tasks across multiple organizations, thereby making continuity of care prone to problems for which single, simple solutions have yet to emerge.

This often results in health deterioration and readmission.

COMMUNICATION ISSUES

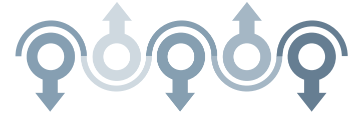
We don’t like to share.

People have a tendency to look out for themselves.

Interdisciplinary meetings often don’t include enough disciplines

CNAs are sometimes the only eyes and ears of a facility.

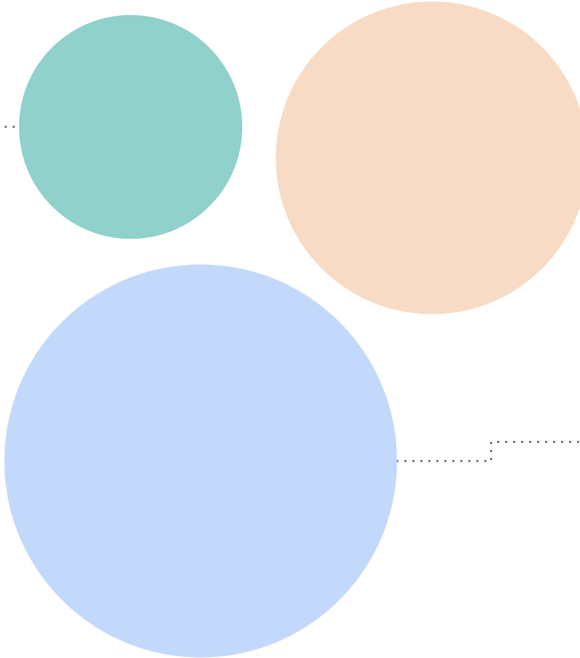
PCPs and Specialists



Too many breaks in the care continuum when it comes to giving report.

MISCONCEPTIONS

IGNORANCE



CONFLICTING IDEAS

MARKETERS AND LIAISONS

- Rely too much on their connections and overpromise
- Insufficiently trained and have narrow understanding of the care continuum
- Community liaisons don't know how to triage patients from the hospitals transferring to a facility or discharging home.
- Have RN case managers follow up in regards to physiological processes.
- MDS/RAC coordinators are key for navigating discharges from facilities.

THE STAFFING
SHORTAGE
CRISIS

Healthcare staff are overworked, underpaid, and underappreciated.

- Overcrowded facilities and agencies
- Demands and expectations
  - Agencies expect too much from understaffed facilities
- Leadership
  - Supporting staff during times of crisis or conflict

CHALLENGES WITH OUT-OF-NETWORK PLANS

- Insurance is a huge hurdle because a lot of agencies don't take the time to understand plans.
- It takes a lot of time to verify eligibility and benefits, and a lot of agencies do not step up to that challenge.
- Agencies don't take time to read the referral packet and then end up calling with too many questions.
- Agencies expect only Medicare referrals.

PSYCHOSOCIAL NEEDS

OUTDOOR TRIGGERS

Leaving one's home can be triggering.

CULTURE & TRADITIONS

Barriers to trust

UNDERSERVED COMMUNITIES

Those without many choices get discouraged and accept the status quo.

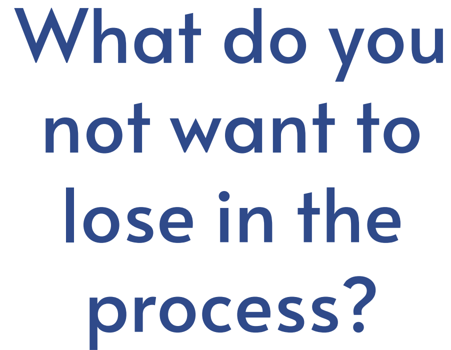
FAMILY INVOLVEMENT

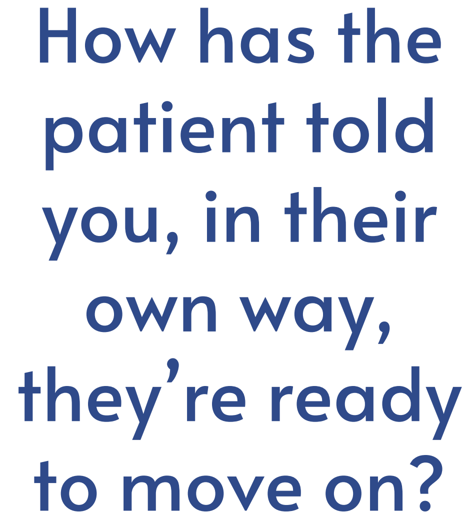
Patient-selected representatives

END-OF-LIFE CARE

How do you want to transition?

What do you consider a good death?


What do you not want to lose in the process?

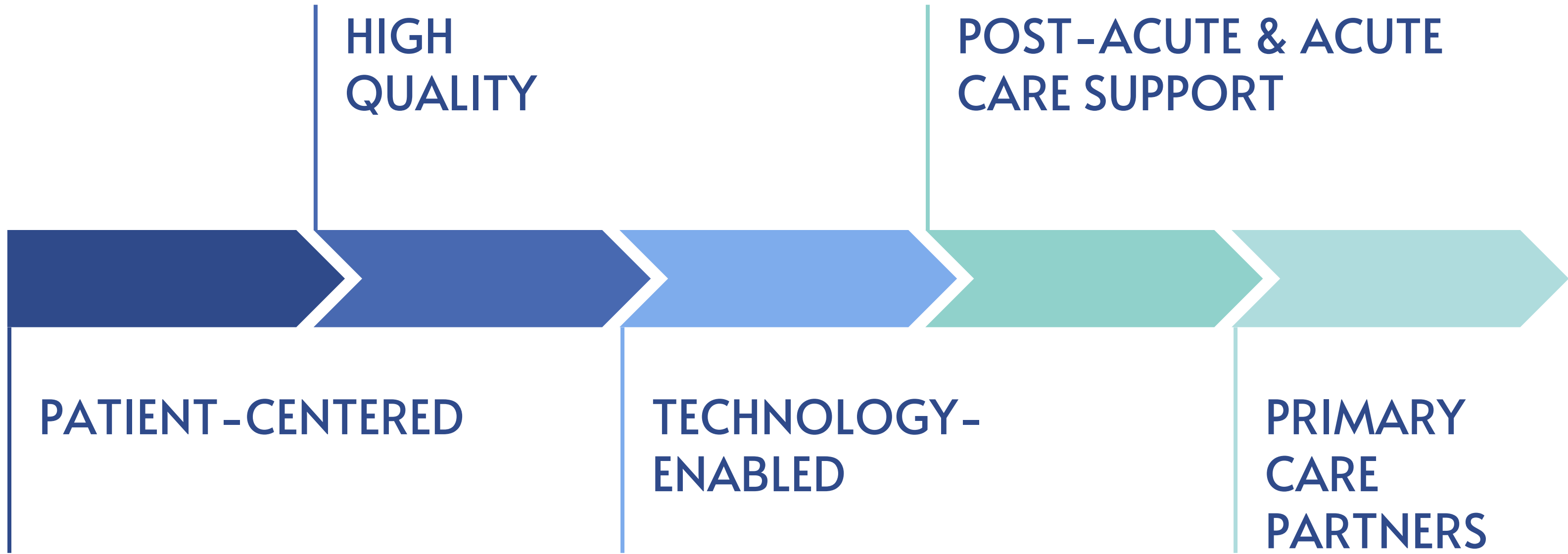

How has the patient told you, in their own way, they're ready to move on?

AN INTEGRATED SOLUTION

Strategies to support the successful bridging of healthcare processes can be accomplished through a multitiered approach involving integration and collaboration across the entire care continuum.

For the most vulnerable populations, an integrated model where healthcare operations and where clinical care is delivered are connected and integrate with one another can deliver the best outcomes.

THE SPECTRUM OF AN INTEGRATED BRIDGING MODEL



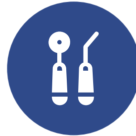
HOME-BASED CARE

INFORMAL PERSONAL CARE

FORMAL PERSONAL CARE

SKILLED HOME HEALTH CARE

PRIMARY CARE

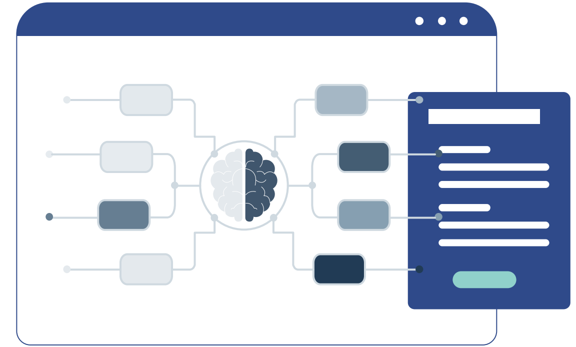


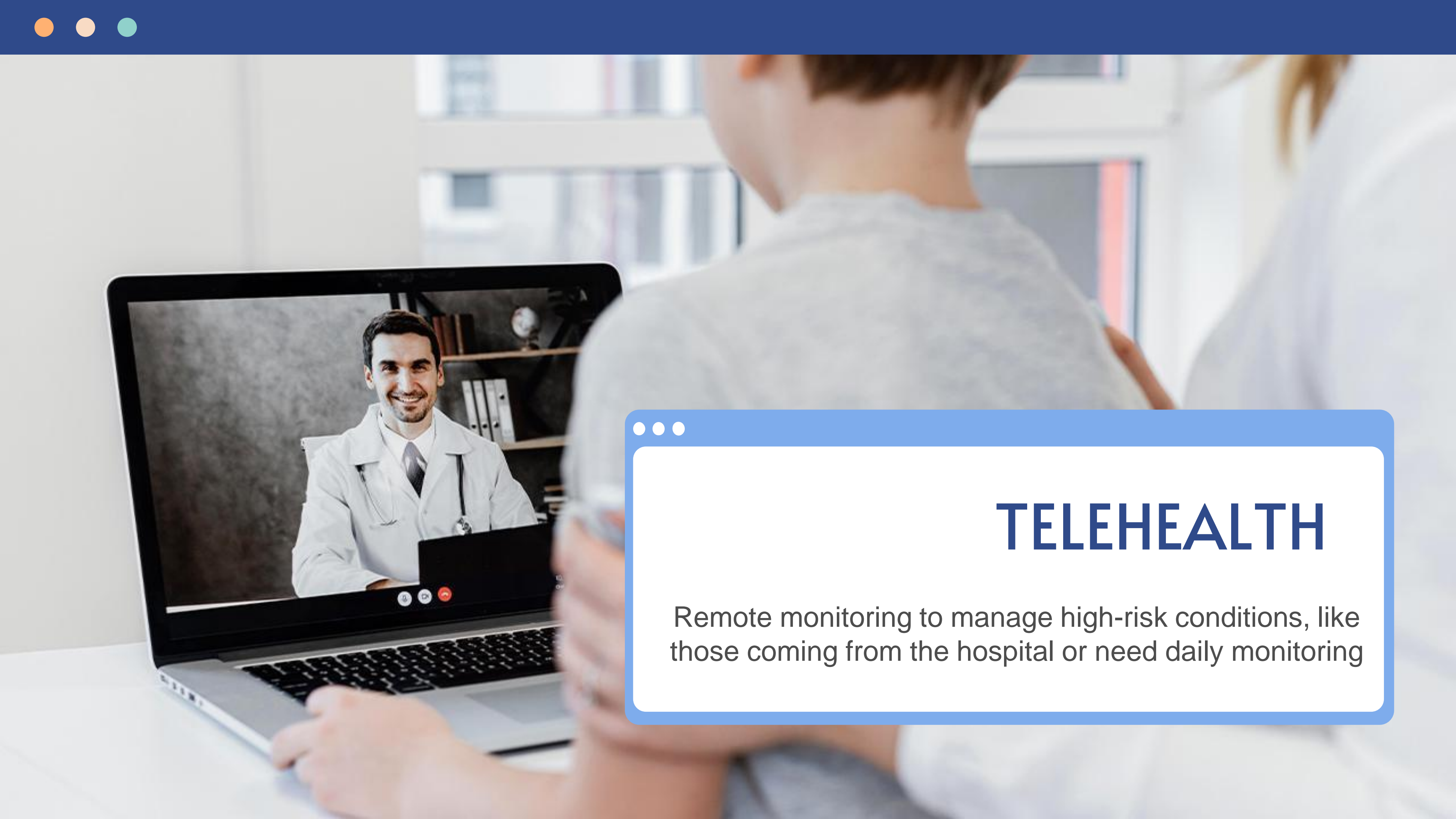
HOSPITAL AT HOME

HOSPICE

ACTIVE CASE MANAGEMENT

- Active Case Management services utilizes on-call nurses available by phone 24/7.
- This all-encompassing and flexible component of home health care bridges many lapses in care, often found in underserved populations, so individuals can get what they need.
- It involves thorough intake, individualized care planning, continuous interdisciplinary consultation, and heavy patient involvement until their goals have been met.

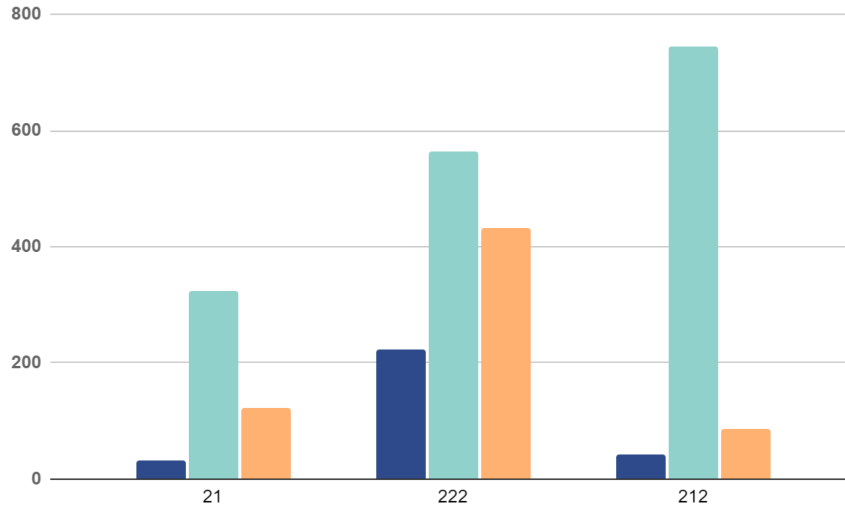



TELEHEALTH
Remote monitoring to manage high-risk conditions, like those coming from the hospital or need daily monitoring

MOBILE CARE

- Avoids unnecessary travel to receive healthcare, including lab work, social services, and nursing and therapy care right where they reside.
- For some, it may be triggering to go outside.

PREDICTIVE ANALYTICS



PREVENTION

Determine likely causes to avoidable hospitalizations and other adverse events

MAINTENANCE

Strengthens the resiliency in the treatment plan, discharge plan, and emergency plan.

ADVANCEMENT

Drives improvements to ensure continuity of care for patients and their family.

PSYCHOSOCIAL SUPPORT

MENTAL HEALTH

HEALTH EQUITY

SAFETY

PUTTING IT ALL TOGETHER

For many people, it's not all about clinical care. It's about reclaiming their lives. And there are many opportunities to meet those needs outside the clinical setting, between care visits.

THANKS!

Do you have any questions?