“There’s no place like home.” For many American seniors, those famous words capture their preferred place to recover after being discharged from a hospital or other acute care setting. But can they receive the “whole person” care they need in their residence?

In many cases, the answer is yes.

The move toward more care at home coincides with increasing awareness of the necessity for treating the whole person: physically, mentally, socially. While providers and caregivers must balance seniors’ desire to be at home with their commitment to ensuring that the patient gets high-quality care, the two trends are complementary in helping to improve outcomes. In other words, keeping patients at home may be the best way to keep them whole — and keeping them whole can keep them at home (and out of the hospital).

The bipartisan Choose Home Care Act would expand Medicare coverage for home health care, giving eligible beneficiaries more post-acute options. At this writing, the bill was awaiting a score from the Congressional Budget Office indicating its projected cost. Also, there have been a number of nationwide surveys that show overwhelming support the Choose Home Care Act amongst the senior population. re spice (NAHC).

“Home care has long been a safe and effective alternative to care in an institutional setting,” the the National Institution for Home Care & Hospice (NAHC) says in support of the Choose Home Care Act. “Reform of Medicare is overdue to provide viable, extended care services at home for patients who otherwise have only one choice, the Skilled Nursing Facility benefit.”

A shared stake in whole person care

A commitment to whole-person health is in everyone’s best interest — beginning with the patient, whose wishes merit weight in any “next step” decision. Hospitals, health systems

and care coordinators also have a shared stake in treating the whole person, particularly as a means to help reduce readmissions with its Medicare population.

In October 2021, the Hospital Readmissions Reduction Program (HRRP) program ended its first decade with Medicare "cutting payments to nearly half the nation's hospitals," according to Kaiser Health News. Medicare evaluated readmission rates for 3,046 hospitals, 2,499 (82%) of which received some penalty, nearly the same rate as a year earlier.

Regardless of participation in value-based arrangements, hospitals and health systems have financial incentives for better understanding the patients they treat. Repeat patients are high-cost patients. Preventive measures that reduce the number of "frequent flyers" will translate to the bottom line.

Providers and systems must coordinate ways to address the increasingly relevant social determinants of health (SDOH) beyond care transitions. Factors such as neighborhood, education, occupation, transportation, discrimination, access to nutritious food and opportunities for exercise can be contributors to one's long-term health outcome.

The deployment of advanced analytics, which scrutinizes a wide range of patient and claims data including SDOH information, can help providers deliver high-quality care while keeping costs in check.

Patient care beyond discharge

"Building a healthier future for all" is the tagline of Healthy People 2030, the latest framework in an ongoing initiative by the Office of Disease Prevention and Health Promotion, part of the U.S. Department of Health and Human Services (HHS). SDOH are a major focus of Healthy People 2030, highlighting the importance of upstream factors, which an article for the American Medical Association (AMA) defines as "what happens outside the walls of hospitals and exam rooms."

The AMA article cites the public health framework of California's Bay Area Regional Health Inequities Initiative, which breaks upstream factors into three categories: social inequities, institutional inequities and living conditions. Attention to these factors at every stage of a patient's health care journey — post-discharge, throughout the health care system, within the community ecosystem — is vital to building healthier communities.

Jaffer Traish
Chief Operations Officer
findhelp

The challenge can sometimes be helping the patient find the help that they need once discharged. Thankfully, there are companies that are looking to assist those who have difficulty meeting their social needs such as findhelp. As the nation's leading social care network, findhelp partners with more than 275 health care and payer organizations through customer platforms and their public site which connects more than 9 million users across the country.

"The positive impact of connecting people to social care and caregiver resources upon discharge from acute settings cannot be overstated. Many people, especially seniors, are in vulnerable positions and may not have friends or family to pick them up from the hospital and support their follow-up care," says Jaffer Traish, Chief Operations Officer at findhelp. "Through our network with this partnership, we make it easier for care coordinators to connect people (and for people to connect themselves) with resources like transportation, housing, and caregiving, so that all people know their options for help."

Improving workflow efficiencies while reducing administrative burden

Not only is data a vital tool for health care professionals but being able to access that information in a timely manner that doesn't add to the administrative burden that can sometimes fall on care coordinators is crucial to improving the care continuum. Whether they work for a hospital, doctor's office, accountable care organization or insurer, data is their friend.

SDOH data, along with clinical and claims data, is helpful in coordinating patient care among providers and facilitating dialogue among interdisciplinary care teams. It's also valuable in educating patients about their condition, answering questions, ensuring patients get the appropriate treatments and other coordinator duties. Social determinants can guide referrals to needed services such as mental health, crisis, housing and employment assistance.

Such information should be easily accessible by those who need to know, integrated efficiently into the workflow.

How to make a whole person care model scalable

How do we create a home and community-based care model that is scalable across America that focuses on whole person care?

Technology is a key factor in the solution, enabling the timely sharing of relevant and actionable information. We must combine predictive technology, a comprehensive decision system and evidence-based protocols with skilled, empathetic and appropriate care. That's how we ensure that every patient receives the right amount of post-acute care, in the right setting, in the right amount of time.

All the parties involved in a patient's care — including the patient — must be engaged in making this happen. Ongoing communication and coordination must be effective and efficient. The role of prevention must increase, proactively addressing the root causes rather than just treating the symptoms. In caring for the whole person and not just the condition, we must consider all the relevant factors.

When all that happens, resources are optimized. Care outside the walls of the acute setting becomes holistic and equitable, providers and health plans reduce their costs related to unnecessary care and readmissions and patients enjoy more days at home. After all, there's no place like it.