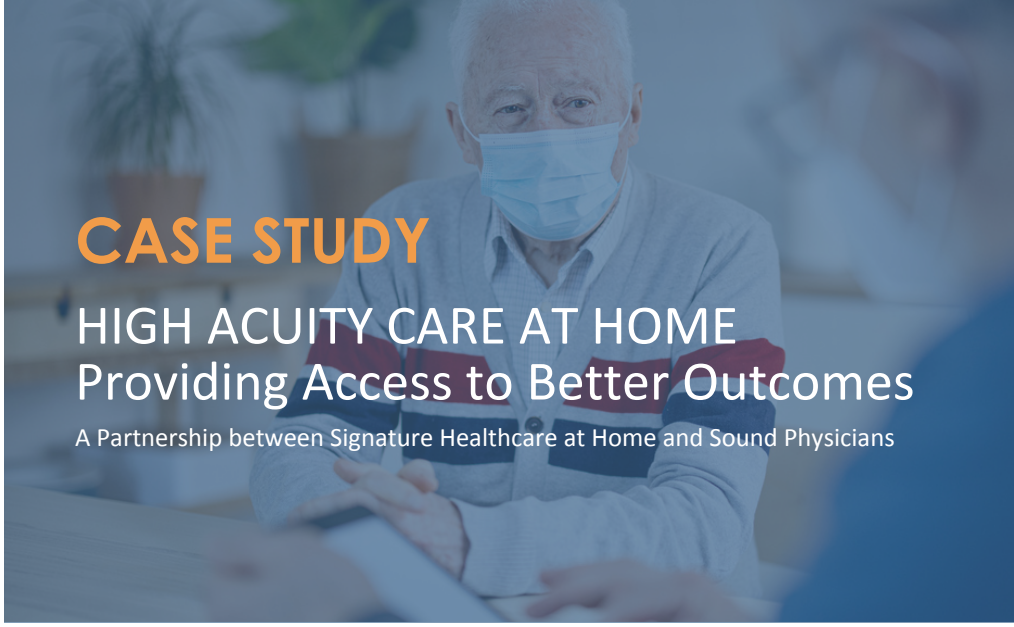

CASE STUDY

HIGH ACUITY CARE AT HOME
Providing Access to Better Outcomes

A Partnership between Signature Healthcare at Home and Sound Physicians

Telemedicine has grown exponentially over the past year, fueled by emergent needs and the regulatory changes brought on by COVID-19. But, according to the American Medical Association, up to 13 million older adults may have difficulty connecting with telehealth services.[1] Telehealth "unreadiness" is more common in older individuals, men, Blacks and Hispanics, and those living in rural areas with less education and lower incomes.[2]

There is a common industry perception that "unready" individuals, who typically lack access to technology, will resist telemedicine, when in fact, the opposite may be true.

This case study highlights how an innovative home health program leveraging engaged tele-hospitalist physicians transformed one high-risk patient's view of the medical system, and enabled a full recovery at home without a hospital readmission.

BACKGROUND

Signature Healthcare at Home provides healthcare to homebound individuals in rural counties throughout Washington, Oregon, Idaho, and Utah. Signature recently launched their High Acuity Care at Home (HACH) telemedicine program in partnership with Sound Physicians. HACH expands home health access to higher-risk individuals and individuals without a primary care physician (PCP). In this telehealth model, the home health nurse brings the telemedicine technology (Samsung tablet, HIPAA compliant software, Wi-Fi hotspot) to the patient, initiates the telemedicine encounter, and handles all technical difficulties, effectively removing the most common barriers to telemedicine faced by disadvantaged individuals.

YEARS WITHOUT HEALTHCARE

After contracting COVID-19 related pneumonia and sepsis, a 78-year-old male patient was admitted to Skagit Valley Hospital for treatment. One of 28% of American men without a PCP,[3] this patient had not been seen by a doctor in over 20 years. While hospitalized, the patient was diagnosed with several unmanaged comorbidities, including diabetes, chronic heart failure, and atrial fibrillation. These conditions complicated his recovery and placed him at high risk for rehospitalization if left untreated.

During his hospital stay, the patient conveyed a deep mistrust of doctors and the medical system in general. Not surprisingly, he strongly opposed a skilled nursing facility stay, expressing his desire to get discharged to home as soon as possible.

Typically, a medically complex patient at high risk for readmission without a PCP would find access to home health nearly impossible. But, the HACH program, in collaboration with Sound Physicians, provided a direct path to a discharge to home with immediate access to home health services.

After an assessment qualified the patient for HACH, a Sound tele-hospitalist and Signature home health RN conducted a Start of Care (SOC) co-visit within 48-hours of the patient's hospital discharge. (In most HACH cases, the SOC visit happens even faster, within the first 24-hours.)

REBUILDING A PATIENT'S TRUST

Following the SOC visit, the home health nurse initiated four additional physician visits for the patient, which took place within the first ten days at home.

With the support of the tele-hospitalist, the home health nurse built out a treatment plan to manage the patient's multiple comorbidities, administered a course of diuretics, and maintained anti-coagulation within therapeutic levels. The patient gradually progressed, regaining independence in the home and eventually returning to his previous lifestyle.

When the patient's conditions stabilized, he "graduated" from HACH into standard home health, with Sound Physicians following him through the home health episode. After working with the patient for a few weeks, the home health nurse observed a change in the patient's attitude:

"During the telemedicine consults, the Sound tele-hospitalist put our patient at ease, which was surprising since he had a general aversion to the medical community. The physician was open, honest, and warm during the visits, and the patient felt confident about the care he received. We feel the tele-hospitalist helped repair this patient's trust in the medical community."

-Home Health RN, Signature Healthcare at Home

Shortly after his telemedicine encounters, the patient enrolled with a primary care physician for the first time in 20 years.

KEYS TO SUCCESS

- **A robust evaluation process to qualify the patient for high acuity care at home**
- **Home health agency and physician group aligned around the goals of care**
- **Strong collaboration and mutual respect between home health nurse and tele-hospitalist**
- **Engaged physicians with the necessary skills, training, and aptitude to work with high-risk patients via telemedicine**

LONG TERM OUTLOOK

With the home health episode completed, it is unknown whether the patient will be able to maintain his plan of care long-term, but the hope is that reengaging with the medical community has improved his willingness to proactively seek treatment, potentially preventing the need for HACH-level services in a future home health episode.

DEVELOPING A REMOTE CONNECTION

"As a Sound tele-hospitalist, I know that listening is the key skill. My training with Sound Physicians has taught me how to make the patient feel comfortable with the technology and how to support the home health team. I also emphasize that my role is to assist the caregivers, including family, during the home health episode. It is essential to ask everyone involved if they have any concerns or questions. Being a good listener is absolutely essential."

- Cecile Muehrke, MD, Tele-hospitalist, Sound Physicians

How Sound Physicians supports Signature Healthcare at Home's HACH Program

A Signature Community Outreach Specialist receives a referral and completes a Risk Assessment for HACH to determine the patient's risk of a hospital readmission

For patients without a PCP, a Sound tele-hospitalist can provide the assessment and certification for the initial home health episode, expediting access

If the patient qualifies for HACH, they receive up to 4 video visits from a tele-physician during the first two weeks at home, based on medical necessity

After graduation from the HACH program, Sound continues to follow the patient as the signing provider for the home health episode

Sound's tele-physicians are available for on-demand support and will manage any escalations or ED transfers for the patient

1. https://www.ama-assn.org/practice-management/digital/why-so-many-patients-still-can-t-connect-doctors-telehealth
2. https://www.ama-assn.org/practice-management/digital/why-so-many-patients-still-can-t-connect-doctors-telehealth
3. https://www.fiercehealthcare.com/practices/many-americans-don-t-have-a-primary-care-doctor