In-Home Rehab Program Improves Patient Outcomes and Reduces Care Costs

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Growing Demand for Home-Based Care

As 70+ million U.S. baby boomers all reach at least age 65 by the end of this decade, demand is skyrocketing for services enabling seniors to "age in place" in their own homes. The U.S. Centers for Disease Control defines aging in place as "the ability to live in one's own home and community safely, independently, and comfortably, regardless of age, income, or ability level."

Nowhere in America is aging-in-place demand being felt more acutely than in California, with more senior residents than in any other state. By 2030, California's senior population is expected to hit 10.8 million, or about

one-fourth of the state's projected population. The Public Policy Institute of California projects that 1+ million of these seniors will require home-based care.

Anticipating this burgeoning demand for home-based care services – and seeking to improve overall healthcare quality – a California-based health system in 2021 began offering home-based rehabilitation services to patients discharged from inpatient, emergency department and skilled nursing facility care. However, due to Covid and staffing shortages, the rehabilitation program stalled. With the pandemic over, the organization sought to re-launch the program and provide more resources to support a broader implementation.

Wanting the re-launched in-home rehabilitation program to rapidly succeed, the organization engaged Freed Associates (Freed) to plan out the program's organization and implementation. Freed offered vast project management experience and direct experience with this organization's operations.

Care Management Strategies to Ensure a Safe Transition of Care to Home

This rehabilitation program sought to provide a series of immediate interventions to facilitate a patient's safe transition home. These services included:

- **Therapist evaluation** – Within 24 hours of discharge, the patient is visited at home by a physical therapist (PT), occupational therapist (OT) and/or speech-language pathologist (SLP), with additional home therapy visits provided, as needed. These services may include a home safety assessment, recommendations to improve body mechanics and posture, risk reduction measures, and mobility device training and education.
- **Nurse case management** – A nurse (and potentially also a social worker) will provide, via telephone, home-based transition support, including managing follow-up appointments, ordering medical equipment and supplies, counseling on complex and chronic conditions, and facilitating connections to community-based services.
- **Pharmacist medication reconciliation** – A pharmacist will provide, via telephone, counsel on a patient's medications, including the appropriateness of each, and guidance on medicine intake.

Considerable research supported the organization's application of these rehabilitation interventions. For example, an effective home exercise program, as overseen by a PT or OT, can decrease fall risk by 30% when compared with a control group. Similarly, pharmacy management and discontinuation of a patient's psychotropic medications can reduce fall risk by up to 64%.

For patients, such rehabilitation interventions – designed around each patient's individual needs – can significantly improve long-term health outcomes and help prevent a patient's functional decline. For providers, these efforts can reduce the likelihood of costly patient readmissions, reduce the cost of care, remove the likelihood of long-term harm to patients, and improve the overall caregiver/patient experience. In short, it creates

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a “win/win” equation for patients and their providers.

Improved Patient Eligibility Criteria

The organization spent considerable time designing its rehabilitation program, including determining suitable criteria for patient eligibility. For example, meeting or exceeding set standards for fall risk, chronic medications (particularly high-risk medications) and co-morbidities (such as cardiac issues, cognitive impairment, and foot problems) would trigger patient participation eligibility.

In addition to helping organize the rehabilitation program overall, Freed focused on ensuring a successful re-introduction of the program to key stakeholders. Potential program referral sources, such as inpatient, Emergency Department and Skilled Nursing Facility discharge, became a key focal area.

Freed facilitated the ability of referral sources to refer patients to the in-home rehabilitation program and worked to build the program’s reputation across the organization’s vast geographic care region. Specifically, Freed identified program champions and trainers from key stakeholder groups who would be important to the program’s success and refresh their knowledge about the program and its benefits. As needed, impacted referral groups were re-trained on patient referral workflows to facilitate the referral and program intake process.

Ultimately, thanks to Freed’s efforts, the organization could roll out a fully functional and optimized in-home rehabilitation program and offer services for the immediate benefit of the organization’s patients.

Provider and Patient Satisfaction Lead to In-Home Rehab Program Growth

Organizational staff feedback on Freed’s efforts to optimize and roll out the patient rehabilitation program was universally positive. Staff members are especially pleased with how the program is helping an increased number of patients more safely transition home.

After an initial, small-scale rollout of the program, the organization made plans to offer it across a broad geographic area. Future efforts for the program will focus on incremental improvements based on provider and patient feedback.

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