



Home is where the health is

Where people receive care is changing, driven by digital technologies and changing consumer sentiment. The shift is toward high-quality healthcare brought directly to patients where and when they need it, likely in the home versus medical facilities.

What's going on

Historically, health and life sciences organizations led patients to engage solely on the organization's terms, creating a one-way power dynamic that impacted both patients and healthcare professionals (HCPs).

To schedule an appointment, they were constrained by the hours and channels offered by the organization. To receive care and medication, they had to travel to wherever the hospital, pharmacy or HCP office was located. And between appointments or treatments, the limited communication touch points or feedback loops left patients (or their caregivers) the burden of becoming their own healthcare advocates.

Pressure for change is growing. Nearly half of all patients reported that they are now getting treatment at home instead of going

to their healthcare provider's office.¹ Another type of pressure is also building. HCPs are feeling burnt out by increasing administrative burdens, diminishing reimbursement and ever-increasing time spent away from the real reason most went into healthcare: helping patients stay healthy.

The COVID-19 pandemic has opened the door to reimagine where, how and by whom care is delivered.

Patients are growing more comfortable with only connecting with their HCPs through video or voice calls if the quality

of interaction can be guaranteed—such as by ensuring similar time and level of care as in-person appointments, good digital experience and assessments fed back into the broader care team.²

HCPs are also open to new ways care can be delivered: 65% said they value self-administration methods for patients, allowing increased treatment at home (auto-injectors, for example, or on-body devices), more than they did pre-COVID-19.³



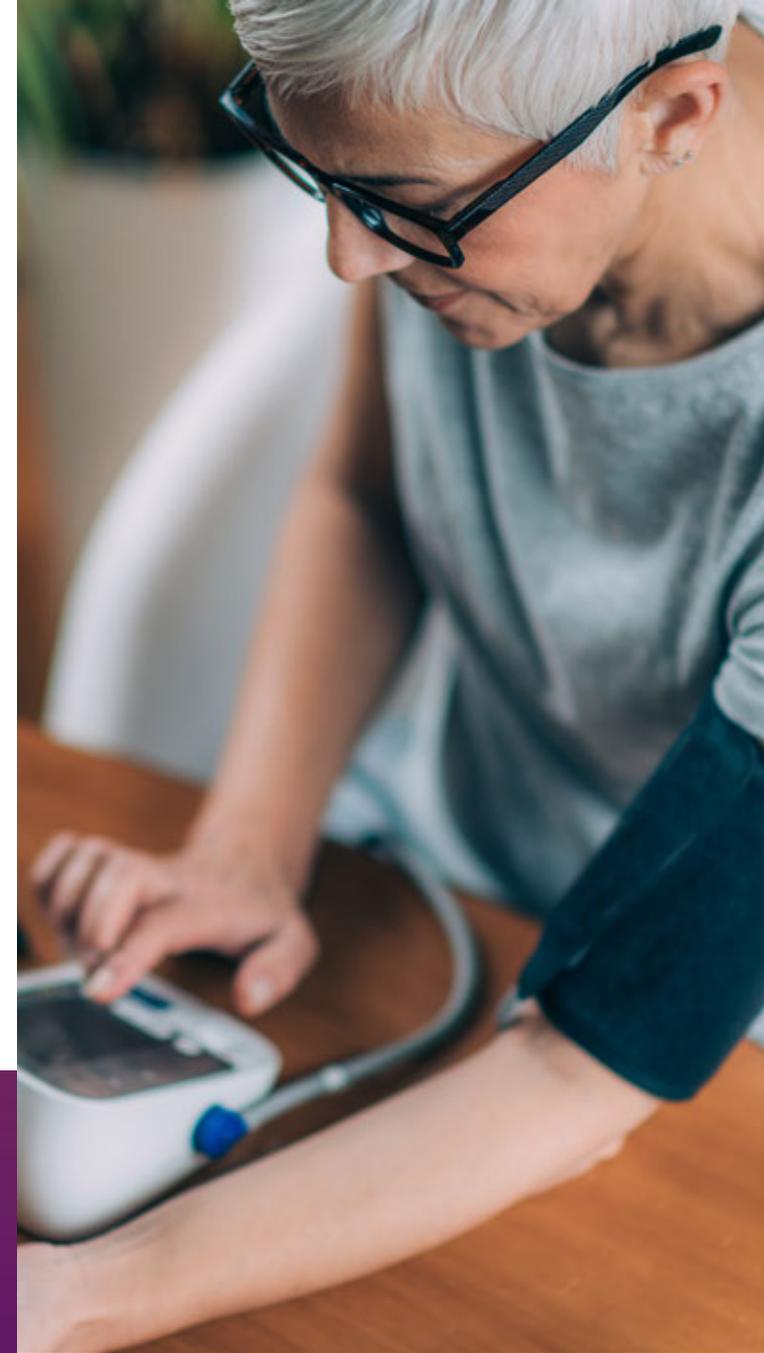
What's next

Market signals for the benefits of providing care at home are accelerating. Funding for hospital-at-home programs has increased.⁴ New remote patient monitoring devices and platforms are maturing.⁵ Meanwhile, a growing number of studies exploring the benefits of shifting care to the home have been published on aspects such as shortened length of inpatient stays,⁶ increased patient satisfaction,⁷ social connections for support and improved health outcomes.⁸

Soon, patients will welcome care into their homes as a permanent, but not always visible, house guest. In a home setting, patients feel more comfortable showing their "true selves" during intimate and vulnerable moments. This will make empathetic care experiences essential.

In the long term, the competencies and capabilities to make some care at home a reality will allow for location-agnostic care. Instead of healthcare always being tied to physical locations, it will at times be connected to the patient wherever he or she is located. For example, 4 in 10 patients (44%) started using new devices or apps during COVID-19 to help manage their conditions, while more than 90% of those using a new device or app rated the experience good or excellent and want to continue using them.⁹

When it comes to making this reimagined experience reality, challenges remain—care financing mechanisms, for example, technology limitations and supply chain logistics. But now is the time to begin designing a future free of the legacy constraints of place-and-time-based care.



Opportunities for reimagination

1. The open (communication) road

Communication technologies will provide the underlying infrastructure of reimagined care at home.

Asynchronous and synchronous messages will speed up between patients, their support circles, HCPs and extended care team members (including medication coordination) in a seamless manner. Passive and active measurements will be tracked, serving up contextual alerts and triggering new workflows.

Many supporting parts and financial investments will be needed to allow this flow of information to run effectively, including a new attitude and culture shift from patients and HCPs in the channel(s), tone and frequency of communications.

New clinical pathways and protocols and a new care team structure will be needed, allowing a financially sustainable approach for HCPs to practice at top of license. New skills such as digital dexterity, service recovery and in-home safety training, along with new devices plugged into an integrated ecosystem, will be required.



Barriers between different stakeholders and channels will need to be removed, and it will be critical to establish clear expectations and governance rules so patients and HCPs can feel safe, comfortable and in control.

2. You've got a package

Delivering care at home requires replacing similar services and experiences typically provided in a medical facility. It also produces preference challenges, which will lead to a need to adapt to how patients and their informal caregivers want to be notified.

Care acuity levels will determine the breadth of services that need to be orchestrated, ordered and tracked, as well as how care is delivered. A patient with lower acuity needs—e.g., someone with a manageable chronic condition—may only need a nurse to come to the home to administer an infusion.

In contrast, a patient with a higher level of acuity may be a candidate for a hospital-at-home program that requires the delivery of durable medical equipment, orchestration of in-home care and virtual specialist care, delivery of replenishable specialty medications, stocking of supplies and consumables, and facilitation of social determinant of health interventions such as food delivery.



New orchestration capabilities and supply chains for the home will need to be created to bring these items to the patient. No healthcare organization can do this alone. Instead, it will take a collaborative effort to stitch together a patchwork of repeatable solutions, dependent on designing experiences and processes that solve for access and affordability issues.

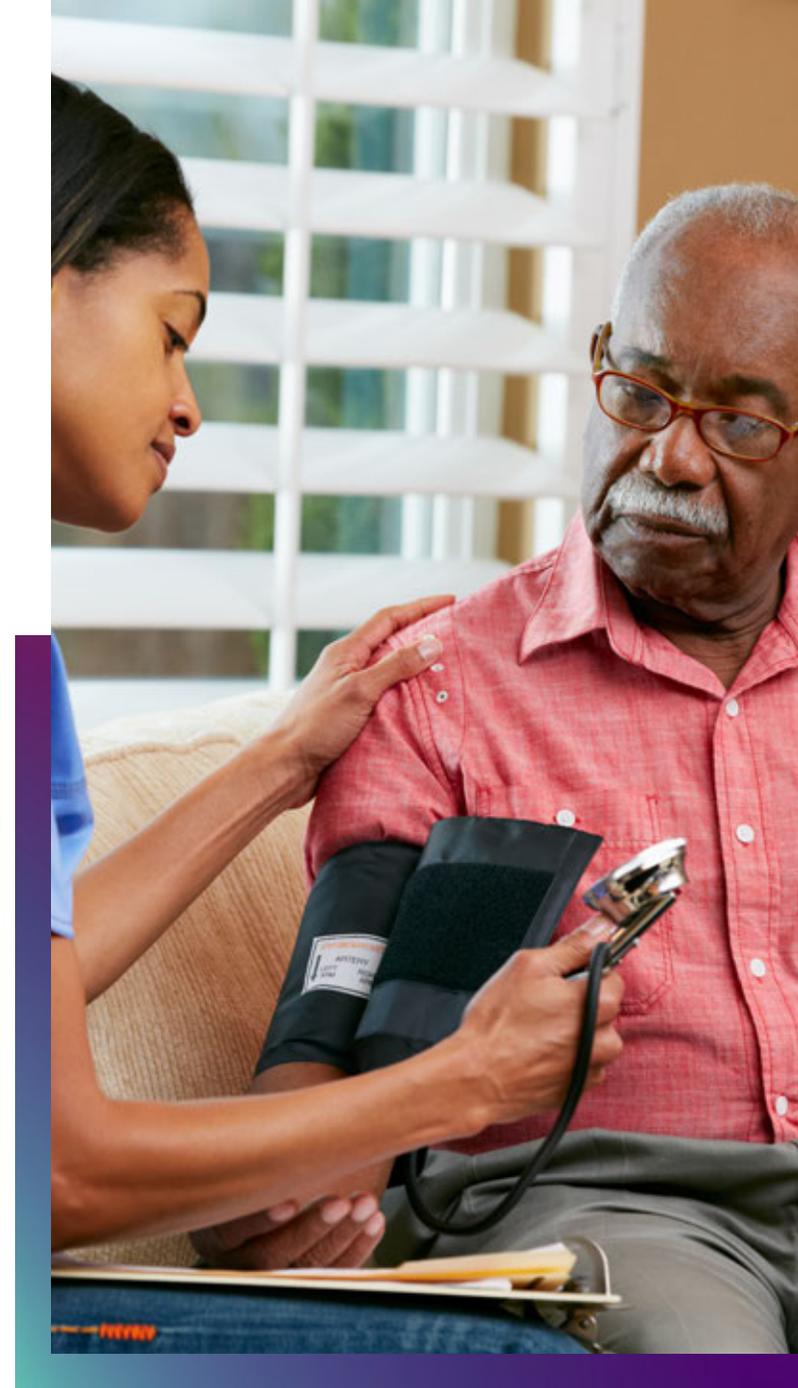
New ecosystem relationships will be essential—particularly with life sciences and distribution partners—as personalized medications become more available and central to a patient’s care. Orchestration across the supply chain will make or break the patient’s experience and contribute to their ability to reliably and comfortably get treatment in their home.

3. My house, your office

When patients are in the hospital and away from their day-to-day responsibilities, they’re able to focus on healing. However, home as a care setting thrusts patients into not only the role of a patient, but also the role of a host.

This increases the hospitality burden of feeling pressure to be always switched “on” and ensuring the home is appropriately set up for a guest. HCPs need to be mindful that patients see them as a guest and do their best to remove any pressure to be hosted.

On the other hand, upon entering a patient’s home either physically or virtually, the HCP is in effect entering their new office. They will be expected to take charge, bringing comfort, safety and security from the medical facility to a new location with more personalized service orientation. Balancing these tensions will be critical to ensuring this transition has staying power beyond the pandemic.



What healthcare leaders can do next

1. Make care easier, portable, scalable

Extending care into the home will put new strains on HCPs to do more while splitting time across multiple care settings.

To mitigate burnout and ensure quality outcomes, HCPs need to be equipped with smart devices that ease time-intensive but relatively low-impact tasks like clinical documentation. In-home diagnostics such as Cologuard¹⁰ can bring labs into the home, freeing up capacity at the office. At-home diagnostic kits like TytoCare can passively observe a patient's vital signs, digitally documenting results and alerting HCPs when an intervention is necessary.¹¹

Such devices can't live independently. Instead, they need to be connected to an ecosystem to allow for easy communication across the entire care team. Seamless team-wide communication will give everyone—including the patient's support circle—care plan visibility. Devices will also need to plug back into a care-at-home "command center" to allow for 24/7 real-time condition monitoring and management.

The shift of care into the home will also impact informal caregivers, who will need to continue performing their normal support responsibilities as well as also learn new technologies and medications—often in emotionally charged environments.

Lastly, organizations will have to solve for curated, personalized care at scale. Each patient's home will have a different layout with different levels of connectivity. Providing individual care experiences at scale will require a complete reimagination of protocols, operations and safety measures.





2. Practice and recognize habit building

Changing behavior is challenging, but it's integral to curbing the rise in chronic disease and bending the cost curve to make care at home financially sustainable. Patients will need to form long-term habits, especially when no one is looking.

Organizations can use a blend of in-person and digital interactions to establish and recognize new behaviors while balancing ethical considerations when developing rewards. These interactions will need to be tailored to the individual in order to be effective. This will require an in-depth understanding of patients' behaviors, motivations and needs that goes beyond typical demographic information and segmentation.

Building new habits and confidence isn't just relevant for the patient. HCPs and healthcare employees also need to develop trust in the new ways of working.

Celebrating successes and progress, no matter the size, will help reinforce new behaviors.

3. Set aside time for learning and support

Improving technology and health literacy is an important part of making the shift to care in the home successful. Time and resources must be allocated to this so that experiences and outcomes don't suffer from patients, informal caregivers and the broader care team not understanding how to use and administer the care-at-home tools.¹²

Providing proper customer support will be critical. Users will need support connecting devices to phones, accessing portals and so on. A hands-off "launch and let go" product strategy will not work, and this will require a major shift for most organizations.

The literacy gap also has the potential to further exacerbate the divide between secure and vulnerable communities. To ensure that care at home is well received, patience, empathy and education must be incorporated into every new experience.



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