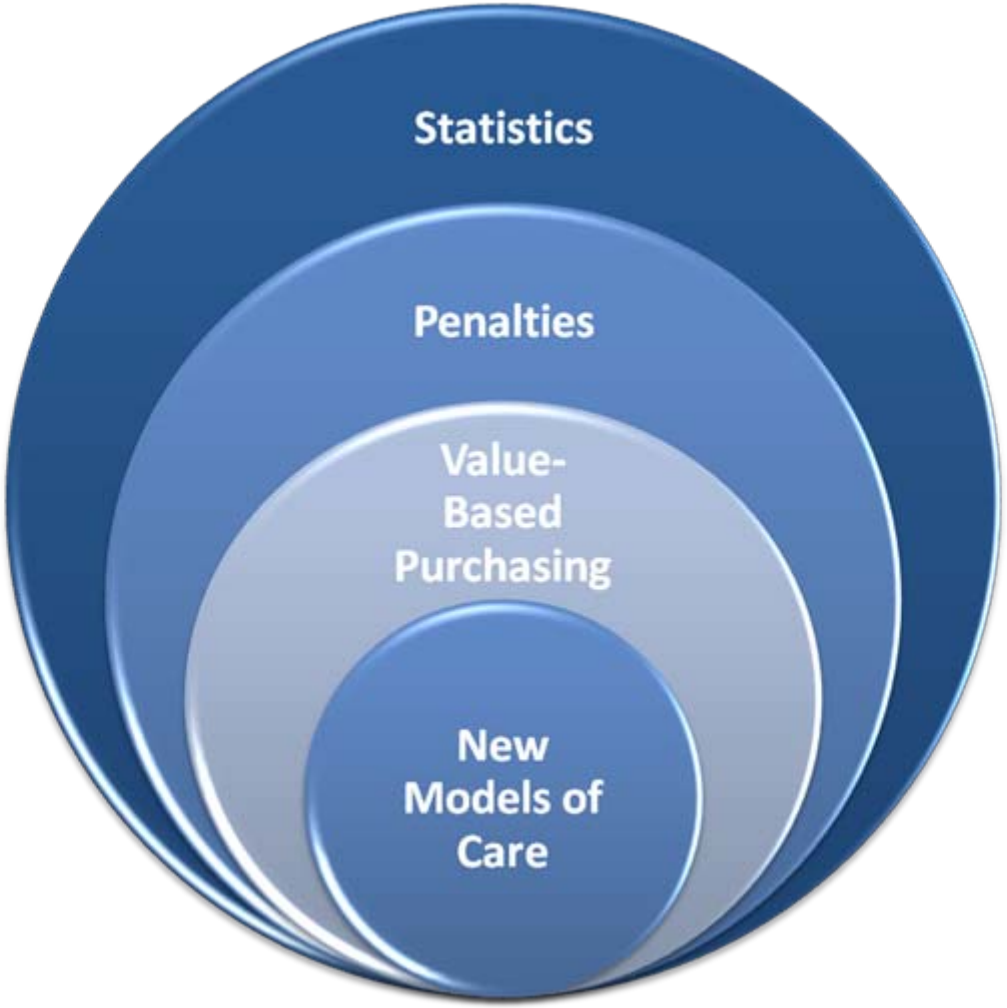
Home Health Agencies & Reducing Readmissions

presented by
Misty Kevech, RN, MS, COS-C, CCP
HHQI RN Project Coordinator
WVMI & Quality Insights

Objectives

- Describe the benefits of collaborating and utilizing home health services to reduce readmissions
- State HHQI's purpose and how to access materials
- Explore key best practice home health interventions to reduce readmissions

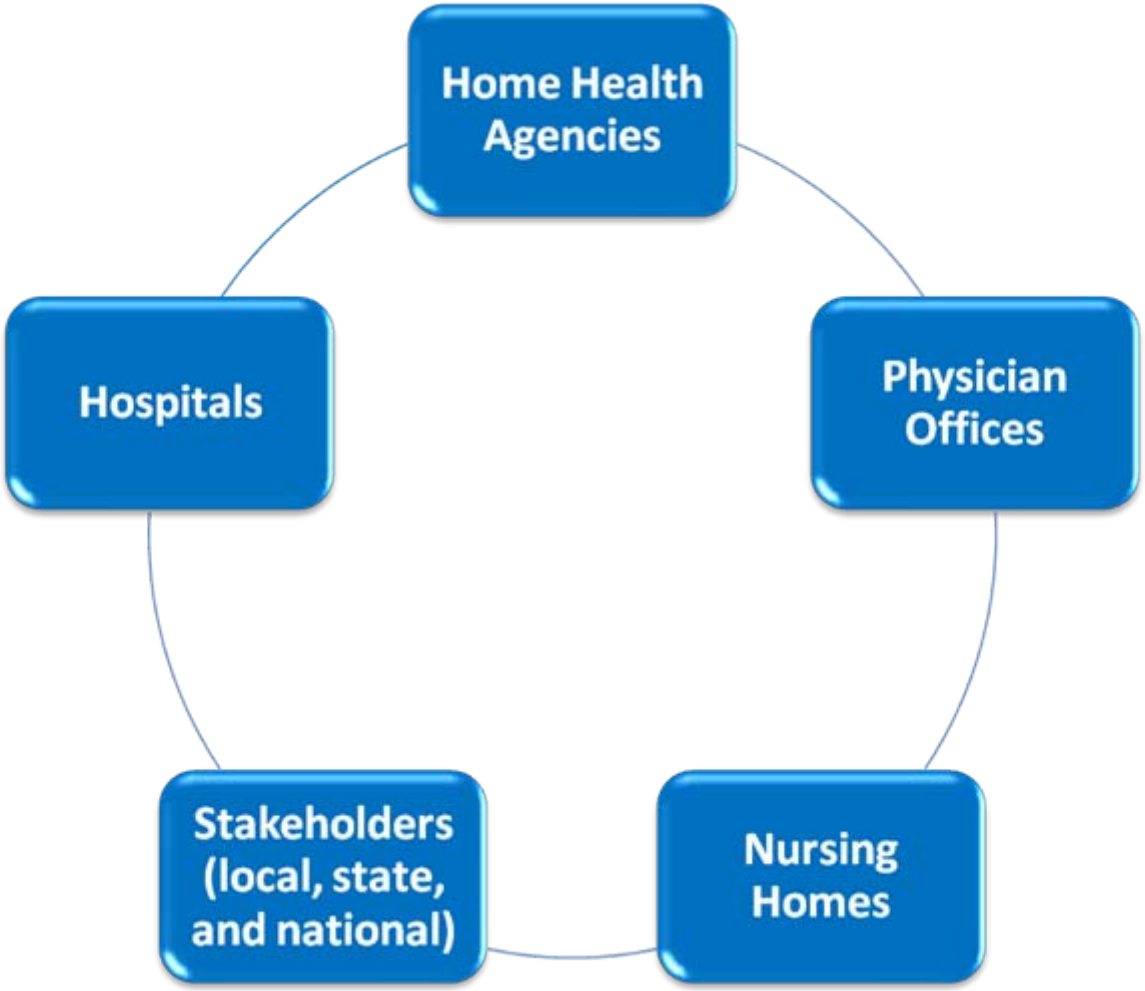
Readmissions



Healthcare Reform

- Increasing *access* to care
- Paying for *quality* (ACOs and OCMHs
- Controlling *cost* (CT, safety, patient experience)
- Increasing health disparities

Patient-Centered Care



Value of Home Health

Medicare Home Health Criteria

1. **Physician orders**
   - Plan of Care
   - Face-to-Face Encounter
2. **Skilled Care**
   - Intermittent skilled nursing care
   - Physical therapy
     - Occupational therapy cannot **initiate** care, but can continue care
   - Speech-language pathology services
3. **Medicare-certified Home Health Agency**
4. **Homebound**
   - See next slide for new rules effective 11/19/13

http://www.medicare.gov/pubs/pdf/10969.pdf

Medicare Home Health Criteria

Criteria-One

- Because of illness or injury, need the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person in order to leave their place of residence;

OR

- Have a condition such that leaving his or her home is medically contraindicated.
- If the patient meets one of the Criteria-One conditions, then the patient must ALSO meet two additional requirements defined in **Criteria-Two** .

Criteria-Two

- There must exist a normal inability to leave home;

AND

- Leaving home must require a considerable and taxing effort.

New changes as of 11/19/13

Home Health Compare (HHC)

- How often HH patients had to be admitted to the hospital
  - National: 17%*
- Urgent, unplanned ED Visits:
  - National: 12%*
- HHC data is based upon ending of an episode – not 30 days

* Based on claims data for Jan. – Dec. 2012

www.HomeHealthQuality.org

HHQI

Special Project funded by
Centers for Medicare & Medicaid Services

Initial campaign 2007 and currently in 3rd Phase

Goal: Improve the quality of care home health patients receive through a cross-setting approach

Free tools, resources, & networking

Topic Focus

- Acute Care Hospitalization
- Oral Medication Management
- Influenza & Pneumococcal Immunization
- Underserved Populations
- And now…Cardiovascular Prevention

HHQI
Home Health
Quality Improvement

HHQI is Touching Millions of Lives

- From August 2012 to July 2013:
  - **3,595,657** patients received care from HHQI-participating home health agencies
  - This is **81%** of all patients cared for by home health agencies

What We Offer

- Home health and cross-setting free resources
- Four categories:
  - **E**ducation
  - **D**ata
  - **N**etworking
  - **A**ssistance

Campaign Website

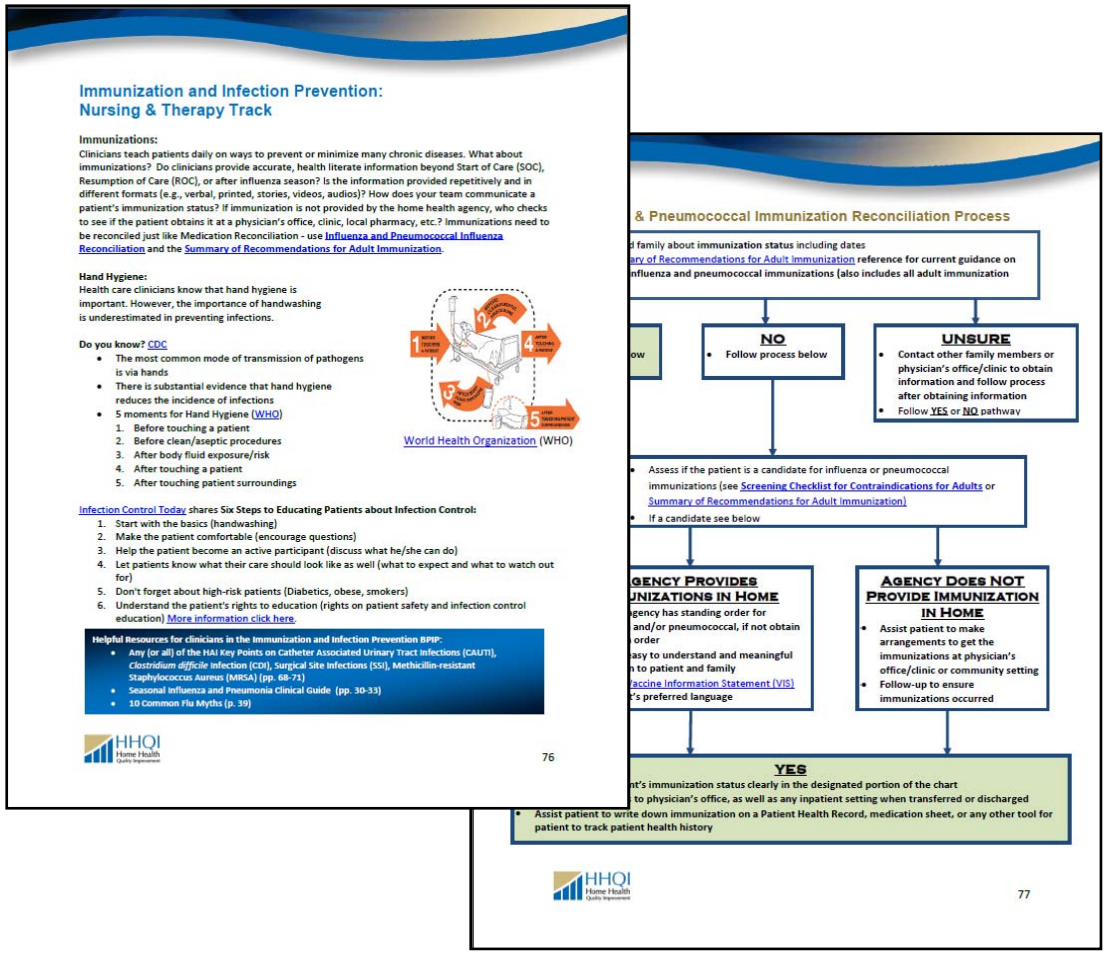
www.HomeHealthQuality.org

BPIP: Leadership

- Evidence-based Practices
- Application
- Tools & Resources
- Cross-setting Approach

BPIP: Discipline Tracks

- Nursing
- Therapy
- Social Worker
- Aide



Immunization and Infection Prevention: Nursing & Therapy Track

Immunizations:
Clinicians teach patients daily on ways to prevent or minimize many chronic diseases. What about immunizations? Do clinicians provide accurate, health literate information beyond Start of Care (SOC), Resumption of Care (ROC), or after influenza season? Is the information provided repetitively and in different formats (e.g., verbal, printed, stories, videos, audios)? How does your team communicate a patient's immunization status? If immunization is not provided by the home health agency, who checks to see if the patient obtains it at a physician's office, clinic, local pharmacy, etc.? Immunizations need to be reconciled just like Medication Reconciliation - use Influenza and Pneumococcal Influenza Reconciliation and the Summary of Recommendations for Adult Immunization.

Hand Hygiene:
Health care clinicians know that hand hygiene is important. However, the importance of handwashing is underestimated in preventing infections.

Do you know? CDC

- The most common mode of transmission of pathogens is via hands
- There is substantial evidence that hand hygiene reduces the incidence of infections
- 5 moments for Hand Hygiene (WHO)
  1. Before touching a patient
  2. Before clean/aseptic procedures
  3. After body fluid exposure/risk
  4. After touching a patient
  5. After touching patient surroundings

World Health Organization (WHO)

Infection Control Today shares **Six Steps to Educating Patients about Infection Control:**

1. Start with the basics (handwashing)
2. Make the patient comfortable (encourage questions)
3. Help the patient become an active participant (discuss what he/she can do)
4. Let patients know what their care should look like as well (what to expect and what to watch out for)
5. Don't forget about high-risk patients (Diabetics, obese, smokers)
6. Understand the patient's rights to education (rights on patient safety and infection control education) More information click here.

Helpful Resources for clinicians in the Immunization and Infection Prevention BPIP:

- Any (or all) of the HAI Key Points on Catheter Associated Urinary Tract Infections (CAUTI), *Clostridium difficile* Infection (CDI), Surgical Site Infections (SSI), Methicillin-resistant Staphylococcus Aureus (MRSA) (pp. 68-71)
- Seasonal Influenza and Pneumonia Clinical Guide (pp. 30-33)
- 10 Common Flu Myths (p. 39)

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& Pneumococcal Immunization Reconciliation Process

d family about **immunization status** including dates
ary of Recommendations for Adult Immunization **reference for current guidance on** influenza and pneumococcal immunizations (also includes all adult immunization

NO
- Follow process below

UNSURE
- Contact other family members or physician's office/clinic to obtain information and follow process after obtaining information
- Follow YES or NO pathway

- Assess if the patient is a candidate for influenza or pneumococcal immunizations (see Screening Checklist for Contraindications for Adults or Summary of Recommendations for Adult Immunization)
- If a candidate see below

GENCY PROVIDES UNIZATIONS IN HOME
gency has standing order for and/or pneumococcal, if not obtain order
easy to understand and meaningful to patient and family
Vaccine Information Statement (VIS)
t's preferred language

AGENCY DOES NOT PROVIDE IMMUNIZATION IN HOME
- Assist patient to make arrangements to get the immunizations at physician's office/clinic or community setting
- Follow-up to ensure immunizations occurred

YES
nt's immunization status clearly in the designated portion of the chart
to physician's office, as well as any inpatient setting when transferred or discharged
- Assist patient to write down immunization on a Patient Health Record, medication sheet, or any other tool for patient to track patient health history

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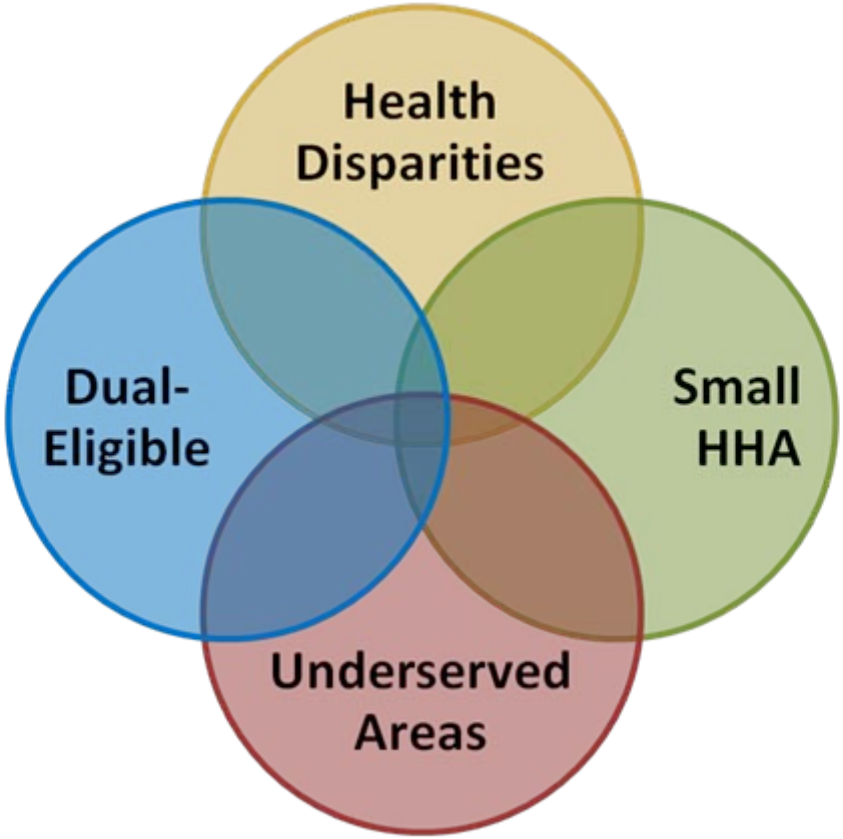
Underserved Populations (UP) Network



Essential Best Practice Interventions
to Reduce Readmissions

- Hospitalization Risk Assessment
- Emergency Care Planning
  - Easy access to a nurse (24/7 call)
- Medication Management
- Frontloading based on risk assessment
- Phone Monitoring and/or Telehealth
- Patient Self-Management
- Disease Management Programs
- Care Transitions

Hospital Risk Assessment

Hospitalization Risk Assessment

Purpose: Screening tool to identify those at risk for hospitalization.

Patient Name: _____ Record # _____

Date: _____

Prior pattern: Check all that apply	
❑ > 1 Hospitalizations or ER visits in the past 12 months (M1032)	❑ History of falls * (M1032 and M1910)
Chronic conditions: Check all that apply (M1020/1022/1024)	
❑ HF (M1500 and M1510)	❑ Chronic skin ulcers *(Wound consult if indicated for any wounds)*
❑ Diabetes	
❑ COPD	❑ HIV/AIDS
Risk Factors: Check all that apply	
❑ Discharged from hospital or skilled nursing facility (M1000)	❑ Help with managing medications needed (M2020) ► ★
❑ More than 2 secondary diagnoses (M1022 and 1024)	❑ Non-compliance with medication regimen ♦ ★
❑ Low socioeconomic status or financial concerns ♦	❑ Confusion (M1710) ♦ ★
❑ Lives alone (M1100) ► ♦	❑ Pressure ulcer (M1300, M1302 and M1306) ★
❑ Inadequate support network (M1100) ♦	❑ Stasis ulcer (M1330) ★
❑ ADL assistance needed ► (M2100 and M2110)	❑ Overall Poor Status/Prognosis (M1034) ■
❑ Home safety risks ► ♦	❑ Low literacy level ♦
❑ Dyspnea (M1400 ► ★	❑ Depression (M1730) ♦
►Consider Therapy referral (PT, OT, ST) / ♦ Consider MSW referral	■ Consider Hospice referral / ★Consider RN referral, if not ordered
Total # of checked boxes is ___. **Your agency may want to select a threshold score to target patients at high risk.** (*For example: 5 or greater risk factors may indicate that the patient is at risk for hospitalization.* Note: This number is for convenience only and has not been tested or validated. The agency may modify the score based upon the needs of their patient population.)	

Hospital Risk Assessment

Call Me First!

Stay safe and well at home.
Avoid unneeded trips to the hospital.
Tell me when you have health changes:

- Get sick
- Just don't feel right
- Find it harder to stand up from a chair

I can help you if I know you need help!

Call Me First!

Because I Care!

Name:_____

Local Number: _____

(Anytime: 24 Hours/7 Days a Week)

_____

AGENCY LOGO

This material was prepared by the West Virginia Medical Institute, the Quality Improvement Organization supporting the Home Health Quality Campaign, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The views presented do not necessarily reflect CMS policy. Publication number: 10SOW-WV-HH-BC-102312. Exp. 10/12 Revised and adapted from Caring Health Care

My Emergency Plan

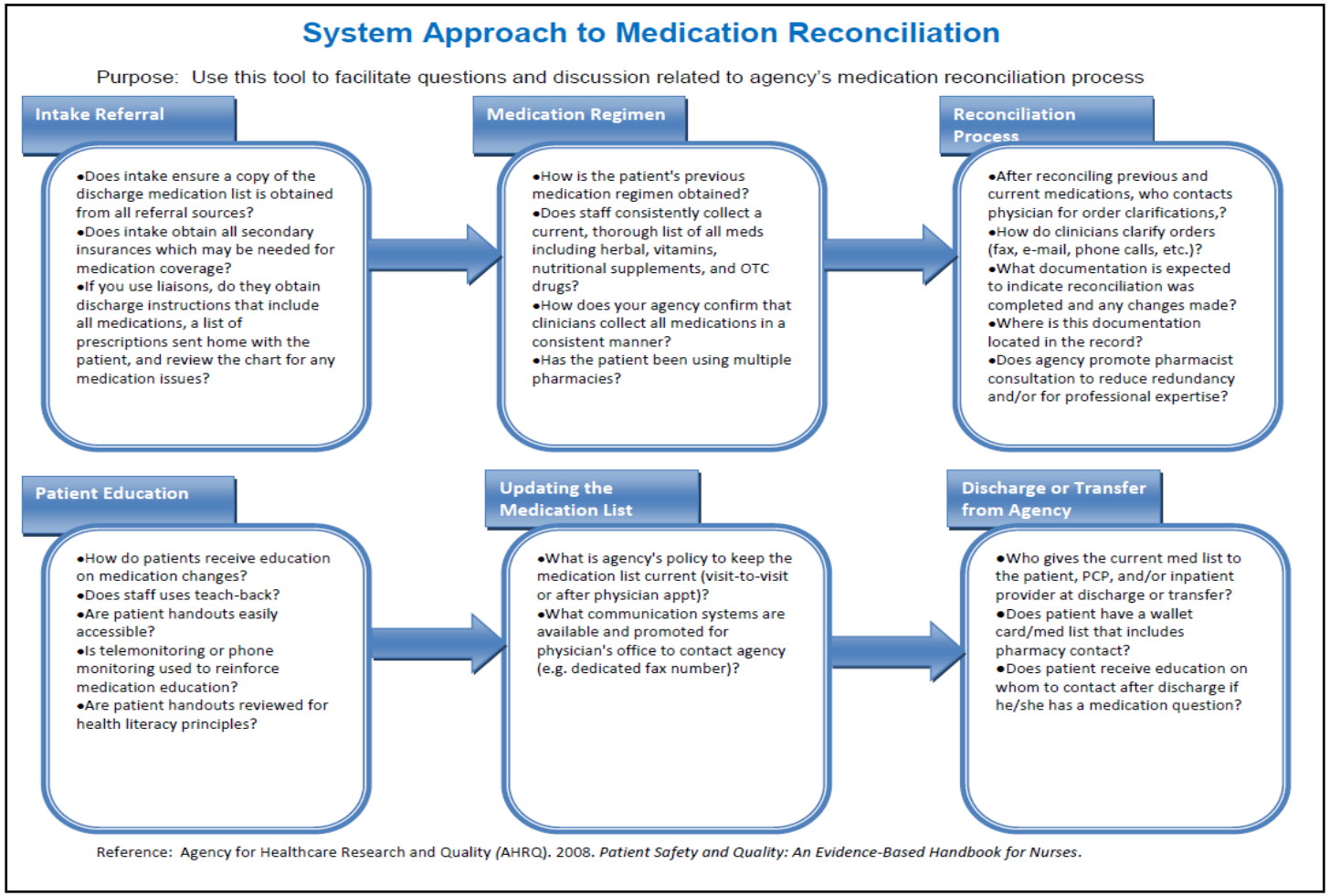
[Agency Name & Agency Phone Number]

Patient Name _____

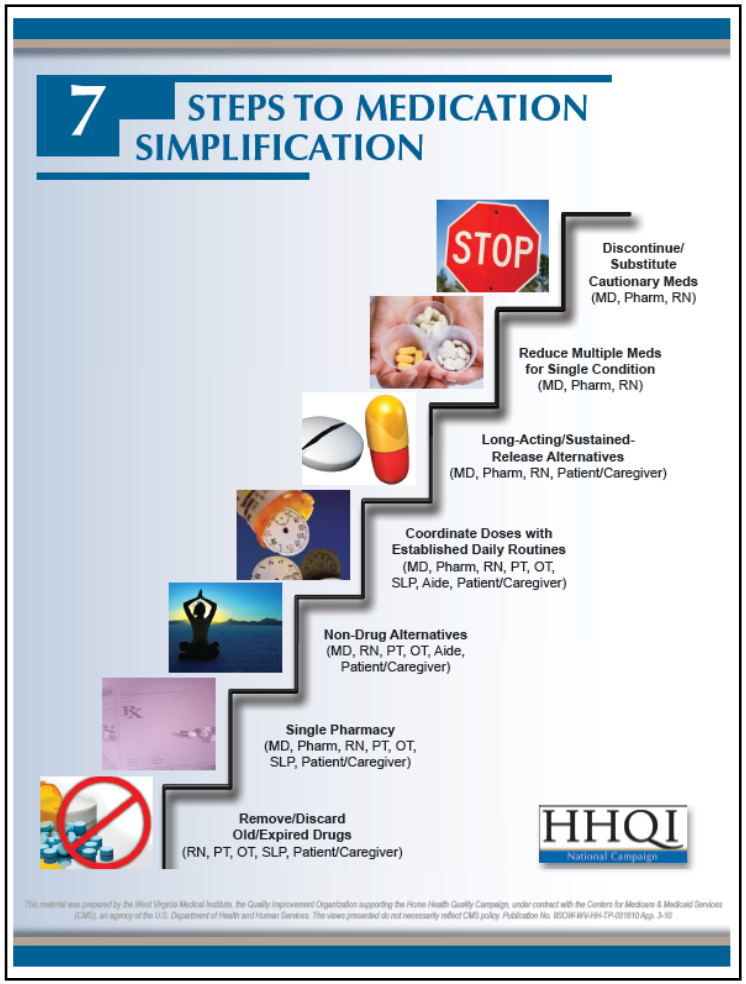
MY EMERGENCY PLAN

WHAT TO DO?	CALL MY HOME HEALTH AGENCY WHEN:	CALL 911 WHEN:
 **I hurt**	• New pain OR pain is worse than usual • Unusual bad headache • Ears are ringing • My blood pressure is above: _____/_____ • Unusual low back pain • Chest pain or tightness of chest RELIEVED by rest or medication	• Severe or prolonged pain • Pain/discomfort in neck, jaw, back, one or both arms, or stomach • Chest discomfort with sweating/nausea • Sudden severe unusual headache • Sudden chest pain or pressure & medications don't help (e.g. Nitroglycerin as ordered by physician), OR • Chest pain went away & came back
 **I have trouble breathing**	• Cough is worse • Harder to breathe when I lie flat • Chest tightness RELIEVED by rest or medication • My inhalers don't work • Changed color, thickness, odor of sputum (spit)	• I can't breathe! • My skin is gray OR fingers/lips are blue • Fainting • Frothy sputum (spit)
 **I have fever or chills**	• Fever is above _____ F • Chills/can't get warm	• Fever is above _____ F with chills, confusion or difficulty concentrating
 **I fell**	• Dizziness or trouble with balance • Fell and hurt myself • Fell but didn't hurt myself	• Fell and have severe pain

Medication Management

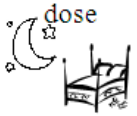


Medication Management



Medication Management

Medicine schedule for: _____

Medicine name, strength	Morning dose 	Noon dose 	Evening dose 	Bedtime dose 	As needed dose	Notes:

Schedule was last updated on _____ Page _____ of _____

Medication Management

MEDICATION NON-ADHERENCE – A Staff Education Tool

Purpose: To promote a comprehensive and standardized approach to evaluating the presence and possible underlying causes of medication non-adherence.
When general assessment findings suggest patient is not taking oral medications as prescribed, assess further.

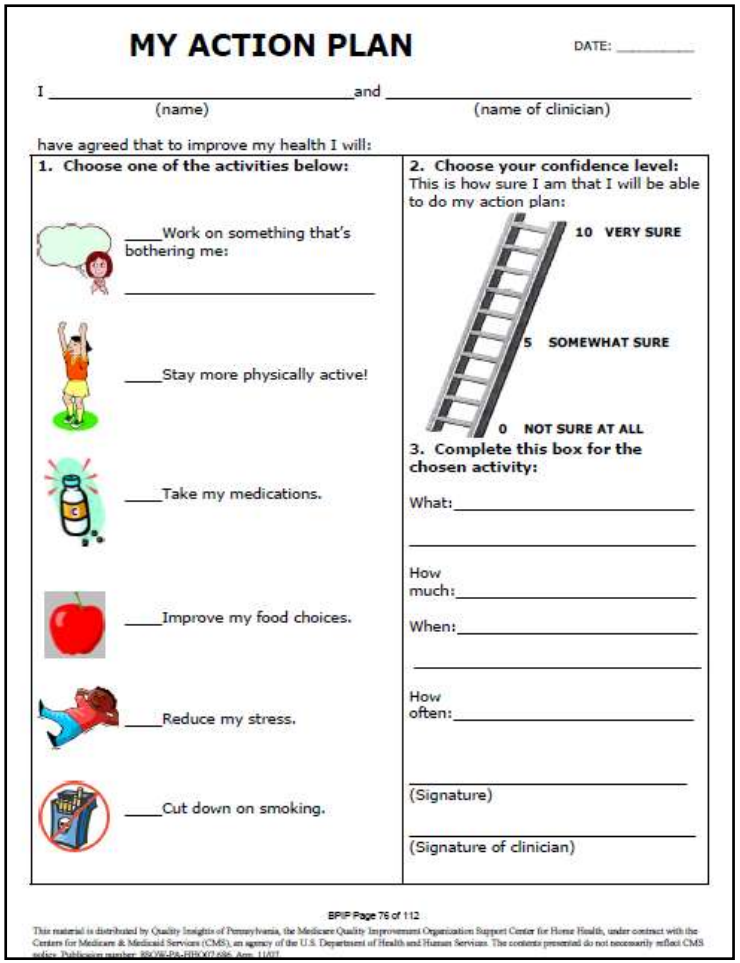
Potential Non-Adherence Issues	Assessment Strategies	Referral Triggers?
Knowledge Deficit 	Is there evidence to support/suggest that patient/caregiver does not understand medication regimen? • "I'm not having (symptom) anymore, so I'm not sure whether to keep taking this." • "That makes my stomach upset, so I try not to take it." • "I don't know when to take my meds or what dose to take."	RN
Illiteracy 	Is there evidence to support/suggest that patient's/caregiver's inability to read is affecting medication compliance? • Unable to read medication name, frequency, does, other instructions.	RN, SLP, OT
Financial Concerns* 	Is there evidence to support/suggest that patient is limiting medication use to save drug (i.e. to save money)? • "I take it when I really need it." • "I sometimes only take half the ordered amount."	RN, MSW
Fear of Addiction* 	Is there evidence to support/suggest that patient is limiting medication use due to concerns he or she will become addicted? • "I want to get off that stuff." • "I only take it when I can't stand it anymore."	RN, MSW
Drug Diversion or Over-Medicating* 	Is there evidence to support/suggest that patient is taking too much medication? • "I need a refill; the bottle spilled in the sink." • "Even doubling the prescribed amount does not touch the pain." (don not assume intentional over-medicating without evaluating for true ineffectiveness of current meds, need for adjuvant therapy, etc.	RN, MSW
Health Belief/Expectations 	Is there evidence to support/suggest that the patient's medication non-compliance may be due to general beliefs or expectations about health and illness? • "If he is meant to get better, it will happen." • "If I take the pills, it will show a lack of faith."	RN, MSW
Memory Deficits 	Is there evidence to support/suggest that the patient is forgetting to take medications, or forgetting that medications have already been taken-resulting in non-compliance? • "I usually take one after lunch, but my daughter called, and I can't remember if I took it." • Pills found in chair, on table by cup, etc. • Incorrect pill counts • Signs of ineffective drug therapy	RN, OT, SLP
Functional Deficits 	Is there evidence to support/suggest that patient/caregiver non-adherence is due to functional deficits? • Fine motor/gross motor/mobility • Vision • Swallowing	OT, SLP, PT
Disorganization 	Is there evidence to support/suggest that the patient's medication administration methods lack organization? • Bottles/pills in multiple locations • Unable to locate all medications • Reported administration methods vary from day to day (inconsistent) • Lack of established or predictable routines (sleep, meals, ADLs, etc.)	RN, OT, SLP, MSW

*May not affect patient's ability to take medications, therefore may not impact M2020. Referrals should be made based on patient need, state practice acts, and agency policy.

Medication Non-adherence (staff education tool) "Best Practices in Management of Oral Medications" OASIS ANSWERS, Inc. © 2005.

This material was modified from The Home Care Comprehensive Assessment and Drug Regimen Review: Competency Assessment & Training Program for Home Care Therapists and distributed by the West Virginia Medical Institute, the Quality Improvement Organization supporting the Home Health Quality Improvement National Campaign, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. Publication Number: 9SOW-WV-HH-BBK-031210. App. 03/10.

Patient Self-Management



MY ACTION PLAN

DATE: _____

I _____ and _____
(name) (name of clinician)

have agreed that to improve my health I will:

1. Choose one of the activities below:

____Work on something that's bothering me:
_____

____Stay more physically active!

____Take my medications.

____Improve my food choices.

____Reduce my stress.

____Cut down on smoking.

2. Choose your confidence level:
This is how sure I am that I will be able to do my action plan:

10 VERY SURE

5 SOMEWHAT SURE

0 NOT SURE AT ALL

3. Complete this box for the chosen activity:

What: _____

How much: _____

When: _____

How often: _____

_____
(Signature)

_____
(Signature of clinician)

BPIP Page 76 of 112

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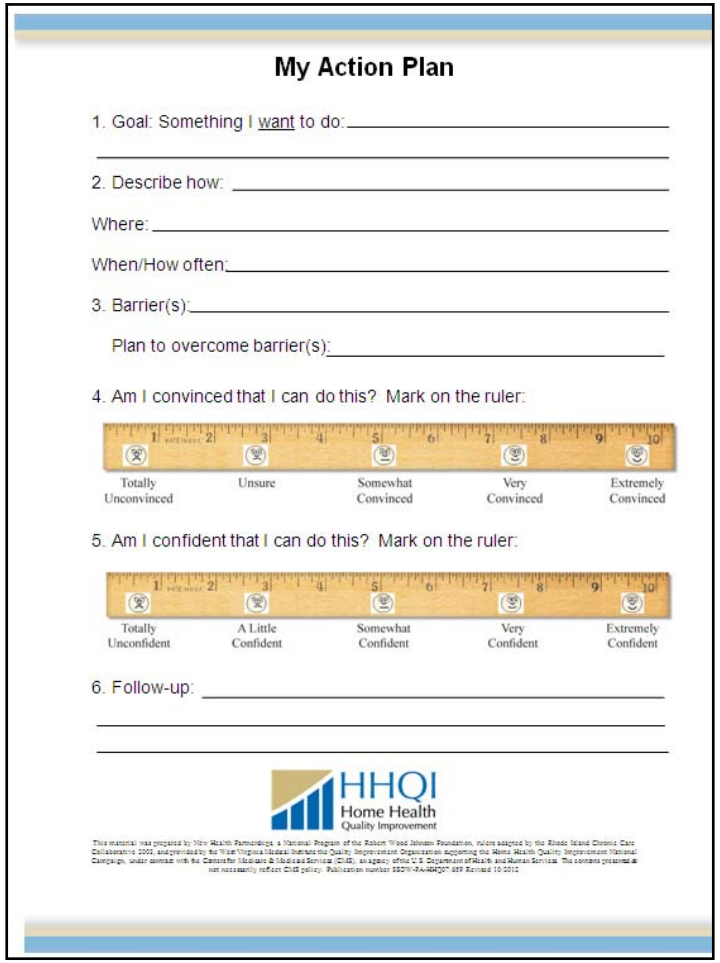


My Action Plan

1. Goal: Something I want to do: _____
_____

2. Describe how: _____

Where: _____

When/How often: _____

3. Barrier(s): _____

Plan to overcome barrier(s): _____

4. Am I convinced that I can do this? Mark on the ruler:

Totally Unconvinced | Unsure | Somewhat Convinced | Very Convinced | Extremely Convinced

5. Am I confident that I can do this? Mark on the ruler:

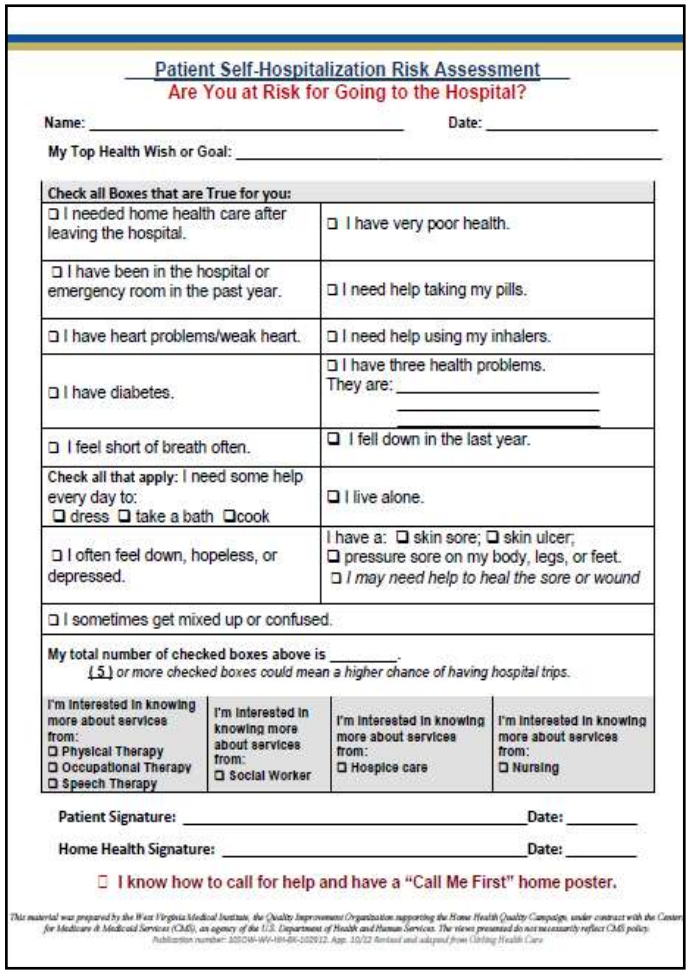
Totally Unconfident | A Little Confident | Somewhat Confident | Very Confident | Extremely Confident

6. Follow-up: _____
_____
_____

HHQI Home Health Quality Improvement

This material was prepared by New Health Partnerships, a National Program of the Robert Wood Johnson Foundation, tailors adapted by the Rhode Island Chronic Care Collaborative 2005, and provided by the West Virginia Medical Institute the Quality Improvement Organization supporting the Home Health Quality Improvement National Campaign, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. Publication number: SSCP6-PA-MMQO7-699 Revised 10/2012

Patient Self-Management



Patient Self-Hospitalization Risk Assessment

Are You at Risk for Going to the Hospital?

Name: _____ **Date:** _____

My Top Health Wish or Goal: _____

Check all Boxes that are True for you:	
❑ I needed home health care after leaving the hospital.	❑ I have very poor health.
❑ I have been in the hospital or emergency room in the past year.	❑ I need help taking my pills.
❑ I have heart problems/weak heart.	❑ I need help using my inhalers.
❑ I have diabetes.	❑ I have three health problems. They are: _____ _____ _____
❑ I feel short of breath often.	❑ I fell down in the last year.
Check all that apply: I need some help every day to: ❑ dress ❑ take a bath ❑cook	❑ I live alone.
❑ I often feel down, hopeless, or depressed.	I have a: ❑ skin sore; ❑ skin ulcer; ❑ pressure sore on my body, legs, or feet. ❑ *I may need help to heal the sore or wound*
❑ I sometimes get mixed up or confused.	

My total number of checked boxes above is _____.

{5} or more checked boxes could mean a higher chance of having hospital trips.

I'm interested in knowing more about services from: ❑ **Physical Therapy** ❑ **Occupational Therapy** ❑ **Speech Therapy**	**I'm interested in knowing more about services from:** ❑ **Social Worker**	**I'm interested in knowing more about services from:** ❑ **Hospice care**	**I'm interested in knowing more about services from:** ❑ **Nursing**

Patient Signature: _____ **Date:** _____

Home Health Signature: _____ **Date:** _____

❑ I know how to call for help and have a "Call Me First" home poster.

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Personal Health Record

To better manage my health and medications I will…

Take this Personal Health Record with me wherever I go, including all doctor visits, emergencies or hospitalizations.

Call my doctor or pharmacist if I have questions about my medications.

Tell my doctors and pharmacist about all medications I am taking, including over-the-counter drugs, vitamins and herbal formulas.

Know why I am taking each of my medications.

Know how much, when and for how long I am to take each medication.

Know possible medication side-effects to watch out for and what to do if I notice any.

Ask for help when I'm uncertain about my health care goals.

Keep this record up to date if anything changes.

Hospital Discharge List

- ☐ This is important information to know if I am hospitalized and I will complete this checklist before I leave the hospital.
- ☐ I have been involved in decisions about what will take place after I leave the hospital.
- ☐ My doctor, nurse or discharge planner has answered my most important questions prior to leaving the hospital.
- ☐ I understand where I am going after I leave and what will happen to me once I arrive.
  - Discharge home to self or family
  - Discharged home with a home health agency follow up
  - Discharged to another facility for rehabilitation
- ☐ My family or someone close to me knows that I am coming home.
- ☐ I have the name and phone number of a person I should contact if a problem arises.
- ☐ I understand what my medications are, how to get them, how to take them and possible side effects.
- ☐ I understand how to keep my health problems from becoming worse.
- ☐ I understand what symptoms I need to watch out for and whom to call if I should notice them.
- ☐ I have answers for how to get help at home when I need it.
- ☐ I have a scheduled follow up appointment with my doctor.

10

Doctor Appointments

Date	Doctor	Reason

Hospitalization Information

Date Admitted: _ / _ / _ Date Admitted: _ / _ / _

Hospital: _____

Reason: _____

Date Admitted: _ / _ / _ Date Admitted: _ / _ / _

Hospital: _____

Reason: _____

Date Admitted: _ / _ / _ Date Admitted: _ / _ / _

Hospital: _____

Reason: _____

Every time you talk with your doctor, use the **Ask Me 3** questions to better understand your health.

1. **What is my main problem?**
2. **What do I need to do?**
3. **Why is it important for me to do this?**

7

Things I need to Watch for

Warning signs that my _____ condition may be getting worse:

Warning Signs	What I need to do

4

Disease Management

CONGESTIVE HEART FAILURE ZONES for MANAGEMENT

Green Zone: All Clear

Your Admission Weight:_____

Your Goal weight:_____

- No shortness of breath
- No swelling
- No weight gain
- No chest pain
- No decrease in your ability to maintain your activity level

Green Zone Means:

- Your symptoms are under control
- Continue taking your medications as ordered
- Continue daily weights
- Follow low salt diet
- Keep all your physician appointments

Yellow Zone: Caution

If you have any of the following symptoms:

- **Increased weight (2-3 lbs. in one day or 4-5 lbs. in the past 5 days)**
- Increased cough
- Increased swelling of legs, feet and/or ankles

- Increased shortness of breath with activity
- Increase in the number of pillows needed
- Anything else that bothers you

Call your AGENCY NAME nurse **EARLY** in the day, or as soon as the symptoms occur.
You are in the YELLOW ZONE.

Yellow Zone Means:

- Your symptoms indicate you need an adjustment of your medications

AGENCY NAME
PHONE NUMBER

Red Zone: Medical Alert

- Unrelieved symptoms of shortness of breath, or shortness of breath at rest
- Unrelieved chest pain
- Wheezing or chest tightness at rest
- Need to sit in a chair to sleep
- Weight gain of more that 5 lbs.
- Confusion or mental status changes

** CALL YOUR PHYSICIAN IMMEDIATELY

Red Zone Means:

This indicates you need to be evaluated by a physician right away.

Physician:_____
Number:_____

AGENCY NAME
Diabetes Emergency Plan

Green Zone: Great Control

Your Goal HbA1C:

- HbA1c is under 7
- Average Blood Sugars typically under 150
- Most fasting blood sugars under 150

Green Zone Means:

- Your blood sugars are under control
- Continue taking your medications as ordered
- Continue routine blood glucose monitoring
- Follow healthy eating habits
- Keep all physician appointments

Yellow Zone: Caution

- HbA1c between 7 and 9
- Average blood sugar between 150 – 210
- Most fasting blood sugar under 200

Work closely with your health care team if you are going into the YELLOW zone.

Yellow Zone Means:

- Your blood sugar may indicate that you need an adjustment of your medication
- Improve your eating habits
- Increase your activity level

Call your nurse or doctor if changes in your activity level or eating habits do not decrease your fasting blood sugar levels
Name:_____
Number:_____

Red Zone: Stop and Think

- HbA1c greater than 9
- Average blood sugars are over 210
- Most fasting blood sugars are well over 200

Call your physician if you are going into the RED zone.

Red Zone Means:

You need to be evaluated by your physician. If you have a blood sugar over _____follow these instructions_____
_____

Call your physician
Name:_____
Number:_____

Disease Management

Self Management Plan for Heart Disease

Name:_____ Date:_____

Green Zone = "All Clear" • No shortness of breath • No swelling • No weight gain • No decrease in your ability to maintain normal activity level	**Green Zone Means:** • Your symptoms are under control • Continue taking your medications • Continue to follow your diet • Keep your Home Care Nurse appointments • Keep physician appointments
Yellow Zone = "Caution" If you have any of the following signs or symptoms: • Increased weight (2-3 lbs, in one day or 4-5 lbs in the past 5 days) • Increased cough • Increased swelling of legs, ankles and/or feet • Increased shortness of breath with activity • Chest Pain • Increased number of pillows needed to sleep or need to sleep in a chair • Anything else unusual that bothers you	**Yellow Zone Means:** • Your symptoms indicate that you may need an adjustment in your medications • Call your Home Health Nurse and/or your physician Agency Name 24 hour phone number is: Agency Phone Number Primary MD:_____ Phone Number:_____ *(Please notify your Home Care Nurse if you contact or go see your MD)*
Red Zone = "Medical Alert" • Unrelieved shortness of breath • Unrelieved chest pain • Wheezing or chest tightness at rest • Chest pain not relieved or reoccurs after taking _____ Nitro tablets • Mental changes	**Red Zone Means:** • This indicates that you need to be evaluated by a physician right away Primary MD:_____ Phone Number:_____ Agency Name 24 hour phone number is: Agency Phone Number *(Please notify your Home Care Nurse if you go to the emergency room or are hospitalized)*

Care Transitions

Cross-Settings I BPIP

- Different care transition's models
  - The Care Transitions Program®
  - Transitional Care Model© (TCM)
  - Better Outcomes for Older adults through Safe Transitions (BOOST)
  - Project Re-Engineered Discharge (Project RED)
  - IHI's Transitional Home
  - State Action on Avoidable Rehospitalizations(STARR)Initiative
- Care Transitions and Coaching is focus of this package

Medicare Beneficiary Discharge Planning REFERENCE LIST

Patient Choice	Section 4321(a) of the Balanced Budget Act of 1997 requires that Medicare participating hospitals, as part of the discharge planning process, share with each beneficiary a list of Medicare-certified home health agencies (HHAs) that serve the beneficiary's geographic area and which request to be listed. In addition, the statute prohibits hospitals from specifying that beneficiaries receive services from a particular HHA. Further, the statute requires that hospitals identify any HHA or other entity in which they have a disclosable financial interest or which have a financial interest in them. The intent of section 4321(a) is to protect patient choice. (*Federal Register* / Vol. 67, No. 226 / Friday, November 22, 2002 / Proposed Rules)
To qualify for Medicare Home Health Services	■ The patient is under the care of a physician (community physician willing to sign home care orders). ■ The patient requires skilled nursing, physical therapy, or speech therapy services; or has a continuing need for occupational therapy on an intermittent basis. (If daily, then there is an endpoint to daily care.) ■ Services are provided in the patient's home. ■ Services must be reasonable and necessary. ■ The patient is homebound.
Definition of homebound	Homebound means the condition of the patient causes an inability to leave home. When the patient does leave home, it requires a considerable and taxing effort. **Homebound Qualifiers:** ■ Absences from the home are infrequent or of short duration Examples of infrequent or short duration absences • Attendance at religious service • Attendance at a significant family event • Trip to barber or hairdresser • Walk outdoors ■ To receive health care treatment ■ To receive medical daycare services Considerable and taxing effort means the patient requires use of a supportive device (walker, cane, wheelchair), use of special transportation, or assistance of another person to leave their home; or leaving home is medically contraindicated.
Definition of reasonable and necessary	■ Skilled services are reasonable and necessary if there is a reasonable **potential** of a complication or further acute episode. ■ Skilled services are usually covered for a reasonable period of time (three weeks), or more as long as there remains a reasonable potential of a complication or further acute episode.
Willing, able, and available caregiver	Home health services are reimbursed regardless if there is someone available to furnish the services. Where there is a caregiver willing and able to provide the services that adequately meet the patient's needs, it would not be reasonable for the home health agency to provide the services. Ordinarily, it is presumed there is no able and willing person in the home, or no one is available to provide the services rendered by the home health agency.
Definition of skilled service	Skilled services encompass observation and assessment, teaching and training, performance of skilled treatments and procedures, or management and evaluation of the care plan. ■ There is a likelihood of a change in the patient's condition that may require a change in the patient's plan of care. ■ There is complexity of the patient's condition ■ Teaching includes evaluating the ability of the patient/caregiver to learn and to demonstrate/verbalize information taught by the clinician.

Source: *CMS Online Manual Medicare Benefit Policy Manual* Publication 100-2 Chapter Seven: Home Health Services (http://www.cms.hhs.gov/Manuals/IOM/list.asp)

Pfaadt, M., (2000). A Review of the Basics – Understanding the Categories of Skilled Nursing Services. *Home Healthcare Nurse,* 18 (5), 297

FIVE QUESTIONS TO ASK

1. Does the patient have Medicare?
2. Is the patient under the care of a physician?
3. Does the patient have a willing, able, and available caregiver?
4. Is the patient homebound?
5. Does the patient require a skilled service (nursing, physical or speech therapy)?

IF YES to all ,the patient qualifies for home care services under the Medicare benefit.

CONSIDERATION: Has the home care referral and plan been shared with the patient's caregiver? ☐ Yes ☐ No

This material was prepared by IPRO, the Medicare Quality Improvement Organization for New York State, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. 8SOW-NY-TSK1B-08-17

CRITICAL PATIENT INFORMATION

to include when transitioning patients between health care settings

- ☐ 1. Date and time of transfer
- ☐ 2. Patient name
- ☐ 3. Sex
- ☐ 4. Date of birth
- ☐ 5. Address
- ☐ 6. Insurance information, including documentation of payer authorization for transfer of care to the receiving healthcare provider and transportation payer
- ☐ 7. Medical diagnosis
- ☐ 8. Treatment provided with timeframes
- ☐ 9. Clinical condition
- ☐ 10. Medical summary that includes history and physical with update for discharge disposition, including influenza and pneumococcal immunization status
- ☐ 11. Recent reports of lab work, x-rays, EKG, and other relevant tests
- ☐ 12. Medications and treatments required by the patient (if applicable, include medications patient was administered on the day of discharge)
- ☐ 13. Prescriptions
- ☐ 14. DNR and/or Advance Directive information (health care proxy)
- ☐ 15. Physician's order for treatment
- ☐ 16. Relevant therapy notes (if applicable)
- ☐ 17. Psychosocial history/summary
- ☐ 18. Summary of nursing care needs
- ☐ 19. Physician order to transfer—signed, dated, and timed
- ☐ 20. Reason for discharge/transfer
- ☐ 21. Patient destination
- ☐ 22. Current discharge plans, including discharge arrangements
- ☐ 23. Patient/family agreement to discharge
- ☐ 24. Discharge PRI/SCREEN (if applicable)
- ☐ 25. List of personal effects, money, valuables (if transferring to another facility)
- ☐ 26. Any other required patient assessment documentation (MDS/OASIS/M11Q/M27R)
- ☐ 27. Sending and receiving facility transfer/discharge documents
- ☐ 28. Mode of transfer (transportation)
- ☐ 29. COBRA transfer form (if applicable)
- ☐ 30. Summary of patient education, assessment of learning and response to teach back provided during episode of care

Source: New York State Finger Lakes Region Community-Wide Transfer Agreement

This information is provided as guidance and should not be considered to be an all inclusive list of discharge planning options. Providers need to select and/or develop protocols that apply to their specific patient population and region.

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Discharge/Transfer Form

DISCHARGE CRITERIA

✔ CHECK ALL THAT APPLY

LOW RISK DISCHARGE

- ☐ Independent in ADL's
- ☐ Caregivers in the home and available to assist
- ☐ Lives alone with community support
- ☐ Independent with management of chronic disease/meds
- ☐ Adherent to treatment plan
- ☐ Able to direct medical care
- ☐ Consistently followed by MD/Practitioner

Discharge to Community

Refer to home care services (including patients who reside in Adult Home or Assisted Living Facility)

MODERATE RISK DISCHARGE

- ☐ Lives alone with limited community support
- ☐ Requires assistance with medications
- ☐ Issues of health literacy
- ☐ History of mental illness
- ☐ Polypharmacy (greater than 7 meds)
- ☐ Requires temporary assistance with IADL's and ADL's
- ☐ Requires assistance in:
  - Ambulating
  - Transferring
  - Wound Care
  - Management of oxygen and/or nebulizer

If ≥ 2 then refer to home health agency

Refer to home care services for:

Patient received services from home care prior to hospitalization?

☐ Yes ☐ No If Yes, name of agency:

Skilled Nursing

- *Observation and assessment*
- *Teaching and training*
- *Performance of skilled treatment or procedure*
- *Management and evaluation of a client care plan*

AND/OR

- *Physical, occupational and/or speech therapy*
- *Medical social work*
- *Home health aide service for personal care and/or therapeutic exercises*
- *Telehealth Care Management*

HIGH RISK DISCHARGE

- ☐ Lives alone with no community support
- ☐ Lives with family that is not actively involved in care
- ☐ Clinically complex (multiple co-morbidities, repeat hospitalizations or ED visits, needs considerable assistance to manage or is unable to manage medical needs independently)
- ☐ History of falls
- ☐ Acute/chronic wound or pressure ulcer
- ☐ Incontinent
- ☐ Cognitive impairment
- ☐ History of mental illness
- ☐ CHF and/or COPD and/or diabetes and/or HIV/AIDS
- ☐ End stage condition
- ☐ Requires considerable assistance in:
  - Transferring
  - Ambulating
  - Medication management (greater than 7 meds)
  - Management of oxygen and/or nebulizer

If ≥ 4 then refer to home health agency upon patient admission to hospital

THIS PATIENT IS HIGH RISK FOR REHOSPITALIZATION REFER TO HOME CARE SERVICES IMMEDIATELY

Other Outpatient Referrals

Services not provided by home care agencies: ☐ Outpatient mental health ☐ Medicaid/Public Assistance ☐ Social Security Office

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IPRO Experts in Defining and Improving the Quality of Health Care

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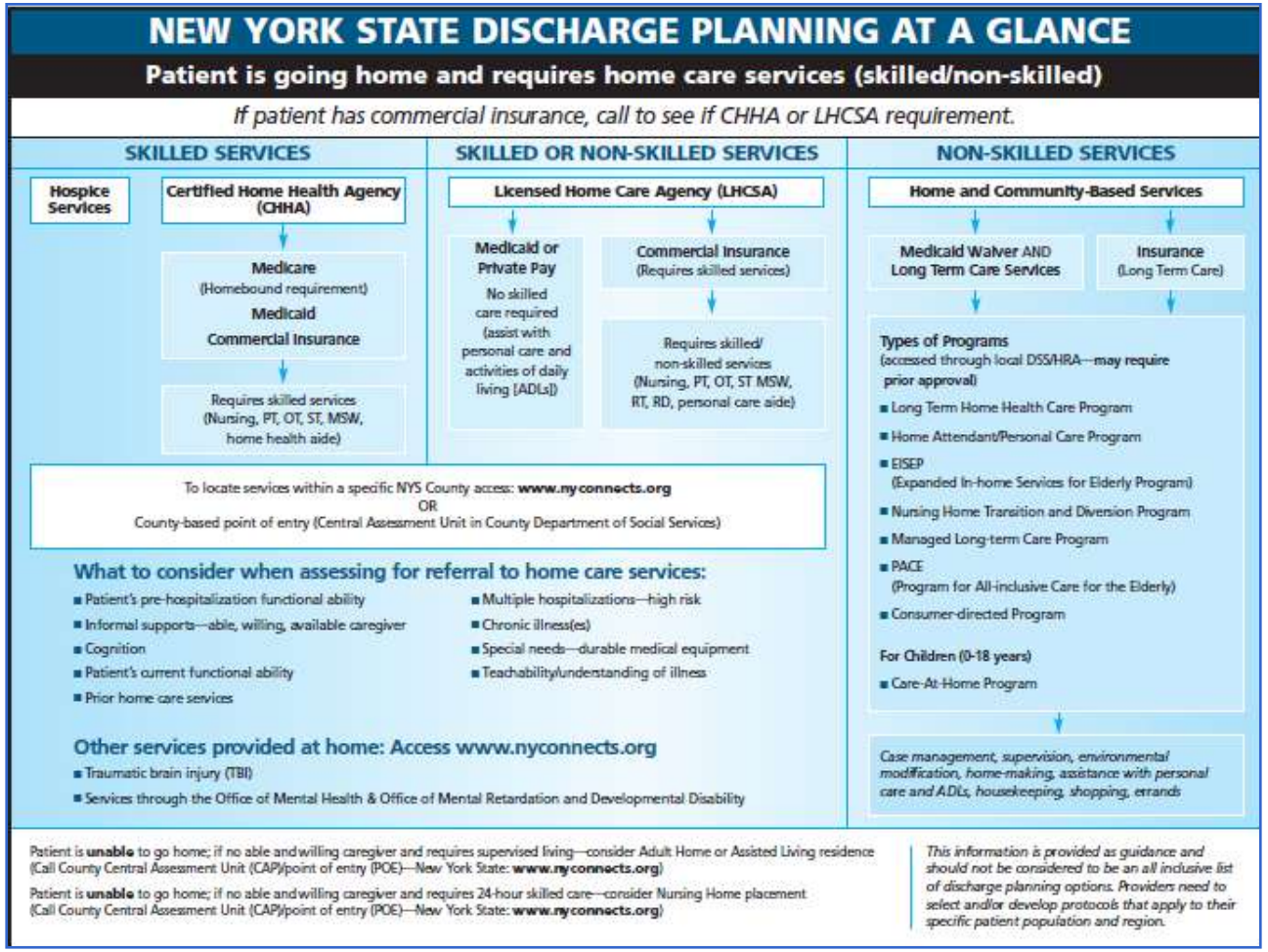
8SOW-NY-TSK1B-07-11

Discharge/Transfer Form



NEW YORK STATE DISCHARGE PLANNING AT A GLANCE

Patient is going home and requires home care services (skilled/non-skilled)

If patient has commercial insurance, call to see if CHHA or LHCSA requirement.

SKILLED SERVICES

Hospice Services

Certified Home Health Agency (CHHA)

Medicare
(Homebound requirement)
Medicaid
Commercial Insurance

Requires skilled services (Nursing, PT, OT, ST, MSW, home health aide)

SKILLED OR NON-SKILLED SERVICES

Licensed Home Care Agency (LHCSA)

Medicaid or Private Pay
No skilled care required (assist with personal care and activities of daily living [ADLs])

Commercial Insurance
(Requires skilled services)

Requires skilled/ non-skilled services (Nursing, PT, OT, ST MSW, RT, RD, personal care aide)

NON-SKILLED SERVICES

Home and Community-Based Services

Medicaid Waiver AND Long Term Care Services

Insurance
(Long Term Care)

Types of Programs
(accessed through local DSS/HRA—may require prior approval)

- Long Term Home Health Care Program
- Home Attendant/Personal Care Program
- EISEP
  (Expanded In-home Services for Elderly Program)
- Nursing Home Transition and Diversion Program
- Managed Long-term Care Program
- PACE
  (Program for All-inclusive Care for the Elderly)
- Consumer-directed Program

For Children (0-18 years)

- Care-At-Home Program

Case management, supervision, environmental modification, home-making, assistance with personal care and ADLs, housekeeping, shopping, errands

To locate services within a specific NYS County access: **www.nyconnects.org**
OR
County-based point of entry (Central Assessment Unit in County Department of Social Services)

What to consider when assessing for referral to home care services:

- Patient's pre-hospitalization functional ability
- Informal supports—able, willing, available caregiver
- Cognition
- Patient's current functional ability
- Prior home care services
- Multiple hospitalizations—high risk
- Chronic illness(es)
- Special needs—durable medical equipment
- Teachability/understanding of illness

Other services provided at home: Access www.nyconnects.org

- Traumatic brain injury (TBI)
- Services through the Office of Mental Health & Office of Mental Retardation and Developmental Disability

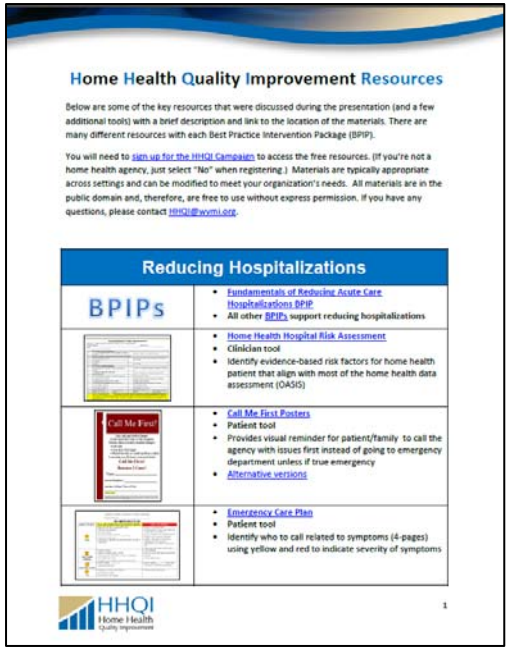
Patient is **unable** to go home; if no able and willing caregiver and requires supervised living—consider Adult Home or Assisted Living residence (Call County Central Assessment Unit (CAP)/point of entry (POE)—New York State: **www.nyconnects.org**)

Patient is **unable** to go home; if no able and willing caregiver and requires 24-hour skilled care—consider Nursing Home placement (Call County Central Assessment Unit (CAP)/point of entry (POE)—New York State: **www.nyconnects.org**)

This information is provided as guidance and should not be considered to be an all inclusive list of discharge planning options. Providers need to select and/or develop protocols that apply to their specific patient population and region.

Resource Handout

- Additional handout - PDF document of key resources your organization may want to use or modify
  - Many more tools and resources available - free



Home Health Quality Improvement Resources

Below are some of the key resources that were discussed during the presentation (and a few additional tools) with a brief description and link to the location of the materials. There are many different resources with each Best Practice Intervention Package (BPIP).

You will need to sign up for the HHQI Campaign to access the free resources. (If you're not a home health agency, just select "No" when registering.) Materials are typically appropriate across settings and can be modified to meet your organization's needs. All materials are in the public domain and, therefore, are free to use without express permission. If you have any questions, please contact HHQI@wvmi.org.

Reducing Hospitalizations	
BPIPs	• Fundamentals of Reducing Acute Care Hospitalizations BPIP • All other BPIPs support reducing hospitalizations
	• Home Health Hospital Risk Assessment • Clinician tool • Identify evidence-based risk factors for home health patient that align with most of the home health data assessment (OASIS)
	• Call Me First Posters • Patient tool • Provides visual reminder for patient/family to call the agency with issues first instead of going to emergency department unless if true emergency • Alternative versions
	• Emergency Care Plan • Patient tool • Identify who to call related to symptoms (4-pages) using yellow and red to indicate severity of symptoms

HHQI Home Health Quality Improvement

1

Cardiovascular Health Improvement Initiative

- Cardiovascular Health Educational Resources
  - Part 1: Aspirin as appropriate & Blood pressure control
  - Part 2: Cholesterol management & Smoking cessation
- Home Health Cardiac Council
- Cardiovascular Risk Report
- Cardiovascular Data Registry

HHQI
Home Health
Quality Improvement

Additional HHQI Resources

- Webinars including UP Networking 
- LiveChat 

- Discussion Forums 
- MyHHQI Blog 
- Social Networking 

Questions?

Thank You!

mkevech@wvmi.org

www.HomeHealthQuality.org

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