



EDUCATIONAL RESOURCES

REDUCING EMERGENT CARE & ACUTE HOSPITALIZATIONS FOR HOME HEALTH PATIENTS

Presented by:

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OBJECTIVES

- Understand CoP requirements for Coordination of Care
- Review steps involved in effective discharge planning
- Learn how to identify patients at high-risk for ER or hospitalization
- Discuss prevention of unplanned hospital care



EDUCATIONAL RESOURCES

DISCHARGE PLANNING

- Learn CoP Requirements, Coordination of Care

DISCHARGE PLANNING



CONDITION OF PARTICIPATION REGULATION

484.60 – Care Planning, Coordination of Services, Quality Care Standard – (c) Review and Revision of the Plan of Care

- G598 – Interpretive Guidelines 484.60(c)(3)(ii)
- Discharge planning begins early in the provision of care and must be revised as the patient's condition or life circumstances change. There must be evidence in the clinical record that the HHA discussed any such changes with the patient, his or her representative (if any) and the responsible physician. Other physicians who contributed orders to the patient's plan of care must also be notified of changes to the patient's discharge plan.

INITIAL ASSESSMENT VISIT

- Explain the primary goal of services
- Discuss an anticipated discharge date
 - This is NOT the 60-day episode
- During assessment:
 - Evaluate what other disciplines are required in order to meet the needs and goals of the patient
- The full team must then Plan the Episode- identify Goals and Outcomes which lead to Discharge.

ONE CLINICIAN CONVENTION

- Comprehensive assessment will continue to be the responsibility of one clinician as required by the CoPs but.....
 - *Allows the assessing clinician to get feedback from other agency staff to complete any or all OASIS items*
- M0090 – Date assessment completed may need changed
 - The last day the assessing clinician gathered or received any input to complete the comprehensive assessment document

References: Chapter 1 in the OASIS-D Guidance Manual

Website: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/Downloads/OASIS-D-Guidance-Manual-final.pdf>

PLAN OF CARE & PROJECTING THE EPISODE

- The team projects number of visits per week and schedules as a team
 - Spread out visits
 - Be each other's eyes and ears - report issues to each other
- Front load visits
 - Increase frequency for all disciplines at beginning of care
 - Then decrease plan as episode progresses and patient works towards the goals set by the team

COMMUNICATION

- Identify what should be communicated
 - Important to avoid lengthy and/or detailed communication
 - Coordination of care communication needs to be pertinent information between the entire team
- Identify methods and how often:
 - Electronic,
 - Voicemail, and/or
 - Face to face
- All coordination of care must be documented in the medical record

COMMUNICATION

- Sub-contracted disciplines
 - Agency 'owns' the patient and is responsible for coordination of care
 - Hold sub-contractors accountable
 - Set up processes and meet
 - Sub-contractors must interact with the team as if they were your employee

DISCHARGE

- A formal case conference is advised at least monthly to plan for the upcoming month
 - Each Team meets and discusses their shared patient case load.
- Patients with ending episodes approaching in 2 – 3 weeks should be discussed as a team
 - A team decision should be made to:
 - Discharge from care,
 - Discharge from a discipline, or
 - Recertify
- Always case conference before a discipline discharges, formally or informally

DISCHARGE OR RECERTIFICATION

- Whether to discharge or to recertify is not an easy decision in many cases, and the decision should not be made by one person; this needs to be the team's decision in order to assure that goal driven care is provided.
- While discussing the need to discharge or recert, it may become clear that one discipline should discharge, while another needs to recertify.
- Be sure there is skilled need when decision is made to recertify.

DISCHARGE

- For Planned discharge
 - Ensure discharge planning has taken place and that it is documented
 - Ask the question – Is the patient/caregiver, if any prepared for post home health?
 - Preparation should include that Patient/ Caregiver are:
 - Aware of next scheduled MD visit
 - Able to recognize worsening symptoms and state a plan for accessing urgent care services
 - Understand medication management, refills, and how and where they will get their medications

DISCHARGE

- When discharging the patient, again ensure that the comprehensive OASIS assessment is done in a thorough and objective manner, using the same approaches at admission and throughout care
- Collaborate with the team
- Watch the patient perform the tasks , assessment items and explain the medications, etc.
- The results of your patient's outcomes and of your agency's outcome measurements and 5 Star Rating depend on this consistency



EDUCATIONAL RESOURCES

PREVENTING UNPLANNED HOSPITAL CARE

PREVENTING UNPLANNED HOSPITAL CARE

- Acute Care Hospitalization during the first 60 days
- Emergency Department use w/o hospitalization during the first 60 days
- Discharged to Community

PREVENTING UNPLANNED HOSPITAL CARE

Common Goals:

- Keep the Home care patient in the home and/or community during the episode and at discharge
- What do we do to impact change in our outcomes?
 - Care Management Model as discussed above
 - Continuity of Care
 - Team Goals to improve patient outcomes
 - Be each other's Eyes & Ears
 - Excellent Communication between team, patient/cg and physician

IDENTIFYING PATIENTS AT HIGH RISK FOR ER OR HOSPITALIZATION

- On Admission, perform a Risk Assessment
 - Past frequent ER visits and hospital admissions
 - “Frequent flyer” to home health
 - Non-compliance
 - Socioeconomic and/or Psychosocial factors
 - Share with Care Team prior to their initial visits

IDENTIFYING PATIENTS AT HIGH RISK FOR ER OR HOSPITALIZATION

- **Plan- Individualize per patient**

- Front load visits by scheduling visits on alternating days so patient is seen by someone most days following the SOC for the first 7-14 days
 - Frequent ER or Hospitalization in these first 2 weeks
- Be each other's eyes and ears – COMMUNICATE to each other!
- Communicate with On Call staff on high-risk patient with pertinent data

ON CALL

- Assess your On Call process to ensure staffing is adequate for coverage, skill level.
- Ensure escalation process is appropriate, i.e., when is supervisor notified to discuss if visit should be made.
- Develop scenarios and scripts per disease process and/or procedures.
- Provide additional training to On-Call staff:
 - Regarding new On Call procedures and process
 - Goal that the On Call staff must understand is to avoid ER visits and Hospitalizations

Audit ALL ER visits and hospitalizations that are after hours!

PHYSICIAN NOTIFICATION – EARLY & TIMELY!

- With First changes in patient
 - All disciplines!
 - Communicate in Real Time to appropriate members of the patient's care team, and then appropriate clinician contacts physician promptly.

Examples:

- Is patient more fatigued when OT is working with them?
- Did patient cough frequently with aide?
- Is BP up when PTA with patient?
- Is there more pain not relieved appropriately with current pain meds?
- Any new or worsening symptoms!

PHYSICIAN NOTIFICATION – EARLY & TIMELY!

- With First changes in patient
 - All disciplines!
 - Often when clinical record reviews are done after an ER visit or hospitalization, these types of issues are documented...often with NO coordination with the other disciplines and NO Physician Notification!
 - This alone can prevent ER visits and Hospitalizations!

COMMUNICATION WITH PATIENT BETWEEN VISITS

- Telehealth & Patient/Caregiver communication to agency
- Telehealth is very important to:
 - Continue with patient compliance
 - Determine if there are any changes in patient
 - Maintain a good rapport with your patient and family
 - Identify risks!
- **This is an excellent method to prevent ER visits and hospitalization!**

COMMUNICATION WITH PATIENT BETWEEN VISITS

Telehealth Methods:

Can be remote patient monitoring, other telecommunications technology, or audio-only technology.

- Frequent Telephone Calls – in between visit days, including evening and weekends for high-risk patients
 - Have a script individualized for patients (by risk and/or disease).
 - Patient / Family Communication to Agency
 - Tell patient **EVERY VISIT** to call the HHA before going to the ER unless emergencies!
 - Again, explain to them what types of things to call HHA for, even minor changes that you have discussed with them. Ex: A CHF patient notes increased edema in feet and ankles.
 - Also inform them to contact HHA right away after ER visit, or if hospitalized.

COMMUNICATION WITH PATIENT BETWEEN VISITS

Telehealth Methods:

Can be remote patient monitoring, other telecommunications technology, or audio-only technology.

- **Telehealth Units** - customize peripherals to pt risk and/or disease
- **Video Conferencing** - many agencies planning to use Skype/other video technology “to speak with patients”
 - For high-risk patients, should consider this!
 - Great for wounds, CHF, COPD, CVA, post-surgery, etc.
 - Ensure HIPAA compliance beyond the PHE

COMMUNICATION WITH PATIENT BETWEEN VISITS

- Telehealth & patient/caregiver communication to agency
- Home Health CY 2021 Final Rule
- Any provision of remote patient monitoring or other services furnished via a telecommunications system or audio-only technology must be:
 - Included on the plan of care
 - Tied to the patient-specific needs as identified in the comprehensive assessment
 - Clinician must document in the patient's medical record information of how telehealth services will help to achieve the goals outlined on the plan of care

COMMUNICATION WITH PATIENT BETWEEN VISITS

- Telehealth & patient/caregiver communication to agency
- Home Health CY 2021 Final Rule
- Services furnished via remote patient monitoring, other telecommunications technology, or audio-only technology cannot be considered a home visit for the purposes of eligibility or payment, however, use of this technology can improve patient outcomes, including ER use and Acute Care Hospitalizations!

UTILIZATION OF SERVICES

- **Proper utilization of services can increase patient outcomes in many areas and keep patient out of ER & Hospital**
- Is OT in appropriately? – Great discipline to help increase outcomes!
- MSW if any issues identified by the team – Valuable discipline to have involved on any high-risk patients! Plan dc to community when able with resources to keep patient at home.
- Aide - low usage today! Aides can be with your patients more frequently for a longer time and be able to “SEE” important issues! Be sure the aide communicates ALL to supervisor (RN on team and after COPs, can be therapist!)

UTILIZATION OF SERVICES

- **Watch Frequencies!** 1w9w won't keep your patients out of the ER and hospital!
 - After frontloading first 2 weeks, wean down → *Example: 3w2w, 2w2w, 1w5w.*
 - *ALL Disciplines can Front Load! Shows Pt Improvement and progress to goals!*

PATIENT EDUCATION

- On Call Services → 24/7 call HHA Before going to ER (unless Emergency)
- Medication Management → Ongoing & In Depth
 - Are all disciplines paying attention to patient's compliance to meds?
 - Are clinicians teaching the patients Every Visit?
 - Are medications not relieving issues reported to the physician
- Disease Management → Specific teaching plan for visits for all of the Care Team
 - In order to coordinate the teaching together have a greater impact on outcomes

PATIENT EDUCATION

- Potentially avoidable events → Specific, frequent education.
 - ER for Falls with injury, hypo/hyperglycemia, wounds, medications
- Patient education tools → Discuss frequently, not just at admission!
- Leave patients detailed tools that are easily accessed → be creative!
 - Flyers, magnets, magazines related to disease
- Telehealth is not for emergency use.

AGENCY ACTION PLAN FOR HIGH-RISK PATIENTS

- **Care Team to take action from results of patient education**
 - Communicate within team – come up with a revised plan as needed
- **Scheduling** – Care team schedules with schedules / management oversight
 - To avoid long weekend gap and see patients frequently:
 - Staff more patient visits on Mondays
 - Have weekend staff – all disciplines - doing routine visits and/or phone calls

M2420 – DISCHARGE DISPOSITION

- Where is the patient going after discharge from your agency?
 - Patient remained in community (without formal assistance)
 - Patient remained in community (with formal assistance)
 - Patient transferred to non-institutional hospice
 - Unknown-patient moved to geographic area not serviced by HHA
 - Other unknown

M2420 – DISCHARGE DISPOSITION

- If the agency can identify that they have a high rate of hospital admissions that are avoidable, it will help improve this, depending on when the admission occurs.
- This measure looks at # of episodes where the DC indicates DC to community (numerator) over the # of episodes where the number of episodes end in a DC to inpatient facility (denominator)

Example: If your HHA has 35 DC to community and 7 Inpatient facility admissions, then you are sending 5 x more pts to community than to the hospital.

ER VISIT WITHOUT HOSPITALIZATION - BEST PRACTICE

- Have a nursing visit prior to an ER visit, when you know of a change in patient.
- Note: If patient goes to ER and isn't hospitalized, that may indicate that homecare could have prevented the ER visit!
- Audit all ER visits without hospitalization in Real Time to ascertain if agency could have done something that may have prevented this:
 - Physician Notification
 - Additional Visit from telehealth
 - Increased medication education
 - Education re contacting HHA prior to going to ER unless emergency
 - Care team not reporting signs and symptoms to each other



EDUCATIONAL RESOURCES

QUALITY MEASURES

Preventing Unplanned Hospital Care

UNPLANNED HOSPITAL CARE – OASIS ITEMS

- M2301 – Emergent Care – LOOK BACK ITEM
 - 0 – No
 - 1 – Yes, used hospital emergency department WITHOUT hospital admission
 - 2 – YES, used hospital emergency department WITH hospital admission
 - UK - Unknown
- At the time of or at any time since the most recent SOC/ROC assessment has the patient utilized a hospital emergency department (includes holding and observation only in the hospital ER dept)?
- Item excludes urgent care services not provided in a hospital ER, including care provided at a doctor's office, by an ambulance crew, or care received in an urgent care facility.
- Used in calculation for the iQIES Potentially Avoidable Event (PAE) report

UNPLANNED HOSPITAL CARE – OASIS ITEMS

- M2310 – Emergent Care: For what reason(s) did the patient seek and/or receive emergent care (with or without hospitalization)?
 - 1. - Improper medications
 - 10. - Hypo/Hyperglycemia
 - 19. - Other than above reasons
 - UK – Reason unknown
- Item excludes urgent care services not provided in a hospital ER, including care provided at a doctor's office, by an ambulance crew, or care received in an urgent care facility.
- Used in calculation for the iQIES Potentially Avoidable Event (PAE) report

IQIES REPORT – OUTCOME REPORT – CLAIMS-BASED OUTCOMES (RISK ADJUSTED)

- Claims based outcomes on iQIES Reports
(Based on Medicare FFS Claims, not OASIS)
 - Acute Care Hospitalization During the First 60 Days of Home Health
 - Emergency Department w/o Hospitalization During the First 60 Days of Home Health
 - Potentially Preventable 30-day Post-Discharge Readmission
 - Discharge to Community

POTENTIALLY PREVENTABLE 30-DAY POST-DISCHARGE READMISSION MEASURE

- The potentially preventable readmission (PPR) measure estimates the risk-standardized rate of unplanned, potentially preventable readmissions for patients (Medicare FFS beneficiaries) who receive services in a home health agency (HHA).
- This outcome measure reflects readmission rates for patients who are readmitted to a short-stay acute-care hospital or an LTCH with a principal diagnosis considered to be unplanned and potentially preventable.
- This measure assesses PPR **within a 30-day window beginning 2 days after discharge** from HHA for patients who had an acute inpatient discharge within the 30 days before the start of their home health stay.

POTENTIALLY PREVENTABLE 30-DAY POST-DISCHARGE READMISSION MEASURE

- It was developed to meet the resource use and other measures domain as mandated by the IMPACT Act.
- The measure calculates a risk-adjusted PPR rate for a HHA.
- For this PPR measure, readmissions that are usually for planned procedures are not counted as being potentially preventable.

DISCHARGE TO COMMUNITY MEASURE

- This claims-based outcome measure assesses successful discharge to the community from a PAC setting, with successful discharge to the community including no unplanned re-hospitalizations, to an acute care hospital or LTCH, and no death in the 31 days following discharge.
- This measure was developed to address the resource use and other measures domain as mandated by the IMPACT Act.

References: Home Health Quality Reporting Program Measure Calculations and Reporting User's Manual

Website: <https://www.cms.gov/files/document/hh-qrp-qm-users-manual-v1-addendum.pdf>

PREVENTING UNPLANNED HOSPITAL CARE & ER UTILIZATION

- Physician notification – early and timely!
- Case Management
 - Report to each other frequently and document it in a user-friendly location
 - Don't wait for a scheduled case conference to communicate issues
 - Stagger visits throughout the week in order to visit patient more often
 - Consider frontloading visits

PREVENTING UNPLANNED HOSPITAL CARE & ER UTILIZATION

- Telehealth
 - Communication with patient between visits
 - More than just a phone call to say, “How are you doing?”
 - Document visit note regarding telehealth contact
 - Agency should develop standardized telehealth processes and documentation guidelines
 - Education on when to notify home care

PREVENTING UNPLANNED HOSPITAL CARE & ER UTILIZATION

- Proper utilization of services
- In-depth medication reconciliation
- Know your patient's health history and level of compliance
- Continuity of care
- If poor outcomes, consider a QAPI indicator for either or both!

EXAMPLE: QUALITY INDICATOR REASONS FOR EMERGENT CARE

- Potentially Avoidable Event Report:
 - Improper medications – 2.05% current / 0 prior / 0.78% national
 - Hypo/Hyperglycemia – 2.08% current / 5.68% prior / 1.50% national
 - Other– 3.01% current / 1.44% prior / 3.78% national
- Indicator:
 - QI coordinator or designee will review 100% of patient OASIS - reason for emergent care quarterly.

EXAMPLE: QUALITY INDICATOR REASONS FOR EMERGENT CARE

- If 'improper medications' or 'hypo-hyperglycemia' are the reason for emergent care, then a clinical record review will be completed to identify if the agency could have done anything to prevent these occurrences.
 - Goal:
 - Improper medications- 0.80%
 - Hypo/Hyperglycemia – 1.50%

IMPROPER MEDICATIONS

Criteria: ER - Improper Medications

Patient

Patient

Patient

Not scored – Is the patient taking any medications?

M2001 Drug regimen review: If problem found was the correct score completed? If no, was a problem seen in documentation but was not stated?

M2003 Medication Follow-up: If answered, did score correlate with documentation of physician notification?

M2010 Patient/Caregiver High-Risk Drug Education: If patient taking high risk drugs, was the item scored 1-Yes? If not, does documentation support score?

M2020 Management of Oral Medications: Was item scored correctly based on documentation? If patient needed assistance, did documentation include if caregiver was available to assist?

M2030 Management of Injectable Medications: Was item scored correctly based on documentation? If patient needed assistance, did documentation include if caregiver was available to assist?

Was physician notified for all medication issues?

Was medication education documented?

Not scored – did the patient/caregiver contact the HHA prior to going to the ER?

If yes, did the nurse call the physician and/or make a visit?

Was there anything the HHA could have done to prevent emergent care for medication reasons?

Total per Patient

Total Compliance

HYPO/HYPERGLYCEMIA

Criteria: ER – Hypo/Hyperglycemia

	Patient	Patient	Patient
Did patient experience emergent care for Hypo/Hyperglycemia?			
Did patient experience hospitalization for Hypo/Hyperglycemia?			
Did Plan of Care include blood glucose parameters ?			
If patient blood glucose readings were outside of parameters, was physician notified?			
Were endocrine assessments complete and thorough including blood sugar readings?			
Was diabetic education documented?			
Was understanding of education by patient/caregiver documented?			
Not scored – did the patient/caregiver contact the HHA prior to going to the ER?			
If yes, did the nurse call the physician and/or make a visit?			
Was there anything the HHA could have done to prevent emergent care for hypo/hyperglycemia?			
	Total per Patient		
	Total Compliance		

CONCLUSION

- **Review**
 - iQIES Outcome Reports (CASPER)
 - Care Compare (Home Health Compare) / Star Ratings
- **Identify Areas of Improvement**
 - Do something with the information
- **Educate ALL staff**
 - Outcomes
 - OASIS
- **Case Management is Crucial**
- **Work Together as a Team!**



EDUCATIONAL RESOURCES

QUESTIONS?



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THANK YOU!

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