Case Management in a VBP World

KHCHA, November 29, 2023

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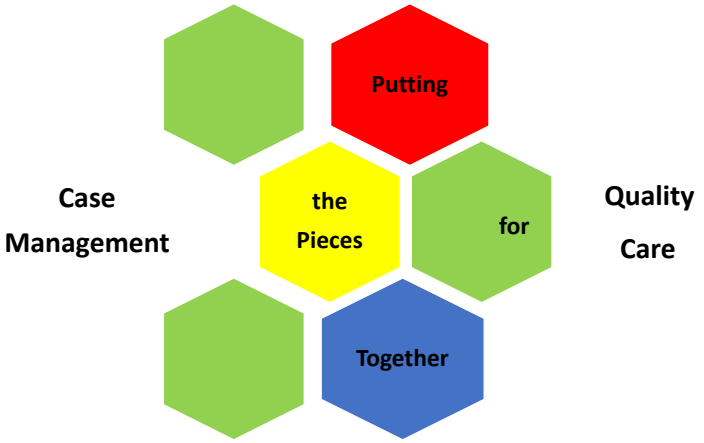
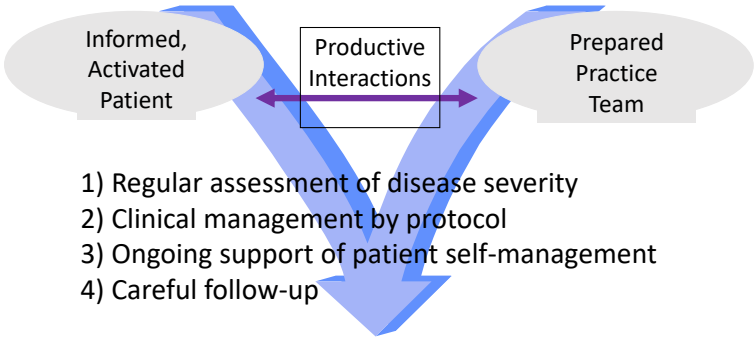


What does it take to change health status in chronic disease?



1) Regular assessment of disease severity
2) Clinical management by protocol
3) Ongoing support of patient self-management
4) Careful follow-up

Healthier more satisfied patients, higher quality care, cost savings

Research Shows

- 80 percent of patients will forget what their providers say.
- Almost 50 percent of what patients remember is recalled incorrectly.
- Health literacy costs health care systems as much as $58 billion/year.
- 33 percent of patients are unable to read basic health care material.
- 42 percent of patients do not understand directions for taking medications on an empty stomach.
- In 2017, over 5 million people said they had delayed medical appointments as a result of inaccessibility to suitable means of transportation.

What is Case Management?

How will Home Health Value-Based Purchasing affect HH Case Management?

Case Management is NOT…

- Completing clinical tasks
- Supervising a homecare aide or therapy assistant
- Writing up a case conference note
- Inconsistent interventions and information documented by various clinicians and agency staff
- Repetitive generic language in documentation that isn't specific to patient's needs/situation

Case Management IS…

- Communication with patient, caregivers, nurses, therapists, aides, other providers
- Identifying and solving problems
- Progress toward goals, outcome improvement
- Organization, prioritization, time management
- Coordination of care between disciplines, with community services
- Meeting regulatory requirements
- Considering reimbursement impact
- Patient advocacy

Definition

- An interdisciplinary team working together towards collaborative goals and coordinating patient care in a proactive manner.
- *So…identify the problems that are most important to the patient's health and safety, then establish and implement a plan of care for coordinated multidisciplinary actions to address and resolve those problems to the satisfaction of the patient, caregiver/family, and physician.*
- *Ultimate goal: patient able to manage self care*

Home Health Value-Based Purchasing Timeline

- Baseline year: 2022, for 2023 and 2024 performance years
- First performance year: 2023
- First Payment year: 2025
- HHVBP may increase or decrease your overall traditional Medicare payments by up to 5% in the payment year
- Agencies will be placed in a large or small cohort group
- CMS will allow payments to be determined in one of two ways:
  - Achievement- meeting a threshold for quality scores compared to other agencies in the cohort
  - Improvement- showing agency gains in HHVBP quality scores compared to the baseline year

OASIS-Based VBP Measures for 2023-2024

Domain	Title	Type	Source	Numerator	Denominator
Clinical Quality	**Improvement in Dyspnea** Weight = 5.83%	Outcome	M1400	Number of HH episodes of care where discharge assessment shows less dyspnea at DC than SOC/ROC	Number of HH episodes ending with DC in the period (with exclusions)
Communication and Care Coordination	**Discharge to the Community** Weight = 5.83%	Outcome	M2420	Number of HH episodes where DC assessment showed pt remained in the community	Number of HH episodes ending with DC or TRF to i/p facility in the period (with exclusions)
Patient Safety	**Improvement in Mgt of Oral Medications** Weight = 5.83%	Outcome	M2020	Number…where pt showed less impairment at DC than SOC	Number of episodes ending with DC in the period (w/excl)

OASIS-Based VBP Composite Measures for 2023-2024

Domain	Title	Type	Source	Numerator	Denominator
Patient and Family Engagement	**Composite Change in Mobility** Weight = 8.75%	Outcome (Composite Score)	M1840 M1850 M1860	Total normalized change in mobility functioning across 3 items	Prediction model is computed at episode level. Based on a risk adjusted rate for the agency
Patient and Family Engagement	**Composite Change in Self Care** Weight = 8.75%	Outcome (Composite Score)	M1800 M1810 M1820 M1830 M1845 M1870	Total normalized change in self care functioning across 6 items	Prediction model is computed at episode level. Based on a risk adjusted rate for the agency

Claims-based Measures: 2023-2024

Domain	Title	Type	Source	Numerator	Denominator
Efficiency and Cost Reduction	**Acute Care Hospitalization – during first 60 days of HH care** Weight = 26.25%	Outcome	CCW Claims	Number of stays for patients who have a Medicare claim for an unplanned admission to an ACH in the 60 days following the SOC	Number of stays beginning during the 12 month observation period. Stay is a sequence of payment periods separated from other payment periods by at least 60 days
Efficiency and Cost Reduction	**ED Use without ACH – during first 60 days of HH care** Weight = 8.75%	Outcome	CCW Claims	Number of stays for patients who have a Medicare claim for outpt ED use & no ACH claim in the 60 days following the SOC	Same as above

The HH-CAHPS Measures

Measure Title	Description	Questions	Positive Credit
Professional Care Composite	How often HHA team gave care in a professional way	9, 16, 19, 24	9, 16, 19: % “Always” 24: % responding “No”
Communication Composite	How well did HHA team communicate with patients	2, 22 15, 17. 18 23	2, 22: % “yes” 15, 17, 18 : % “always” 23: % “same day”
Discussion of Care Composite	Did the HHA team discuss medicines, pain and home safety with patients	3, 4, 5, 10. 11. 12. 13	All: % “yes”
Overall Care	How do patients rate overall care from the HHA?	20: overall rating of care from 0-10 scale	% responding 9 or 10
Likely to Recommend	Would patients recommend HHA to friends and family?	25: likelihood to recommend the agency	% responding “definitely yes”

Weighted Scoring for TPS 2023-2024

Measure Category and TPS Weight	Quality Measures Within Category	Weight in Category
OASIS= 35% Total Performance	TNC Self Care	25%
	TNC Mobility	25%
	Dyspnea	16.67%
	Discharged to Community	16.67%
	Oral Medications	16.67%
CLAIMS= 35% Total Performance	Acute Care Admission	75%
	Emergency Department Use	25%
HHCAHPS= 30% Total Performance	Professional Care	20%
	Communication	20%
	Team Discussion	20%
	Overall Rating	20%
	Willingness to Recommend	20%

HH VBP Program Adjustments

- The first performance year is 2023, with baseline year of 2022 for 2023 and 2024. Starting for performance year 2025, the baseline year will change from 2022 to 2023.
- Five measure sets are removed from the 2025 performance year
- Three measure sets are added to the 2025 performance year
- OASIS-based and Claims-based measures will have weight adjustments applied for performance year 2025

Five Measures to be Retired

- Total Normalized Composite (TNC) Measure for Self-Care
- Total Normalized Composite (tNC) Measure for Mobility
- OASIS-based Discharge to Community Measure
- Claims-based Acute Care Hospitalization During the First 60 Days of Home Health Use Measure
- Emergency Department Use without Hospitalization During the First 60 Days of Home Health Measure
- All will be retired effective January 1, 2025 and replaced with new measures

Three Measures to be Added

- Discharge Function Score measure (OASIS-based)
- Claims-based Discharge to Community Post-Acute Care Measure (DTC-PAC)
- Claims-based Potentially Preventable Hospitalization (PPH) within Home Health Stay Measure

Discharge Function Measure

Numerator: number of home health episodes with an observed discharge function score that is equal to or higher than the calculated ***expected discharge function score***

Denominator: number of home health episodes of care ending with a discharge during the reporting period, other than those covered by generic or measure-specific exclusions

OASIS items GG0130 and GG0170

Beginning with patients discharged between April 1, 2023 and March 31, 2024 for CY 2025 HH QRP. Reported on Care Compare beginning Jan. 1, 2025

OASIS Items for DC Function Measure

- GG0130A
- GG0130B
- GG0130C
- GG0170A
- GG0170C
- GG0170D
- GG0170E
- GG0170F
- GG0170I
- GG0170J
- GG0170R

- Eating
- Oral hygiene
- Toileting hygiene
- Roll left and right
- Lying to sitting on side of bed
- Sit to stand
- Chair/bed-to-chair transfer
- Toilet transfer
- Walk 10 feet
- Walk 50 ft with 2 turns
- Wheel 50 ft with 2 turns

What is the expected discharge function score?

- This measure considers the self-care and mobility activities in GG0130 and GG0170
  - This measure does not compare the DC response to the SOC/ROC response
- Missing data (responses 88, 09, 10 and dashed items) will be accounted for by using statistical imputation to recode missing functional status data to a *likely value* if the status had been assessed.
  - Currently, the imputation approach implemented in the existing function outcome measures recodes missing data to the *lowest* functional status.
- The actual Discharge response is compared to the imputed/expected DC score

OASIS Items to determine expected DC score

- Age at time of SOC/ROC
- Admission functional score (GGs added up gives score 10-60)
- Admission source
- Prior surgery, Prior functional level/device use
- Presence of pressure ulcer/injury, Body Mass Index
- Cognitive functioning, Confusion (M1710)
- Vision, Incontinence, Medication management needs (M2020)
- Risk for hospitalization (M1033)
- Supervision and safety source of assistance (M2102)
- Specific diagnosis comorbidities

Claims-Based Discharge to Community

Numerator: number of home health stays for patients who have a Medicare FFS claim with a Patient Discharge Status codes 01 and 81, do not have an unplanned admission to an acute care hospital or LTCH in the 31-day post discharge observation window, and who remain alive during the post-discharge observation window

Denominator: number of home health stays that begin during the 2-year observation period (excludes DC to hospice)

Home Health Within Stay Potentially Preventable Hospitalization

Numerator: number of patients with at least one potentially preventable hospitalization (to an ACH or LTCH or observation stay) during the HH stay. For the PPH measure, a stay is a sequence of HH payment episodes separated from other HH payment episodes by at least two days

Denominator: all Medicare FFS patients in the HH setting that do not meet the exclusion criteria

TABLE D3. CURRENT AND PROPOSED MEASURE CATEGORY WEIGHTS BY QUALITY MEASURE IN THE EXPANDED HHVBP MODEL

Measure	Measure Weights			
	Larger-Volume Cohort		Smaller-Volume Cohort	
	Current	Proposed	Current	Proposed
OASIS-based Measures				
Discharged to Community (OASIS-based)	X	-	X	-
Improvement in Dyspnea	X	X	X	X
Improvement in Management of Oral Medications	X	X	X	X
Total Normalized Composite (TNC) Change in Mobility	X	-	X	-
Total Normalized Composite (TNC) Change in Self-Care	X	-	X	-
DC Function	-	X	-	X
Sum of OASIS-based Measures	**35.000**	**35.000**	**50.000**	**50.000**
Claims-based Measures				
Acute Care Hospitalizations	X	-	X	-
Emergency Department Use Without Hospitalization	X	-	X	-
Potentially Preventable Hospitalization	-	X	-	X
Discharged to Community (Claims-based)	-	X	-	X
Sum of Claims-based Measures	**35.000**	**35.000**	**50.000**	**50.000**
HHCAHPS Survey-based Measures				
Care of Patients	X	X	-	-
Communications Between Providers and Patients	X	X	-	-
Specific Care Issues	X	X	-	-
Overall Rating of Home Health Care	X	X	-	-
Willingness to Recommend the Agency	X	X	-	-
Sum of HHCAHPS Survey-based Measures	**30.00**	**30.000**	-	-
Sum of All Measures	**100.000**	**100.000**	**100.000**	**100.000**

Weight Adjustment for TPS Measurement

- Due to the change in the number of measures, weights for each measure will be re-distributed
- No further TNC measures for self-care and mobility, will be replaced by DC Function score
- Increase weight on Improvement in Management of Oral Meds, slight increase weight on Improvement in Dyspnea

Other Considerations from CY2024 Final Rule

- Minor changes in clinical grouper (primary diagnosis)
- Update cormorbidity subgroups
- Update the functional impairment levels of OASIS items
- Update the LUPA thresholds
- Recalibrate the PDGM case-mix weights
- Discussion re: access to home health aide services, which will guide CMS policy development and future regulatory updates to HHA
  - Consider HH Aide utilization in Case Management

Case-Mix Weight Changes

- Some diagnosis groupers will have significant changes in payment
- Higher acuity Groups will have decreases in payment (Wound, Neuro and MS Rehab, Surgical aftercare)
- Some lower acuity Groups will have slight increases in payment (Behavioral health, Cardiac, Endocrine)
- Lowest payment Group is Complex Nursing Group after the 2024 adjustment in weight for Behavioral Health Group

Clinical Groupers by 30-day Periods of Care

Clinical Grouping	CY 2018 (simulated)	CY 2019 (simulated)	CY 2020	CY 2021	CY 2022
Behavior health	1.7%	1.5%	2.3%	2.4%	2.3%
Complex nursing	2.6%	2.5%	3.5%	3.3%	3.2%
MMTA Cardiac	16.5%	16.1%	18.9%	18.5%	17.9%
MMTA Endocrine	17.3%	17.4%	7.2%	6.9%	6.8%
MMTA GI/GU	2.2%	2.3%	4.7%	4.7%	4.9%
MMTA Infectious	2.9%	2.7%	4.8%	4.6%	4.6%
MMTA Other	4.7%	4.7%	3.1%	3.6%	3.5%
MMTA Respiratory	4.3%	4.1%	7.8%	8.0%	7.8%
MMTA Surgical aftercare	1.8%	1.8%	3.6%	3.4%	3.4%
MS Rehab	17.1%	17.3%	19.4%	19.8%	20.8%
Neuro Rehab	14.4%	14.5%	10.5%	10.9%	11.0%
Wounds	14.5%	15.1%	14.2%	13.9%	13.7%

LUPA Threshold Changes

- Significant increases in the LUPA thresholds, up to 5 visits
  - Cardiac – Medium Functional Impairment – Early – Institutional – Comorbidity 2 medium = LUPA threshold 5 visits
  - Surgical Aftercare – Medium Functional Impairment – Early – Institutional – Comorbidity 2 medium = LUPA threshold 5 visits
  - Neuro and MS Rehab – High Functional Impairment – Early – most all = 5
- Changes in LUPA threshold by Functional Impairment level
- Significant increase in LUPA thresholds for Community Early periods
- See Table B12

CY 2024 Per-Visit Payments

TABLE B26: CY 2024 NATIONAL PER-VISIT PAYMENT AMOUNTS

HH Discipline	CY 2023 Per-Visit Payment Amount	CY 2024 Wage Index Budget Neutrality Factor	CY 2024 Labor-Related Share Neutrality Factor	CY 2024 HH Payment Update	CY 2024 Per-Visit Payment Amount
Home Health Aide	$73.93	1.0012	0.9999	1.030	$76.23
Medical Social Services	$261.72	1.0012	0.9999	1.030	$269.87
Occupational Therapy	$179.70	1.0012	0.9999	1.030	$185.29
Physical Therapy	$178.47	1.0012	0.9999	1.030	$184.03
Skilled Nursing	$163.29	1.0012	0.9999	1.030	$168.37
Speech-Language Pathology	$194.00	1.0012	0.9999	1.030	$200.04

Final OASIS Points Table for 2024

OASIS Item	Response	CY 2023	CY2 2024
M1800 Grooming	0 or 1	0	0
	2 or 3	3	3
M1810 Upper Body Dressing	0 or 1	0	0
	2 or 3	5	5
M1820 Lower Body Dressing	0 or 1	0	0
	2	4	3
	3	12	11
M1830 Bathing	0 or 1	0	0
	2	2	0
	3 or 4	10	7
	5 or 6	17	14
M1840 Toilet Transferring	0 or 1	0	0
	2, 3 or 4	6	6

Final OASIS Points Table for 2024

OASIS Item	Response	CY 2023	CY 2024
M1850 Bed Transferring	0	0	0
	1	3	3
	2, 3, 4 or 5	6	6
M1860 Ambulation/Locomotion	0 or 1	0	0
	2	6	6
	3	5	4
	4, 5 or 6	20	20
M1033 Risk for Hospitalization	4 or more responses checked	10	11

CMS goal for Functional Impairment is to have an even distribution of 1/3 in each level, in each group.

For 2022, average score was 33 points, estimated average will be 28 points in 2024

TABLE B8: FINAL THRESHOLDS FOR FUNCTIONAL LEVELS BY CLINICAL GROUP, FOR CY 2024

Clinical Group	Level of Impairment	Points (2022)
MMTA – Other	Low	0-28
	Medium	29-41
	High	42+
Behavioral Health	Low	0-28
	Medium	29-41
	High	42+
Complex Nursing Interventions	Low	0-28
	Medium	29-52
	High	53+
Musculoskeletal Rehabilitation	Low	0-28
	Medium	29-41
	High	42+
Neuro Rehabilitation	Low	0-34
	Medium	35-49
	High	50+
Wound	Low	0-28
	Medium	29-49
	High	50+
MMTA - Surgical Aftercare	Low	0-28
	Medium	29-39
	High	40+
MMTA - Cardiac and Circulatory	Low	0-28
	Medium	29-41
	High	42+
MMTA – Endocrine	Low	0-27
	Medium	28-39
	High	40+
MMTA - Gastrointestinal tract and Genitourinary system	Low	0-31
	Medium	32-46
	High	47+
MMTA - Infectious Disease, Neoplasms, and Blood-Forming Diseases	Low	0-28
	Medium	29-43
	High	44+
MMTA – Respiratory	Low	0-29
	Medium	30-44
	High	45+

Clinical Group Functional Impairment Changes

Clinical Group	Low 2023	Low 2024	Med 2023	Med 2024	High 2023	High 2024
MS Rehab	0-33	0-28	34-45	29-41	46+	42+
Neuro Rehab	0-35	0-34	36-51	35-49	52+	50+
Wound	0-33	0-28	34-51	29-49	52+	50+
Complex Nursing	0-33	0-28	34-54	29-52	55+	53+
Behavioral Health	0-31	0-28	32-43	29-41	44+	42+
MMTA Aftercare	0-33	0-28	34-43	29-39	44+	40+
MMTA Cardiac	0-31	0-28	32-43	29-41	44+	42+
MMTA Endocrine	0-30	0-27	31-43	28-39	44+	40+
MMTA GI/GU	0-33	0-31	34-49	32-46	50+	47+
MMTA Infection	0-33	0-28	34-45	29-43	46+	44+
MMTA Respiratory	0-33	0-29	34-46	30-44	47+	45+
MMTA Other	0-32	0-28	33-43	29-41	44+	42+

Functional Impairment Level Distribution

Functional Impairment Level	CY 2018 (simulated)	CY 2019 (simulated)	CY 2020	CY 2021	CY 2022
Low	33.9%	31.9%	25.7%	23.2%	28.1%
Medium	34.9%	35.5%	32.7%	32.6%	33.1%
High	31.2%	32.6%	41.7%	44.2%	38.9%

Simulated: CMS did not have data on Functional Impairment Level prior to CY 2020 and PDGM

When will the rate cuts stop?

- CMS has been reducing overall payments to home health agencies for several years, but the Home Health Quality Outcome and Utilization Measures continue to show improvement
- CMS believes consolidation of home health providers will lead to efficiencies in services and lower costs for care to beneficiaries

OIG Focus on Falls Reporting Issued 9/5/23

- For Medicare home health patients hospitalized for falls with major injury, 55% of the falls were not reported on patient assessments by home health agencies, as required.
  - Beginning in 2019, J1800-J1900 added to OASIS data set
  - Beginning in 2022, added to Care Compare public reported measures
- Incidental finding: there were no OASIS assessments for many HH patients who fell and were hospitalized (no Transfer OASIS submitted)
- OIG concern: potential non-compliance with data submission requirements, accuracy of OASIS data and the information presented on Care Compare

OIG Recommendations to CMS

- Take steps to ensure complete and accurate OASIS data reported by HHAs used to calculate the falls with major injury quality measure
- Use data sources in addition to OASIS assessments to improve accuracy of falls with major injury quality measure
- Ensure that HHAs submit required OASIS assessments when patients are hospitalized
- Explore whether improvements to the quality measure r/t falls with major injury can also be used to improve the accuracy of other home health quality measures

Impact on Case Management

- Consider improvement in HHVBP quality measures when setting goals
- Pick the right primary diagnosis
- Ensure OASIS accuracy with ongoing training
- Consider LUPA thresholds when scheduling visits
- Consider episode payment to ensure services are reasonable
- Be aware of length of stay – consider if patient could benefit from extending visits through the certification period (second 30-day period)

Case Management Model

- Patient's problems and needs are identified and prioritized
- All disciplines and clinicians communicate with each other to plan the episode care
- Care is goal oriented, rather than task oriented
- All disciplines and clinicians work together in a coordinated way to improve the patient's outcome and meet goals
- The patient/family are partners in care

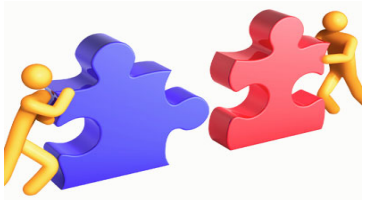
Case Management Process Steps

Shared Decision-Making Model

A mutually respectful exchange that recognizes the individuality of the patient, and a process in which responsibility is divided among the patient, family/caregivers,

physician(s)

and agency



Step 1: Intake

- Accurate intake data collection
  - Who takes referral?
  - What information is obtained?
  - Are appropriate patients accepted for care?
  - How are orders and information transferred to POC?
- Availability of intake data to clinicians
- Correction of any errors on intake information
- Verify any points with physician if needed

Step 2: Assessment

- OASIS data collection, comprehensive assessment, med reconciliation
- Identify patient's problems, concerns, risks
  - Consider social determinants of health
- Investigate prior level of function for goal setting
- Identify knowledge deficits for patient and caregivers, ability and interest in learning
- Identify *patient's* goals for home care
- Start discharge planning at initial visit

Step 2: Admission Visit

- Initial assessment of appropriateness for HH
- Explanation of patient rights and signing of paperwork
- Medication review and reconciliation
- Physical assessment, vital signs
- Functional assessment (OASIS walk, sweep)
- Knowledge assessment, history, goals for HH
- Essential education, ordered tasks
- Follow up with provider on patient status, questions, issues
- Coordination with other disciplines on patient needs
- Documentation

Step 3: Determine Plan of Care

- After initial evaluations by all disciplines
- Identifying problems/needs, setting goals
  - Objective, specific, measureable
- Utilizing disciplines effectively
- Determining interventions, physician orders
- Planning visit frequency
  - Front-loading and staggered visits for nursing, therapy
- Timeframe for home care interventions
- Documentation of admission case conference

Step 4: Implement the POC

- Plan each visit, be flexible to patient's needs
  - Clinical Pathways, teaching checklist
- Address the primary diagnosis every visit; other diagnoses at least once during episode (more if problems); be specific on teaching topics
- Evaluate progress each visit
  - Teach, assess recall, have patient "teach back"
- Revise POC as needed based on progress and response to treatment
  - Interventions and goals
- Deal with problems
- Communication between disciplines, with patient/family, with physician(s)/provider(s), with community resources

Step 5: Evaluate Progress Toward Goals

- Evaluate progress every visit, by every discipline
  - Compare back to SOC/ROC and to last visit
  - Measurable, achievable, relevant
- Each intervention should be directed towards achieving goals
- Coordination between all disciplines towards goals
- Examples: wound healing, decreased dyspnea with activity, ambulating increased distance, no falls, knowledge level improved

Recertify or Discharge?

- Still homebound?
- Skilled need? Medically necessary and reasonable?
  - Changes in diagnoses, conditions exacerbated?
  - Revised plan of care?
  - Observation and assessment?
  - Skilled, qualifying, ongoing task?
  - Management and evaluation of care plan?
- Unmet goals?
  - Reasonable and achievable? Any progress?
  - Functional reason for goal?
  - Does goal need to be revised if recertifying?

Case management links to financial management

- Avoid a LUPA if possible
- Disciplines and visit frequencies
  - Use of PRN visits
- Manage supplies
- Monitor progress toward goals, revise POC goals prn
- Track outcome achievement
- Obtaining and documenting orders

Patient/Caregiver Education Issues

- Lack of documentation of knowledge deficit
- No explanation why further education needed when "full understanding" achieved
- "Teaching topics" vague
- Response to teaching not specific and measurable
- "Barriers to education" not supported by other documentation in record

Patient Performance

- Document assessment of pt/cg knowledge level, describe any deficit, tailor teaching interventions to address deficit
- *If no knowledge deficit identified for patient or caregiver, no need for skilled teaching!*
- Document assessment of pt/cg ability to demonstrate tasks, cues needed, assistance needed, safety

Caregiver Assistance

- If patient is unable to perform task safely, document the following:
  - Reason assistance is necessary
  - Degree and type of assist needed
  - Who will provide assist and their availability
  - Knowledge/ability of caregiver to perform task for patient
  - Teaching done with caregiver
  - Caregiver demonstration of task performance

Critical Clinician Skills for Case Management

- Assessment skills
- Communication skills
- Collaboration skills
- Task performance skills
- Teaching skills

Care Coordination

Key component of Case Management

Coordination of Care

- Communication with physician
- Communication between different clinicians visiting patient
- Communication among disciplines
- Communication w/pt, cg, family

Physician Coordination

- SOC: patient status, address any problems, medication reconciliation, approval of POC
- ROC: patient status, address any problems, med reconciliation, approval of any changes to POC
- ANY changes in patient condition or adverse s/sx, complications
- ALL missed visits by all disciplines
- Progress updates on wounds – how often?
- Goals: progress, revisions to POC

Interdisciplinary Coordination

- RN – LPN
- Nursing – Therapy
- PT – OT – PTA – COTA
- Home Health Aide (personal care)
- MSW

Interdisciplinary Coordination

- SOC (within 5 days)
- ROC (within 2 days)
- Prior to recertification
- Prior to discontinuation of a discipline
- Prior to discharge
- Any problems, complications, s/sx of exacerbations or adverse events on same day

Case Conference Should Address:

- Focus of care?
- Other problems to address?
- Goals? Barriers to meeting goals?
- Disciplines needed? Frequency?
- Interventions?
- Outcome measures?
- Anticipated final outcome for episode?

SOC Conference Points

- Primary diagnosis, focus of care
- Top 5 other diagnoses
- Problem issues
  - Pain, meds, wound care, fall risk
- Patient coping, understanding, motivation
  - Patient's goals for home care services
- Support / caregiving situation
- Risk for hospitalization, how to mitigate risk factors
- Coordination with disciplines to meet problem issues, number of therapy visits planned, goals

More than OASIS verification!

ROC Conference Points

- Reason for hospitalization
- Interventions to reduce re-hospitalization risk
  - Changes needed to prevent repeat
- Primary and other diagnoses
- Problem issues
- Support situation and patient coping, etc.
- Revisions to plan of care and goals
  - Focus and responsibilities of each discipline
  - Complete orders for ROC

Recertification Conference Points

- Evaluate progress toward goals on POC
- Review scores on SOC/ROC OASIS items for outcome measures, evaluate current scores
- Determine if outcome improvement possible and interventions needed to achieve
- Revise goals and plan of care if indicated
- Identify specific responsibilities for each discipline to prepare pt/cg for discharge, evaluate if achievable within this cert period
- Decide if recertify or discharge

Discharge of Discipline Conference Points

- Goals for discipline achieved
- Identify any unachieved goals, reasons
- Review specific improvement on OASIS items related to outcome measures
- Identify any other changes in plan of care as a result of discipline discharge
  - Plan for PT/INR, dc home health aide, etc.

Discharge Conference Points

- Review goals on POC, evaluate if achieved
- Review scores on OASIS items, assess if improvement achieved on outcomes
- Identify if teaching done, understanding level:
  - All medications
  - Diabetes and foot care if DM diagnosis
  - Pain management
  - Prevention of falls, pressure ulcers
- Assess patient/caregiver readiness for discharge

Interdisciplinary Coordination

- Opportunity to support medical necessity, homebound status and skilled need
- Information from all disciplines should agree
- Avoid contradictions between disciplines
- Follow up on problems identified
- Provide supporting education and assessment of effectiveness of interventions

"Case Conference"

- Who should be involved?
- What should be discussed?
- When should conference be done?
- How should it be documented?
  - SBAR format
- Why do we case conference?

Reason for Conference: (circle one or more)

SOC ROC Recert Discharge Problem _____

Situation: (Clinical concerns, diagnoses and focus of care, problems)

Background: (Summary of Interventions)

Assessment:

Pertinent Outcome Measures:	SOC/ROC score	current score	DC goal
M _____	_____		
M _____	_____		
M _____	_____		
M _____	_____		

Resolution: (Plan)

Patient aware of plan:

Yes___ No___ Comments:

Case Management to Reduce ACH

Case Management to Reduce ACH

- Assessment:
  - M1033 identifies risk factors for ACH
  - O0110 Special treatments, Procedures and Programs: these identify complex care issues that contribute to ACH risk
  - Knowledge deficits, especially about medication administration and side effects, disease management and how to recognize s/sx early warning of exacerbation or complication (like infection)
  - Pain management issues
  - Literacy issues
  - Caregiver support system strengths and deficits

Best Practices to Reduce ACH

- Enhanced information transfer at handovers
  - Complete, accurate, current info to receiving provider
  - Discharge summary to PCP timely
  - Transfer summary to subsequent provider timely
  - Identify personnel for liaison responsibility
  - Standardized tool and process for info transfer
- Follow-up care established prior to discharge
  - Make follow-up PCP appointment before the patient leaves the inpatient facility, and schedule date within 1 week of DC
  - Arrange transportation to appointment, verify with caregiver

Best Practices to Reduce ACH

- Medication Management at transition
  - Reconcile discharge meds with prior home meds and medications in home at SOC/ROC visit
  - Educate patient/caregiver on med regimen
  - Ensure how meds will be obtained
  - Address pain management interventions/meds
- Plan of Care
  - Collaborative development of post-acute care plan includes history, strategies to mitigate patterns of ER and hospital use, preferences for end-of-life issues

Best Practices to Reduce ACH

- Telemedicine
  - Remote monitoring and care delivery to detect warning s/sx
- Telephone follow-up
  - Calls made before or shortly after acute setting discharge to prepare for HH admission
  - Provide info/education, symptom management, early monitoring of complications, reassurance
  - Call on days clinician does not visit

Best Practices to Reduce ACH

- Electronic health record
  - Data access systems to standardize info across care settings
- Clinical protocols, best practices, guidelines
  - Ensures best practice standards within and across settings
- Palliative care consultation/support
  - Improved assessment of needs, patient/family preferences for end-of-life care, appropriate referrals for hospice care

Best Practices to Reduce ACH

- Patient/Family/Caregiver Education
  - Materials at appropriate literacy level
  - Include disease self-management, treatment options, expectations, available resources
- Coaching
  - Improved patient-centeredness, self-reliance
  - Ensure common understanding of treatments and support needs among patient, family members, etc.
  - Use scenarios to practice possible events that might lead to hospitalization

Best Practices to Reduce ACH

- Personal Health Record (PHR)
  - Inpatient staff assist patient to establish PHR before inpatient discharge
  - Improved access to current personal medical information
  - Home Health teach patient to maintain info and provide PHR to healthcare personnel at transitions
- Community supports
  - Establish communication links with community resources prior to discharge, appropriate referrals to needed services and equipment; HH assess at SOC

Best Practices to Reduce ACH

- Intake/Referral:
  - Obtain complete referral information from inpatient facility or physician office
  - Verify physician that will sign plan of care and assume responsibility for patient's care oversight
  - Obtain current medication list
  - Obtain contact info for next of kin or emergency contact
  - Ask: What brought the patient into the hospital for this admission? Does patient have a history of recent re-hospitalizations?

Best Practices to Reduce ACH

- At SOC / ROC visit:
  - Perform Drug Regimen Review and medication reconciliation, determine method for safe administration
  - Perform fall risk assessment and address immediate concerns for safety, therapy and equipment needs
  - Facilitate timely therapy evaluation for patients at risk for falls
  - Identify date of PCP follow up appointment and verify patient/family have transportation arranged
  - Perform knowledge assessment r/t disease management
  - Assess patient's support system, needs for assistance with community resources
  - Establish Emergency Care Plan
  - Complete Hospitalization Risk Assessment tool

Best Practices to Reduce ACH

- Every visit:
  - Verify medication regimen and compliance
  - Ensure pain is effectively managed
  - Provide self-management training on diagnoses, address risk factors
  - Care coordination between disciplines
  - Review Emergency Care Plan
  - Reminders for physician follow up appointments, lab work and testing as ordered
  - Plan for discharge expectations and arrangements
  - Maintain communication to coordinate care with family and caregivers, ongoing assessment of support systems

Plan of Care Components ACH

- Orders and Interventions
  - Order for parameters for physician notification
  - Consider front-loading visits for patients at risk for hospitalization, stagger visits so someone sees pt daily first 1-2 weeks
  - Implement telehealth if available and appropriate
  - Order to assess patient's response to medications, monitor effectiveness, instruct on medication regimen
  - Request PRN orders for likely complications
  - Implement disease-specific protocols to address current diagnoses

Plan of Care Components ACH

- Goals
  - Patient and/or caregiver(s) will be able to state steps in disease management for …
  - Patient will be compliant with medication regimen
  - Patient will follow up with ordered medical care
  - Patient will not have ER visits or hospitalizations within this episode of care
  - Reasonable expectation goals achievable?

Identify common re-admission drivers – considerations for care planning

- Diagnoses: HF, COPD, Pneumonia, GI, psych, other?
- Medications in home? Able to administer?
- Timely PCP follow up appointment?
- Patient/family knowledge of s/sx to report?
- Fall risk factors addressed?
- Use of front-loading, telehealth, telephone calls?
- Education, coaching, validation of understanding?
- Community support services?

Readmission Driver: Diagnoses

- Heart failure
- Pneumonia
- COPD
- Psychoses
- Gastrointestinal problems

Readmission Driver: Medications

- Of 366 patients discharged from hospital with a follow up PCP appointment within two months:
  - 64% used at least one med not ordered at discharge
  - 73% failed to use at least one med ordered at discharge
  - 32% did not take meds ordered at discharge at all

Readmission Driver: Care Delivery

- Inadequate patient education
  - Medical condition
  - Treatment interventions
- Premature hospital discharge
- Poor communication
  - Between patient and physician
  - Between hospital and community physician

Readmission Driver: Follow-up Care

- Inadequate monitoring of illness and/or treatment
- No emergency contact number provided to patient
- Patient unable to get prescribed meds immediately
- Inadequate home/community services/resources
- Delay in follow-up PCP care or post-discharge testing
- Of Medicare beneficiaries readmitted within 30 days:
  - 64% do not receive any post-discharge care before readmission
  - 50% have no physician follow up visit before readmission

What drives your agency ACH and ED use?

- Review patients that had a hospitalization or Emergency Dept. visit –
  - Why did the patient go to ED or hospital?
  - What happened at the last visit before that event?
  - Did you contact the physician? Response?
  - Did you follow up? Coordinate with all staff?
  - Did the pt/cg call the office before going to ED?
  - Compliance with plan of care?
- *What are your readmission drivers?*

Case Management Applications

Examples

Case Management Applications

- Intake and assessment identifies focus of care?
- Assessment identifies other problems to address?
- Patient/Physician/Agency Goals?
- Interventions to achieve goals?
- Disciplines needed? Frequency?
- Outcome measures?
- Anticipated final outcome for episode?

CHF Scenario

Referral from hospital received by Intake:

- 78 year old with CHF exacerbation, hospitalized 6 days
- Other diagnoses: Anemia, depression, generalized weakness
- SN 2w2, 1w2 for assessment, teaching and med setup; HH Aide 1w1, 2w2 needs personal care assistance for bathing
- Based on dx of generalized weakness and discharge from 6 day hospital stay, Intake requested PT evaluation and approved.

Issues at SOC Assessment

- Respiratory status: dyspnea with ambulation <20 ft, faint bibasilar crackles, non-productive cough; weight 142# (hospital weight 141#)
- Constipation: on several new bowel meds, LBM 2 days before SOC date
- Knowledge deficits: patient and husband do not know CHF mgt, med administration, 4Gm sodium diet, high risk meds, bowel mgt.
- Safety: ambulating with cane, weak unsteady gait, no recent falls

PT evaluation on day 1:

- Assessment: patient fell last night, husband called 911 for EMT to assist up, no injury, need for walker for safe ambulating, measured weakness of BLE, needs help of 2 to safely do 3 steps at entrance

CHF Case Management

Case Conference Day 3 with RN, LPN, PT, PTA, HHAide, (manager? QA?)

- Focus of care?
- Other problems to address?
- Goals?
- Disciplines needed? Frequency?
- Interventions?
- Outcome measures?
- Anticipated final outcome for episode?

CHF Case Conference Note

- SN 2w3, 1w3. At risk for recurrent exac. CHF, constipation, SN setting up med planner to help med administration and will work with husband to do set up, start bowel routine, teach on CHF disease process, med regimen, 4Gm Na+ diet, s/sx to report.
- PT 2w1, 3w2, 1w2. Gait/stair training with walker, strength training, develop/instruct on HEP and fall precautions w/pt and husband
- HHAide 1w1, 2w4 for bathing, dressing assistance, note to allow rest periods during care, remind pt to take AM meds and make sure planner set by kitchen sink to remind pt to take PM meds, check LBM date and report to office if >2 days, report any falls.

Reason for Conference: (circle one or more)

(SOC) ROC Recert Discharge Problem _____

Situation: (Clinical concerns, diagnoses and focus of care, problems)

Focus: CHF, weakness and unsteady gait, fall, anemia, depression, constipation, needs teaching

Background: (Summary of Interventions)

SN for CHF mgt, bowel mgt, med/diet teaching; PT for gait/transfer/stair training, fall prev.; HHAide for bathing

Assessment:

Pertinent Outcome Measures:	SOC/ROC score	current score	DC goal
M1400 Dyspnea	2		1
M 1830 Bath	3 or 5		2
M 1850 Bed trf	2		1
M 1860 Ambulation	3		2

Resolution: (Plan)

Will need more than 3 weeks of HH, estimate SN 2w3, 1w3 and PT 2w1, 3w2, 1w2, Aide 1w1, 2w4. If husband doesn't catch on to teaching may need MSW. SN to contact physician to approve extended POC r/t patient's problems and goals.

Patient aware of plan:

Yes_x__ No___ Comments:

Intake/Referral Information for Heart Failure

- Identify all type(s) of heart failure
  - LVEF (left ventricular ejection fraction)
  - Query to verify with physician if necessary
- History of MI or other events that might cause heart muscle damage or lower cardiac output
- Current medication list, any recent changes in cardiac meds
- Any exacerbating events for recent hospitalization, family/support situation, baseline weight

Comprehensive SOC Assessment

- Medical history, conditions potentially exacerbating CHF, pattern of symptom development, hx hospitalizations, pacer/AICD
- Vital signs, lung sounds, respiratory rate, O2 sat, use of accessory muscles, cough, sputum, orthostatic BP, LE edema, JVD
- Physical condition, daily activities + need for modification due to energy level and tolerance, orthopnea, chest pain/palpitations
- Appetite, diet and fluid intake, compliance, weight gain/loss
- Medication compliance, response and effectiveness, side effects (includes oxygen)
- Smoking history, willingness to quit smoking
- Knowledge of disease process and management (meds, diet, activity, s/sx report), cognition, ability to learn/recall, s/sx anxiety / depression
- Support system, family/cg involvement and impact of disease, resources for care
- Discharge plan for patient, family input, need for services
- Scheduled physician follow-up appointment

POC Interventions for CHF by Stage

Stage A and B:

- Monitoring of blood pressure, lipid and cholesterol levels
- Education on:
  - Measures to control hypertension and diabetes
  - Measures to reduce high lipid or cholesterol levels
  - Measures to reduce weight if obese
  - Smoking cessation
  - Medication regimen

Stage C:

- Education on:
  - Medication regimen
  - Monitoring HF symptoms, daily weights
  - Dietary sodium restriction, control fluid intake
  - Exercise/activity

POC Interventions for CHF by Stage

Stage C (con't)

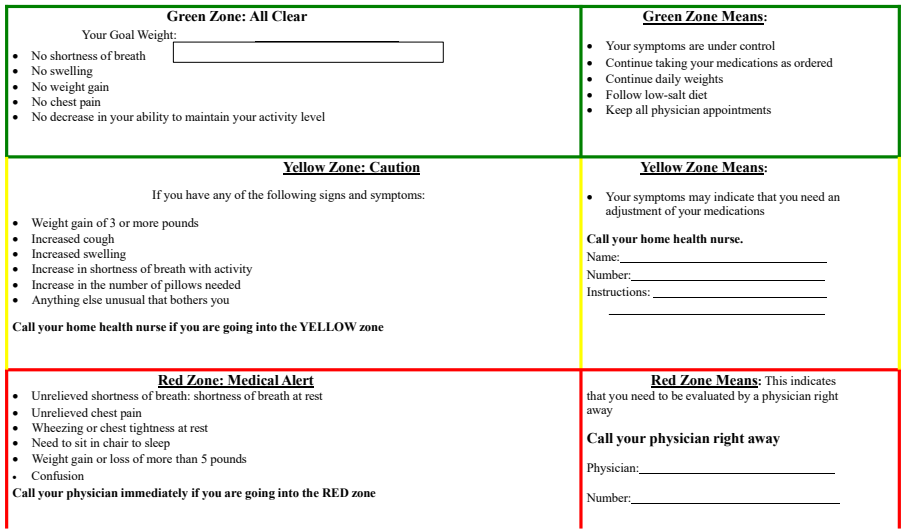
- Social support to reduce stress, promote compliance with treatment and lifestyle changes
- Treat sleep disorders
- Surgical interventions

Stage D:

- Medications
- Palliative and Hospice Care
  - Symptom management and comfort measures
  - Support quality of life choices
  - Caregiver support

Best Practices for Heart Failure

- Front load visit schedule, stagger visits to see patient daily weeks 1-2
- Medication management as ordered
- Physician follow up
- Monitor symptoms and weight
- Follow diet and fluid recommendations
- Adapt exercise and activity level: PT and/or OT referral for strengthening, energy conservation, ease performance of ADL's
- Limit alcohol, caffeine; stop smoking
- Know s/sx to report, emergency plan using ZONE tool: physician or 911
- Discuss practice scenarios to improve self-management skills for CHF



Green Zone: All Clear

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 physician appointments

Yellow Zone: Caution

If you have any of the following signs and symptoms:

- Weight gain of 3 or more pounds
- Increased cough
- Increased swelling
- Increase in shortness of breath with activity
- Increase in the number of pillows needed
- Anything else unusual that bothers you

Call your home health nurse if you are going into the YELLOW zone

Yellow Zone Means:

- Your symptoms may indicate that you need an adjustment of your medications

Call your home health nurse.

Name:_____

Number:_____

Instructions: _____

_____

Red Zone: Medical Alert

- Unrelieved shortness of breath: shortness of breath at rest
- Unrelieved chest pain
- Wheezing or chest tightness at rest
- Need to sit in chair to sleep
- Weight gain or loss of more than 5 pounds
- Confusion

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

Red Zone Means: This indicates that you need to be evaluated by a physician right away

Call your physician right away

Physician:_____

Number:_____

Plan of Care Goals for CHF

- Prevent disease progression by controlling HTN, DM, Metabolic Syndrome, ASHD
- Relieve symptoms
- Improve exercise/activity tolerance
- Improve health status, adjust lifestyle factors
- Prevent and treat complications/exacerbations
- Reduce mortality
- Prevent/minimize side effects of treatment

CHF Assessment Every Visit

- Vital signs: pulses, respiratory rate, BP, O2 sat, weight log
- Lung sounds, cough, wheezes, crackles
- Episodes of orthopnea, increased dyspnea
- Appetite, diet and fluid intake history and compliance
- Changes in activity tolerance
- Medication compliance, response and effectiveness, any side effects or adverse effects
- Progress with smoking cessation
- Knowledge, recall, understanding of disease process and management (meds, diet, activity, s/sx to report)
- Caregiver involvement, DC plan still appropriate

Monitoring and Management - CHF

- Daily weights to identify fluid retention
  - Scale, log record, compliance
  - Parameters to report, use of PRN diuretic
  - Clinician assess weight log EACH VISIT, practice scenarios with pt/cg, associate with sodium intake
- Pulse check
  - Teach radial pulse check, use teach-back return demo, parameters to report

Monitoring and Management - CHF

- Blood pressure
  - Teach procedure using appropriate equipment, parameters to report, associate with sodium intake
- Edema
  - Teach pt/cg to check edema daily, elevate LE's
  - Report increased edema or edema in AM
- Abdominal girth
  - Measure abdominal girth at baseline, teach pt to report if waistband/belt gets tight

Medication Mechanisms for Heart Failure

- Diuretics: reduce sodium retention in renal tubules, reduces blood volume
- Digitalis: slows heart rate, increases contractility and cardiac output
- Beta-blockers: block sympathetic nervous system stress response
- ACE inhibitors: block action of angiotensin converting enzyme on the renin-angiotensin aldosterone system, reduces afterload

Exercise and Activity

- Physician exercise/activity orders, restrictions
- Referral to PT or pulmonary rehab to improve strength, stamina and safety for ADL's
  - Strengthen muscles used for breathing, activities
- Referral to OT for energy conservation, pace activity, environmental adaptations to ease performance of ADL's and IADL's
- Teach simple exercises for limited mobility patients – yoga, chair exercises, low impact senior workout, stretches

Environmental Modifications for Energy Conservation

- Keep things needed for dressing, grooming, cooking, etc., together in easy to reach place
- Simplify routines for cooking, cleaning, chores
- Use a small table or rolling cart to move things around, avoid carrying heavy items, sit
- Do things slowly, pace activities, rest after meals
- Arrange home to avoid climbing stairs often
- Keep home air clean, avoid sprays and fumes
- Wear loose clothes, slip-on shoes
- Avoid going to stores during busy times, crowds
- Avoid very cold, windy or very hot, humid days

Assess for Exacerbation

- Increased shortness of breath, lung crackles, wheezes, cough, sputum changes, orthopnea
- Increased peripheral edema, abdominal girth, JVD, weight gain parameters
- Chest pain/tightness worse with breathing
- Lips/nailbeds dusky or bluish color
- Pulse and/or respiratory rate elevated
- Decreased appetite for >2 days
- Nocturia, oliguria
- Fatigue, lethargy, activity intolerance
- Increased confusion, irritability, sleepiness

Therapy Scenario

- Fall, fracture distal end of right femur shaft, ORIF
- Other diagnoses: COPD/asthma, HTN, post-op pain
- SN 2w1, 1w2; PT 3w2, 2w1, then plan on outpatient therapy
- Patient is 70 years old, lives alone, no children/family live in town, she refused to go to SNF, says she has "lots of help with everything she needs from neighbors and friends"

Issues at SOC Assessment and PT Initial Eval

- Pain: score 6-7/10, all the time in knee, affects ambulation, taking oxycodone 1 tab 2-3x/day with minimal relief, rest and cold also used
- Incisions: stapled, 1st is 2cm, front of upper rt leg; 2nd is 4cm, outer aspect of rt knee, small amount of light yellow drainage; 3rd is 6cm, front rt knee; order to shower and replace island dressing day 3.
- CP status: BP 162/90, dyspnea with ambulation >10ft, poor activity tolerance, has inhaler but does not use correctly
- Safety: lives alone, hx fall, limited ambulation using walker, anxiety
- Knowledge deficit: pain mgt, s/sx infection, wound care, energy conservation and safety awareness

Therapy Case Management

- SOC case coordination note on day 1:
  - Rt. femur fracture, hx rt TKR 2 yrs ago. Patient was mowing grass and fell. PT advance with gait using walker to cane, WBAT. ROM 30-90-90, max at 75-80 at initial eval. Patient states she cannot drive to outpatient clinic, wants HH
- Focus of care?
- Other problems to address?
- Goals?
- Disciplines needed? Frequency?
- Interventions?
- Outcome measures?
- Anticipated final outcome for episode?

Therapy Case Conference Note

- PT 3w3, 2w3 for Right distal femur fracture due to fall, hx of rt TKR. WBAT using walker with goal to advance to cane/independent, increase safety awareness to prevent further falls, increase ROM and strength/support of rt knee joint.
- SN 2w1, 1w2 to assess incision drainage, s/sx infection, teach pain mgt, teach med regimen including BP and pain meds, inhaler use up to 4x/day for SOB, assess anxiety and monitor BP. SN also reinforce pt to do HEP BID and fall prevention measures.

Reason for Conference: (circle one or more)

(SOC) ROC Recert Discharge Problem _____

Situation: (Clinical concerns, diagnoses and focus of care, problems)

Focus: Femur fracture, limited gait/mobility, pain/BP/anxiety mgt, infection?, no cg, needs teaching. No OP fu.

Background: (Summary of Interventions)

SN for infection and BP assessment, pain mgt, med teaching; PT for gait/transfer training, fall prev.

Assessment: incision s/s infection, pain/anxiety/BP, very limited mobility and lives alone

Pertinent Outcome Measures:	SOC/ROC score	current score	DC goal
M 1830 Bathing	___5		1_____
M 1850 Bed trf	___2		1 ____
M 1860 Ambulation	___3 or 5		2_____
M Dyspnea	___3_or 2		2 or 1 __

Resolution: (Plan)

PT 3w3, 2w3 and PT will contact MD, SN keep ordered 2w1, 1w2. May need Aide or MSW for additional help.

Patient aware of plan:

Yes__x_ No___ Comments:

Wound Scenario

Wound Case Management

- Assessment:
  - Tissue management – support granulation and eliminate necrotic tissue and biofilm
  - Inflammation and infection control – address s/s of infection or consider why wound healing stalled
  - Moisture balance – avoid “too wet or too dry” wound bed surfaces
  - Epithelial (edge) advancement – epithelial cells able to migrate from wound edges
- Wound protocols that support healing:
  - Maintain a moist wound bed supporting cell migration
  - Promote a clean wound bed free of necrotic tissue supporting cell migration
  - Maintain a wound free of infection by managing bacteria load

Components of Wound Assessment

- Location, identify laterality
- Size, shape, measurements
- Stage for pressure ulcers ONLY
- Wound bed appearance
- Drainage
- Odor
- Surrounding tissue
- Pain

More Wound Assessment Points

- Wound etiology verified by physician or approved NPP
- Number wounds consistently
- Assess and describe wound every visit
- Measure at least weekly
- Take pictures if possible (what's your agency P&P for pictures?)

Wound Interventions

- Assess pt/cg knowledge of s/sx to report, infection control, safety measures, supply care, nutrition/hydration to promote healing
- Teaching to address wound care procedure, knowledge deficits
- Evaluate recall of instructions, periodically observe return demo of wound care procedure
- Address management of co-morbidities
- Include s/sx wound complications on Emergency Care Plan posted in home
- Document all communication with physician on wound progress or lack of progress

Plan of Care - Wounds

- Diagnosis list
  - All wound diagnoses correct? Verified?
  - If wound care is the focus, does the primary diagnosis code place the case in the Wound Grouper?
  - Match OASIS items? Wound body diagram? Assessment narrative or wound addendum?
- Supplies
  - All supplies listed?
  - Match wound care orders in #21?

Plan of Care - Wounds

- Locator #21: Orders and Interventions
  - Refer to wound by etiology and location in orders for care
  - Cleanser, topical med, dressing(s), secure, frequency, who will perform, infection control, pt/cg instruction, DC when healed
- Locator #22: Goals
  - Refer to wound by type/etiology
  - Include criteria for improvement, demo of caregiver ability, etc.
  - Venous stasis ulcer right ankle will be decreased in size within 4 weeks, healed within 8 weeks, free of s/s of infection. Caregiver will demonstrate ability to perform dressing change and will be able to state s/s of complications to report within 1 week.

Evidence-Based Treatment Best Practices

- Pressure relief, reduce friction/shear for pressure ulcers
- Debride necrotic tissue
- Treat infection
- Moist wound treatment when appropriate: promotes an optimal wound environment and includes films, alginates, hydrocolloids, hydrogels, collagen, negative pressure wound therapy, unna boots, medicated creams/ointments
- Avoid disturbing early granulation tissue

More Best Practices for Wounds

- Assess and instruct on nutrition and hydration
- Instruct on infection control and prevention measures
- Instruct wound care, patient/caregiver provide return demonstration
- Instruct s/sx to report, emergency plan (call the agency first!)
- Inform physician of any complications, regularly update wound progress

Case Management for Diabetes Comorbidity

- Diabetes always affects patient's overall health status
  - Wound healing
  - Impact of infection
  - Additional exertion, calorie demands of healing and rehab activities
  - Impact of stress
- Diabetes management is always part of the plan of care
  - Assess blood sugars every visit, patient's log of blood sugars r/t parameters
  - Assess medication compliance, diet compliance, activity level
  - Assess for s/s of infection, complications
  - Teach to address any knowledge deficits

Diabetes Mgt in Therapy Only Cases

- Monitor blood sugar readings
- Consider daily blood sugar in therapy activities
- Diabetic neuropathy can impact movement, fall risk, safety with ambulation
- Ask about foot care, teach as needed: wear shoes, check shoes and feet daily, s/s to report

Collaboration on Diabetes Care

- SN: diabetes management, use of BGM, diet, skin care, medications,
- PT: exercises to manage blood sugars, neuropathy safety
- OT: energy conservation, low vision adaptations, ADL/IADL tips
- SLP: cognitive issues
- HHAide: assistance with bathing, personal care needs
- MSW: assistance with obtaining BGM supplies, Insulin syringe prefill, transportation to follow up appointments

Can you use these case management techniques to help determine the problems, goals, and interventions for your patients?

To develop an effective plan of care using the disciplines needed to achieve goals?

To track progress toward those goals during the episode of care?

Care Planning is Critical!

If you don't know where you're going, you'll end up someplace else!

- What is patient's baseline at SOC?
  - Prior level of function vs current baseline at SOC
- What are the goals for home care services?
- What interventions will help achieve those goals?
- Are all disciplines included in the plan of care effectively?
- Is the patient/caregiver engaged and willing to participate in the interventions?
- Evaluate progress every visit, revise the plan as needed

Collaboration with Nursing

- Drug Regimen Review
- Identification of focus of home care (primary dx determined with input from therapy and nursing)
- Skill mix to ensure best discipline for right actions
- Education on disease processes and management, medications, post-discharge follow up needs
- WOCN for complex wounds

Collaboration with Therapy

- Functional performance of ADLs, IADLs
- Status of current assistive devices, need for others
- Mobility and safety in home environment
- Fall prevention plan
- Ability to evacuate home in case of emergency
- Scoring of OASIS M1800 and GG items
- POC: reinforce interventions (not duplicate), consider treatment for typical chronic conditions beyond “muscle weakness”

Collaboration with Aide, MSW

- Home care aide
  - Pain, dyspnea, incontinence data
  - Compliance with meds, interventions
  - Patient/family concerns
- MSW
  - Evaluate how patient’s ability and need for assistance impacts family members’ roles and responsibilities – is your goal really going to make a difference in care?
  - Linkage with community resources
  - Payment options for post-discharge care

MSW Referral Indicators from OASIS items

- Social Determinants of Health
  - Health literacy problems
  - Lack of reliable transportation
  - Problems obtaining medications (financial, logistic), setting up planner
  - Social isolation reported by patient
- Poor BIMS score or cognitive deficits
- Vision or hearing issues
- Recent history of, or multiple, hospitalizations
- Assistance/supervision needed but no caregiver available (M2102)

Reasons for MSW Referral

- Community resource identification, planning and coordination
- Advance directives
- Assistance with applications for financial aid
- Teaching about coping with loss and emotional adjustments to life changes
- Grief counseling with impending loss
- Crisis intervention and problem solving

Remember…

- Every interaction with patients and their families counts, from clinical care by staff in the home, to answering the phones in the office, to handling a question at 3 am
- Outcomes improve one patient, one episode at a time
- ***Every detail matters!***
- ***Our goal: the best care for every patient, every time***

CY 2024 Home Health Final Rule

- Issued November 1, 2023
- Calendar Year (CY) 2024 Home Health Prospective Payment System (HH PPS) Rate Update Final Rule (CMS-1780-F)
- PDF in Federal Register 11/13/23, located at:

https://www.federalregister.gov/public-inspection/2023-24455/medicare-program-calendar-year-2024-home-health-prospective-payment-system-rate-update-quality

New OASIS-E Resources

- **Updated OASIS-E Manual**
- The 2024 update to the OASIS-E Manual, and the associated Change Table, are available in the Downloads section on the OASIS Users Manuals page. There are no changes to the OASIS-E instrument. The changes incorporate guidance into the manual and Q&As from the CMS Quarterly Q&As dated July 2022 through October 2023.
- https://www.cms.gov/medicare/quality/home-health/oasis-user-manuals

Staff Safety Concerns

Bonus

Safety of Home Healthcare Staff

- A Connecticut home health nurse was murdered in the home of a patient on October 28, 2023.
- She was reported missing to the police by a family member when she failed to return home from work that evening. The family member was able to track her last location to the home of the patient she was scheduled to visit at 8:00am on that same day. The patient resided at a half-way house for convicted sex offenders.
- Home Health Agencies have a responsibility to ensure a safe work environment for their staff, including when making home visits. However, while most states have laws that protect healthcare workers those laws do not include home care providers.

Safety Concerns for Home Care Staff

- Bloodborne pathogens, exposure to biological hazards, needle sticks
- Allergic reactions, latex sensitivity, exposure to dangerous chemicals
- Ergonomic hazards (lifting, straining, falls, therapy, bathing, etc.)
- Hostile animals (pets and non-pets)
- Unhygienic environment (roaches, bedbugs, infection exposure, animal waste, human waste)
- Violence, guns, illegal drugs, verbal and physical abuse/attack
- Temperature extremes
- Working alone, even in high risk areas; stress, overexertion

Safety Best Practices - Personal

- Lock purse, wallet, personal items in trunk *before* leaving home/office
- Ensure accurate detailed directions to patient's home
- Alert the patient/family of your arrival time
- At apartment buildings or housing projects, check in with building security whenever possible
- Keep car doors locked and windows up
- Park in well-lit, easily accessible and safe areas
- Be aware of surroundings, do not stop/leave car if you feel unsafe
- Nursing bag should be closed, medical supplies out of sight

Safety Best Practices - Personal

- Carry a hand-held alarm regardless of patient or neighborhood safety
- Never walk through a crowd to get to a patient's doorway. Locate an alternate source of entry into the building or home, or contact building security
- Do not engage in discussions on personal or touchy topics with patient, family or neighbors
- Do not provide personal information about yourself or your family to patient/family/caregivers
- Do not attempt to break up domestic arguments in home
- TRUST YOUR INSTINCTS: remove yourself from uncomfortable situations

Safety Practices - Personal

- During visits, remain alert and watch for verbal expressions of anger or frustration, threatening gestures, signs of drug or alcohol use, presence of weapons in home, any signs of possible violence (patient or family member bruising or injury)
- Identify more than one exit from the patient's home if possible and keep a clear path to at least one exit
- If subjected to verbal abuse or threat in a patient's home, calmly ask the speaker to stop; if it continues, leave the home
  - If threatened, make an excuse and exit the home immediately
- Contact office and inform supervisor of any threatening situations

Safety Practices - Agency

- Staff making home visits should have a cell phone, if the area has known safety hazards or no cell reception, issue a two-way radio
- Log in – log out policy. All field staff should check in with agency from first visit and give order of visits for the day, check in between 11am-noon, and check out from the car leaving last visit. Agency should ensure all staff have safely left the field before supervisors leave.
- When traveling to a patient with known safety hazard, notify the office when leaving for the patient's home, describe your route, call office when you arrive and give an estimated length of time for the visit. When finished, call the office when you leave the home. Continue until out of hazardous area/homes.

Safety Practices - Agency

- When the Admission Nurse/Therapist performs admission visit,if concerns are identified, staff should complete the form **Patient "Aggression Towards Others" Assessment Scale**. If the patient receives a rating of 0, a caregiver visiting the patient would practice basic safety awareness and carry basic safety devices. If a patient receives a rating of 1 to 25, an assigned caregiver would practice advanced safety awareness, carry advanced safety awareness devices. For a patient who rated a minimum of 26, a caregiver would practice advanced safety awareness and have an escort present during visits.
- If there have been incidences of violent crime, guns, etc. in a home or neighborhood, agency should provide an escort to accompany agency staff during the home visit.

Safety Practices - Agency

- Written "zero tolerance" policy: employees required to report and document details of all incidents of violence, presence of visible weapons in home, or any threats to staff. Includes all events, from any source, no matter how minor
- Data systems should monitor the exposure of staff members to aggression or threats, measure aggressive events and specific factors that result in hazards (like patient type)
  - Identification of patient/family who are on state high-risk registries?
- Develop quality indicators and safety standards for staff
- Hire security personnel or arrange with local law enforcement to accompany staff to home/area with potential safety hazards

Safety Practices - Agency

- Consider a mobile personal safety system such as Guardian MPS, Mobi Alert, AlertGPS. Scatterling or other options for field staff
  - GPS tracking on phone or personal device
  - Phone apps
  - Voice activated SOS alarm
  - "Panic button" device that calls 911 directly and alerts the office
  - Remote check-in / check-out via automated system from each visit
  - Lone worker safety app automatically notifies emergency contacts (office or 911) when timer expires if it is not re-set
  - Integration between devices: works on cell phone, laptop, tablet, smart watch

Safety Practice - Agency

- Provide on-going staff education on safety:
  - Agency safety policies and protocols
  - Safety and environmental awareness training
  - How to recognize and counter threatened or actual violence
  - How to de-escalate violence or potentially violent situations
  - Table-top practice to role play scenarios and discuss responses
  - Training on personal defense techniques
  - How to report and document incidents
  - Read and discuss *The Gift of Fear: Survival Signals That Protect Us from Violence* by Gavin de Becker
- OIG is publishing General Compliance Guidance in 2024

Thank you for attending!

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