OPT- IN

OPTimum Performance Standards

for Patient Centered Transitions

to and from Home Health Care

HOME CARE ALLIANCE of MASSACHUSETTS
www.thinkhomecare.org

" All health care systems will be aware of and adhere to a set of standards for communication around care transitions..."

Massachusetts Strategic Plan for Care Transitions

STATEMENT OF THE PROBLEM

Moving from one health care setting to another (hospital or rehab to home for example) can often be a very stressful experience for patients and their family members. Changes in health status, treatment plans, medications and working with multiple, unfamiliar clinicians can be overwhelming. Hospital stays are often brief, despite the patient having complex medical conditions and diagnoses. Educating the patient and family members about disease management at home requires time and coordination. Extensive research documents that miscommunication regarding post discharge care can be a detriment to patient healing. Poor communication can result in a patients return to the hospital.

The goal of this project is to establish for the home care industry and its partners across all health care sectors standards that promote seamless care transitions to advance positive outcomes and reduce risks that have been found to cause patient rehospitalizations.

ROLE OF HOME CARE

Home health care services have long been a ***crucial part of the care continuum*** for patients who need continuation of a care regime following an acute care hospitalization or who require longer term medical and supportive care to manage a complex chronic illness. Home health care utilizes a team approach providing comprehensive care to address the patient's complex medical and social needs with the goal of returning the patient to a prior or higher level of health and functioning. The home health care team establishes a patient-centered plan for longer term illness management that supports safe, independent living as long as is possible. Providing teaching to increase patients' skills and confidence in self-managing their health has always been a central focus of a home health plan of care. Patients are coached to manage health conditions and prevent complications, and when possible family caregivers are supported with resources to maintain a care schedule.

REFERRAL TO HOME HEALTH

The ability of home health to support a patient in complying with a post acute care regime depends initially on an appropriate referral. The process for assessing for an optimal and safe discharge home should begin on admission. In considering the appropriateness of referral to home care services, any or all of the following should be considered:

- Patient's pre-hospitalization functional ability
- Informal supports, including presence of an 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

Any or all of the following home care services can be ordered:

- Skilled Nursing: Observation and assessment, teaching and training, performance of skilled treatment or procedure, Management and evaluation of a client's chronic care plan
- Physical, occupational and/or speech therapy
- Medical social work
- Home health aide service for personal care and/or therapeutic exercises
- Telehealth Care Management

THE STANDARDS

Standard I. Referral

The Home Health Agency collaborates with the referral sources to achieve a smooth transition. In the ideal transition home, the agency will participate in a case conference with hospital or other referring entity prior to the admission into home care. Once a referral is made:

- The initial home visit will occur as ordered by the physician. This may be same day as the referral or within 24 hours of discharge
- If no specific date is ordered by the physician, the initial home visit will be conducted no later than 48 hours of referral or within 48 hours of the patient's return home

Standard II. Initial Home Assessment

Each patient receives a patient specific, comprehensive assessment that accurately reflects the patient's current health status and includes information used to establish the plan for home health care. The admitting clinician:

- Evaluates the individual's clinical status, functional status, and service needs
- Assesses living situation and provides teaching regarding a safe home environment
- Reconciles medications (from pre- and post hospitalization), as well as any pre and post hospitalization treatment plan
- Conducts a falls risk assessment
- Performs a depression screening (PHQ-2)1
- Identifies patient who are at high risk for re-hospitalization
- Follows-up with physician within one calendar day to resolve clinically significant treatment and medications issues
- Assesses patient's teaching needs, and ability to manage self-care
- Assesses for home health aide need
- Assesses social support and evaluates for resource need
- Assesses patient's goals and wishes regarding their health care plan
- Develops a plan for home health care collaborating with the patient and physician

[1] Copyright Pfizer Inc.

Standard III. Collaborate with the patient and physician to establish the plan for care at home

Following discussion of the patient's condition with the physician, the home health clinician incorporates the following specific into the plan of care as appropriate to the patient's needs:

- Patient specific parameters for notifying physician of changes in vital signs or other clinical findings
- Diabetic foot care including monitoring for the absence of skin lesions on the lower extremities and patient/caregiver education on proper foot care.
- Falls Prevention interventions
- Depression intervention(s) such as medication, referral for other treatment, or a monitoring plan for the current treatment
- Intervention(s) to monitor and mitigate pain
- Intervention(s) to prevent pressure ulcers
- Pressure ulcer treatment based on principles of moist healing *OR* order for treatment based on moist wound healing has been requested from physician.

Standard IV. Plan of Care /Coordination

For every patient, the plan of care includes an Inter-disciplinary team approach for providing Nursing, Physical Therapy, Occupational Therapy, Speech Therapy, Home Health Aide and Social Services, as needed. Additionally, the plan incorporates:

- Evidence-based practice, as available
- Case Conferencing and ongoing care coordination with primary physician and specialists
- Referral to other disciplines/resources as needed.

Standard V. Health Coaching, Teaching and Enhanced Learning

"Health coaching" and personalized teaching are used to help chronically ill patients to better manage their chronic illness. The home care clinician:

- Customizes education for patient and family/caregiver and provides teaching materials as appropriate. (Cultural competency, language assistance, health literacy considerations)
- Provides patient caregiver with self-management tools for chronic diseases
- Teaches "***RED Flags***" indicators that the patient's condition is worsening and how to respond

- Teaches patient's medication management especially those with complicated medication regimens to guard against harmful adverse drug reactions.
- Uses goal setting, identification of obstacles, and use of personal support systems in development and implementation of plan of care
- Utilizes "teach back," to evaluate the effectiveness of the current teaching process and to monitor the patients understanding of self-care
- Provides information and education about when and who to contact in case of a change in health status or new medical problem ("Call Me First")

Standard VI. Re-assessment

Each patient is re-assessed on an ongoing basis, but no less than every 60 days or as often as the severity of the patient's condition requires:

- For the continuing need for home health care
- To meet the patient's medical, nursing, rehabilitative, and pyscho/social needs
- For discharge planning needs to promote a smooth transition for patient's self-care

Standard VII. Discharge Planning/Transition to Another Facility

Transition coaching completed and discharge is initiated at the point that the patient/caregiver :

- Is aware of importance of maintaining a Personal Health Record
- Is knowledgeable of medications and maintains a written medication list
- Is aware of the need to make Physician/Specialist follow-up appointments and be an active participant in these interactions
- Knows who and when to call with a change in health status
- Is aware of the importance of self-management of chronic disease

In cases of a deteriorating medical condition or the patient or family's inability to provide care or a planned follow-up admission, a plan is put in place for handover to another health care program or facility. The handover at a minimum includes:

- A summary of current home health plan of care, including a medication list is provided to the admitting facility.
- Telephone contact with accepting program/facility to clarify and confirm referral for transition of patient's care

For patients who have a terminal illness or a life expectancy of six months or less, the home health care team facilitates with patient and family a discussion of either a specialized palliative care ("bridge to hospice") or hospice program.

REFERENCES

The framework for these Care Transitions Standards comes from the home health regulatory framework, which includes the federal Medicare Conditions of Participation (CMS-COP's), and the Outcomes Assessment Tool (CMS-OASIS C). Also incorporated are certain accepted industry quality standards put forth by both the JCAHO (Joint Commission, 2009) and the National Quality Forum, as well as the work of Coleman's Care Transitions Model (Coleman, 2003; Coleman, Parry, Chalmers & Min, 2006); Naylor's Quality Cost APN Model of Transitional Care (Naylor, 2000) and Lorig's Chronic Disease Self Management (Lorig & Holman, 2003).

Center for Medicare and Medicaid Services (CMS-COP's) (2009). Conditions of Participation: Home Health Agencies. Accessed 4/28/2010 at http://www.access.gpo.gov/nara/cfr/waisidx_99/42cfr484_99.html

Center for Medicare and Medicaid Services (CMS-OASIS) (2009). OASIS C. Accessed 5/1/2010 http://www.cms.gov/HomeHealthQualityInits/06_OASISC.asp#TopOfPage

Coleman, E. (2003). Falling through the cracks: Challenges and opportunities for improving transitional care for persons with continuous complex care needs. *Journal of the American Geriatrics Society, 51(4)*, 549-555

Coleman, E., Parry, C., Chalmers, S. & Min, S. (2006). The Care Transitions Intervention: Results of a randomized controlled trial. *Archives of Internal Medicine, 166*, 1822-1828.

Joint Commission (2009) *Accreditation Manual for Home Care*. Chicago: Joint Commission

Lorig, K. & Holman, H. (2003). Self-management education: History, definition, outcomes, and mechanisms. *Annals of Behavioral Medicine*, 26(1), 1-7.

Naylor, M. (2000) A Decade of transitional care research with vulnerable elders. *Journal of Cardiovascular Nursing*, 14(3), 1-14

EXPERT PANEL

The following individuals contributed to the content of this document:

Kathleen Aubert, RN
Director of Quality Improvement
Brockton VNA

Colleen Bayard PT, MPA
Director of Quality Management,
Excella Home Care

Keren Diamond, RN
Senior Vice President of Operations,
Visiting Nurse Association of Boston

Meg Doherty, MSN, ANP-BC, MBA
President
Norwell VNA

Merrily Evdokimoff, RN MSN,
Administrator/Director
Acton Public Health Nursing

Cheryl Pacella DNP(c), HHCNS-BC, COS-C, CPHQ
Quality Improvement Manager Hebrew
Senior Life HomeHealth Care

Patricia O'Brien, RN, MBA
Chief Executive Officer
Hebrew Senior Life HomeHealth Care

Helen, Siegel, RN, MSN
Director of Clinical & Regulatory Affairs
Home Care Alliance of Massachusetts

Jeanne M. Ryan, MA, OTR, CHCE, COS
Executive Director
VNA & Hospice of Cooley Dickinson

Laure Rubin
Principal
Quality Works

Jean Zalenski, PT, DPT, MEd.
Director of Community Resource Development
Holyoke VNA