Meeting Proposed Home Health Conditions of Participation by Applying Integrated Care Management Tools and Competencies

Beth Hennessey, BSN, MSN
Paula Suter, RN, BSN, MA
Sutter Center for Integrated Care
October 28th, 2015

Learning Objectives

1. Provide an overview of Home Health’s unique opportunity to achieve compliance with new CoP’s and simultaneously be a value added partner in healthcare reform.

2. Review Integrated Care Management (ICM) best practices and tools that support new CoP’s and enhance:
   1. Patient-centered assessment
   2. Interdisciplinary approach
   3. Outcome oriented PI
   4. Evidence-based processes
   5. Safe guard patient rights
Meet the Sutter Center for Integrated Care Team

Beth Hennessey, RN, MSN
Executive Director

Paula Suter, RN, BSN, MA
Clinical Director

Jennifer Pearce, MPA
Health Literacy Program Manager

Sutter Health at a Glance

One Sutter:
Patient Experience
Operational Excellence
Market Growth
Future Innovation

- 5,000+ physicians
- 55,000+ employees
- 24 acute care hospitals
- Home Health, Home Infusion, Hospice, DME
- Long-term care services
- Health care research, development and dissemination program
Sutter Center for Integrated Care (CIC): Facts About Who We Serve

SCAH

- 28 Locations
- 11 Home Health
- 7 Hospices
- 2 Infusion
- 2 HME
- 1 Private Duty & Geriatric Care Management

1,800 Employees
770 Volunteers
20,000 Average Daily Census

Sutter CIC

Sutter Health: Transitions of Care, Complex Case Management, Advanced Illness Management, PCMH, Patient Experience, Population Health

Outside SCAH/SH:
7000+ Providers (49 States and 3 Countries: US, Canada & Singapore)

Medicare Payments will Significantly Change: Bold Goals Set

1) Alternative Payment Models (ACOs & bundled payments)

30% by 2016
50% by 2018

2) Tied to quality or value

85% by 2016
90% by 2018
Living in Two Worlds at the Same Time is Challenging

Urgency for change to survive and thrive in both worlds calls providers to ...
consistently provide **exceptional high quality care for ALL patients**

Integrated Care Management (ICM): A Care Delivery Model for Exceptional High Quality Outcomes

- **Person Centered**
  - Care with dignity and respect
  - Goals guide care
  - Patient as partner

- **Evidence-Based**
  - Clinical best practices
  - Patient Engagement:
    - Self-management support
    - Health literate care

- **Coordinated Care**
  - Seamless transitions across providers, settings, and time
  - Meaningful and timely information exchange

Improved outcomes leading to better health, better care and lower cost
## New COP’s and ICM Practices/ Tools

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## Person-Centered Assessment: Predictor of Future Health and Risk

At time of transition/admission to home health assess risk using personal assessment of health

“In general would you say your health is… poor (1) fair (2) good (3) very good (4) excellent (5) ?”

Single Item Self-Rating and One Year Event Rates

Discussions in hospital and continued in the home

- What are you most concerned about at this time?
- What would you like to have happen as a result of our care?
- How would you like to feel?
- What is one thing that is most important to you that you want to be able to do again?

Patient Centered Assessment: PHR

Things that are important to me

- I am concerned or worried about: Feeling lonely as I live alone.
- I want to feel:
- I want to be able to: Have enough energy to visit my best friend in the nursing home.
- I need help with:
Patient-centered Evidence-based Interventions:
High Alert Med Tools

A recent study found that four agents were responsible for 2/3 of all drug related hospitalizations:

1. Plavix
2. Coumadin
3. Insulin
4. Oral Hypoglycemics


Person Centered Goal in EMR: Interdisciplinary Approach
Interdisciplinary Tools: Across Providers and Settings

Stoplight Tools
For information on ordering tools, please visit MySutter/SCAH/Pages/Patient-Education.aspx

Appropriate for all care settings

<table>
<thead>
<tr>
<th>Topics</th>
<th>Condition or Symptom Specific</th>
<th>Medicine Specific</th>
<th>Translated*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Ambulatory</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Skilled &amp; Rehab</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Homecare, Palliative &amp; Hospice</td>
<td>X</td>
<td>X</td>
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Connecting to a Cohesive Care Delivery that Promotes Efficiency, Safety, and Access

Sutter Health
We Plus You

Controlling diabetes at home

Connecting to a diabetes at casa

Control over diabetes in the home conditions

Control de la diabetes en casa

Pagcontrol ng diyabetes sa bahay

Kẻm soát bệnh tiểu đường tại nhà
Structured Interdisciplinary Communication and Collaboration: SBAR Application

- Transitions of Care Notes
- Case Conference/care coordination
- EMR Documentation
- New or change order requests of MD
  - Personal Health Record
- Eliciting information from patients/families/caregivers

SBAR for Patients in PHR

1. Who you are
   - Give your name
   - If you are not the patient, say how you know the patient

2. What you are being treated for
   - Include:
     - Names of medical problems
     - Home health care services you have now
     - Medical supplies you use (medication, oxygen, walker)

3. Why you are calling:
   - For example:
     - To ask a question
     - To report a problem or a change from normal
     - Because you noticed new signs or symptoms

4. What you need & how to reach if you need more help
   - For example:
     - To make an appointment
     - Have a test
     - More information

5. End the call by asking how to reach the doctor if you need more help:
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Leading Transformational Change: Steering Committees Set Goals

Put a bold aim with reality and you can drive change.

Jim Conway
Senior Fellow at the Institute for Healthcare Improvement (IHI) in Cambridge, Mass.
Bi-Weekly Huddle Meetings to Review Data: Both Processes and Outcomes Needed

<table>
<thead>
<tr>
<th>Type of measure</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Process measures</td>
<td>% with personal goal documented</td>
</tr>
<tr>
<td></td>
<td>% use of SBAR</td>
</tr>
<tr>
<td></td>
<td>% high risk patients on telehealth</td>
</tr>
<tr>
<td>Outcome measures</td>
<td>30 day readmission rate</td>
</tr>
<tr>
<td></td>
<td>Adverse drug event rate</td>
</tr>
<tr>
<td></td>
<td>Patient satisfaction scores</td>
</tr>
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Monthly Reports: Keeping Data Out in Front

- Sutter Care at Home - Home Health
  Documentation of Patient-Centered Goals

- Sutter Care at Home - Home Health
  Adherence to SBAR format in Case Conference Notes
100% Review of All Re-admissions

Audit Performed By: ________________________________  Formerly Performed By: ________________________________

Patient Initiated: ________________________________

Med Rec #:__________________________________________

Initiation Visit Date: ________________________________

Comprehensive Assessment Date: ________________________

Name of the Patient’s Care Manager: ______________________

<table>
<thead>
<tr>
<th>ITEM</th>
<th>YES</th>
<th>NO</th>
<th>COMMENTS</th>
</tr>
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<tr>
<td>1. Was the RI Note complete (did it address the following)?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Patient’s current goal/concerns</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Medication error risk score</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Level of literacy (low literacy)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Able to teach-back 1 &amp; 1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Personal assessment of health</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Was patient admitted within 24 hours of facility discharge or referral from community?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• H &amp; P</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Medication List</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>3. Were the following documents scanned into HCB prior to admission?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• H &amp; P</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Medication List</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Was targeted assessment done at Initiation Visit?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Did the assessment cover appropriate areas based on RI Note and H &amp; P?</td>
<td></td>
<td></td>
<td></td>
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Improvement Example: ARC Protocol

A review of patient charts revealed those that cancel visits are frequently re-hospitalized

We want patients to go from hospital to home and stay there
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## Initiation Visit – More than Just Timely Initiation of Care

- If high risk for re-admission: Initiation Visit (INV) conducted within 24 hours of discharge

- SOC OASIS completion delayed to second (next day) visit to permit focus on transition pillars
Initiation Visit Areas of Focus

1) Personal concerns reviewed & revised (PHR)

2) Self-management with 4 focuses:
   1) Medication safety/management
   2) Knowledge of signs and symptoms
   3) PCP/specialty care follow up
   4) Home safety

Medication Stoplights: Giving Permission to Focus on Areas of Risk
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Patient Rights – Accessibility To Health Information

Health literacy is part of a person-centered care process and essential to the delivery of cost-effective, safe, and high-quality health services.

Appropriate for All Individuals Regardless of:

- Reading ability
- Education level
- Socio-economic status


Example: Client Friendly Medicine List

<table>
<thead>
<tr>
<th>Medication and Route</th>
<th>Dose</th>
<th>Frequency</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acetaminophen Oral</td>
<td>325 mg</td>
<td>1-2 Tabs</td>
<td>Every 4 Hours - Take Only As Needed</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aspirin Oral</td>
<td>10 mg</td>
<td>1 Tab</td>
<td>Daily</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baclofen Oral</td>
<td>10 mg</td>
<td>1/2 Tab</td>
<td>2 Times Daily</td>
</tr>
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Special Instructions for administration:

- Share any questions or concerns you have about your medicine with your health care team.
- Print name: AUGMENTIN

Font size increased to 14 pt.
Patient Rights...

Every patient has the right to understand. Delivering patient-centered, health literate care is simply the right thing to do.

What questions do you have?

Contact Information
Beth Hennessey: hennesb@sutterhealth.org
Paula Suter: suterp@sutterhealth.org