Home Health Agencies & Reducing Readmissions

presented by
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HHQI RN Project Coordinator
WVMI & Quality Insights
Objectives

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

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

- Home Health Agencies
- Hospitals
- Physician Offices
- Stakeholders (local, state, and national)
- Nursing Homes
Value of Home Health

- Build trust and relationships
- Identify adherence issues or barriers
- Activate and engage patient
- Teach self-management skills
- Provide cross-setting communications
Medicare Home Health Criteria

1. Physician orders
   - Plan of Care
   - Face-to-Face Encounter

2. Skilled Care
   - Intermittent skilled nursing care
   - Physical therapy
     - Occupational therapy cannot initiate care, but can continue care
   - Speech-language pathology services

3. Medicare-certified Home Health Agency

4. Homebound
   - See next slide for new rules effective 11/19/13

Medicare Home Health Criteria

Criteria-One

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

  OR

• Have a condition such that leaving his or her home is medically contraindicated.

• If the patient meets one of the Criteria-One conditions, then the patient must ALSO meet two additional requirements defined in Criteria-Two.

Criteria-Two

• There must exist a normal inability to leave home;  

  AND

• Leaving home must require a considerable and taxing effort.

New changes as of 11/19/13
Home Health Compare (HHC)

• How often HH patients had to be admitted to the hospital
  – National: 17%*

• Urgent, unplanned ED Visits:
  – National: 12%*

• HHC data is based upon ending of an episode – not 30 days

* Based on claims data for Jan. – Dec. 2012
www.HomeHealthQuality.org
HHQI

Special Project funded by Centers for Medicare & Medicaid Services

Initial campaign 2007 and currently in 3rd Phase

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

Free tools, resources, & networking
Topic Focus

• Acute Care Hospitalization
• Oral Medication Management
• Influenza & Pneumococcal Immunization
• Underserved Populations
• And now...Cardiovascular Prevention
HHQI is Touching Millions of Lives

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

• Home health and cross-setting free resources

• Four categories:
  – **Education**
  – **Data**
  – **Networking**
  – **Assistance**
Campaign Website

Welcome to the HHQI National Campaign

Since 2007, the Home Health Quality Improvement (HHQI) National Campaign has been dedicated to improving the quality of care provided to America’s home health patients. Whether you are a home health practitioner directly providing patient care, or an allied partner with a stake in improving the quality of care that home health patients receive, we are here to help you with evidence-based tools, timely data reports and a wealth of engaging educational opportunities. All of our resources are absolutely free and available to everyone. Please explore our site to learn more about this initiative of the Centers for Medicare & Medicaid Services (CMS). Working together, we can make a real difference in patients’ health care and ultimately, their quality of life.

Campaign Resources: Discover our free resources to help improve your patients’ outcomes, including Best Practice Intervention Packages (BPIPs), Data Access Reports, Webinars and the unique HHQI Community of engaged stakeholders united to improve health care quality.

Register Now: Join the campaign for immediate access to our free-quality improvement tools. Simply click on the icon to the left, and fill out the form. It’s that easy to begin improving health care quality using our evidence-based resources and best practice educational tools.

Quick Links

www.HomeHealthQuality.org
BPIP: Leadership

- Evidence-based Practices
- Application
- Tools & Resources
- Cross-setting Approach
BPIP: Discipline Tracks

- Nursing
- Therapy
- Social Worker
- Aide
Underserved Populations (UP) Network

- Health Disparities
- Dual-Eligible
- Small HHA
- Underserved Areas
Essential Best Practice Interventions to Reduce Readmissions

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

**Hospitalization Risk Assessment**

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

**Patient Name:**

**Record #:**

**Date:**

<table>
<thead>
<tr>
<th>Prior pattern</th>
<th>Check all that apply</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□ &gt; 1 Hospitalizations or ER visits in the past 12 months (M1032)</td>
</tr>
<tr>
<td>Chronic conditions</td>
<td>Check all that apply (M1020/1022/1024)</td>
</tr>
<tr>
<td></td>
<td>□ HF (M1500 and M1510)</td>
</tr>
<tr>
<td></td>
<td>□ Diabetes</td>
</tr>
<tr>
<td></td>
<td>□ COPD</td>
</tr>
<tr>
<td></td>
<td>□ Chronic skin ulcers <em>(Wound consult if indicated for any wounds)</em></td>
</tr>
<tr>
<td>Risk Factors</td>
<td>Check all that apply</td>
</tr>
<tr>
<td></td>
<td>□ History of falls <em>(M1032 and M1910)</em></td>
</tr>
<tr>
<td></td>
<td>□ Non-compliance with medication regimen</td>
</tr>
<tr>
<td></td>
<td>□ Low socioeconomic status or financial concerns</td>
</tr>
<tr>
<td></td>
<td>□ Confusion (M1710)</td>
</tr>
<tr>
<td></td>
<td>□ Pressure ulcer (M1300, M1302 and M1306)</td>
</tr>
<tr>
<td></td>
<td>□ Stasis ulcer (M1330)</td>
</tr>
<tr>
<td></td>
<td>□ Overall Poor Status/Prognosis (M1034)</td>
</tr>
<tr>
<td></td>
<td>□ Low literacy level</td>
</tr>
<tr>
<td></td>
<td>□ Depression (M1730)</td>
</tr>
<tr>
<td></td>
<td>□ Consider Therapy referral (PT, OT, ST)</td>
</tr>
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<td></td>
<td>□ Consider MSW referral</td>
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<td></td>
<td>□ Consider Hospice referral</td>
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<tr>
<td></td>
<td>□ Consider RN referral, if not ordered</td>
</tr>
</tbody>
</table>

*Total #: # of checked boxes is ___.*

*Your agency may want to select a threshold score to target patients at high risk.*

*(For example, 5 or greater risk factors may indicate that the patient is at risk for hospitalization. Note: This number is for convenience only and has not been tested or validated. The agency may modify the score based upon the needs of their patient population.)*
Hospital Risk Assessment

Call Me First!

Stay safe and well at home. Avoid unneeded trips to the hospital. Tell me when you have health changes:
- Get sick
- Just don’t feel right
- Find it harder to stand up from a chair

I can help you if I know you need help!

Call Me First! Because I Care!

Name: _______________________

Local Number: _______________

(Anytime: 24 Hours/7 Days a Week)
# My Emergency Plan

[Agency Name & Agency Phone Number]

Patient Name ____________________________

## MY EMERGENCY PLAN

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

System Approach to Medication Reconciliation

Purpose: Use this tool to facilitate questions and discussion related to agency’s medication reconciliation process

Intake Referral
- Does intake ensure a copy of the discharge medication list is obtained from all referral sources?
- Does intake obtain all secondary insurances which may be needed for medication coverage?
- If you use liaisons, do they obtain discharge instructions that include all medications, a list of prescriptions sent home with the patient, and review the chart for any medication issues?

Medication Regimen
- How is the patient’s previous medication regimen obtained?
- Does staff consistently collect a current, thorough list of all meds including herbal, vitamins, nutritional supplements, and OTC drugs?
- How does your agency confirm that clinicians collect all medications in a consistent manner?
- Has the patient been using multiple pharmacies?

Reconciliation Process
- After reconciling previous and current medications, who contacts physician for order clarifications?
- How do clinicians clarify orders (fax, e-mail, phone calls, etc.)?
- What documentation is expected to indicate reconciliation was completed and any changes made?
- Where is this documentation located in the record?
- Does agency promote pharmacist consultation to reduce redundancy and/or for professional expertise?

Patient Education
- How do patients receive education on medication changes?
- Does staff use teach-back?
- Are patient handouts easily accessible?
- Is telemonitoring or phone monitoring used to reinforce medication education?
- Are patient handouts reviewed for health literacy principles?

Updating the Medication List
- What is agency’s policy to keep the medication list current (visit-to-visit or after physician appointment)?
- What communication systems are available and promoted for physician’s office to contact agency (e.g., dedicated fax number)?

Discharge or Transfer from Agency
- Who gives the current med list to the patient, PCP, and/or inpatient provider at discharge or transfer?
- Does patient have a wallet card/med list that includes pharmacy contact?
- Does patient receive education on whom to contact after discharge if he/she has a medication question?

Medication Management

7 STEPS TO MEDICATION SIMPLIFICATION

1. Discontinue/ Substitute Cautions Meds (MD, Pharm, RN)
2. Reduce Multiple Meds for Single Conditions (MD, Pharm, RN)
3. Long-Acting/Sustained Release Alternatives (MD, Pharm, RN, Patient/Caregiver)
4. Coordinate Doses with Established Daily Routines (MD, Pharm, RN, PT, OT, SLP, Aide, Patient/Caregiver)
5. Non-Drug Alternatives (MD, RN, PT, OT, Aide, Patient/Caregiver)
6. Single Pharmacy (MD, Pharm, RN, PT, OT, SLP, Patient/Caregiver)
7. Remove/Discard Old/Expired Drugs (RN, PT, OT, SLP, Patient/Caregiver)
# Medication Management

<table>
<thead>
<tr>
<th>Medicine name, strength</th>
<th>Morning dose</th>
<th>Noon dose</th>
<th>Evening dose</th>
<th>Bedtime dose</th>
<th>As needed dose</th>
<th>Notes:</th>
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</thead>
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</tbody>
</table>

Schedule was last updated on _______________  Page _______________ of _______
Medication Management

MEDICATION NON-ADHERENCE – A Staff Education Tool

<table>
<thead>
<tr>
<th>Potential Non-Adherence Issues</th>
<th>Assessment Strategies</th>
<th>Referral Triggers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowledge Deficit</td>
<td>Is there evidence to support/suggest that patient/caregiver does not understand medication regimen?</td>
<td>RN</td>
</tr>
<tr>
<td></td>
<td>“I’m not having (symptoms) anymore, so I’m not sure whether to keep taking this.”</td>
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<td></td>
<td>“That makes my stomach upset, so I try not to take it.”</td>
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<td></td>
<td>“I don’t know when to take my meds or what dose to take.”</td>
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</tr>
<tr>
<td></td>
<td>Knowledge Deficit:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Is there evidence to support/suggest that patient’s/caregiver’s inability to read is affecting medication compliance?</td>
<td>RN, SLP, OT</td>
</tr>
<tr>
<td></td>
<td>Unable to read medication name, frequency, dosage, instructions.</td>
<td></td>
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<td></td>
<td>Financial Concerns*</td>
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<td></td>
<td>Is there evidence to support/suggest that patient is limiting medication use to save money?</td>
<td>RN, MSW</td>
</tr>
<tr>
<td></td>
<td>“I take it when I really need it.”</td>
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<tr>
<td></td>
<td>“I sometimes only take half the ordered amount.”</td>
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<tr>
<td></td>
<td>Fear of Addiction*</td>
<td></td>
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<tr>
<td></td>
<td>Is there evidence to support/suggest that patient is limiting medication use due to concerns he or she will become addicted?</td>
<td>RN, MSW</td>
</tr>
<tr>
<td></td>
<td>“I want to get off that stuff.”</td>
<td></td>
</tr>
<tr>
<td></td>
<td>“I only take it when I can’t stand it anymore.”</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Drug Diversion or Over-Medicating*</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Is there evidence to support/suggest that patient is taking too much medication?</td>
<td>RN, MSW</td>
</tr>
<tr>
<td></td>
<td>“I need a refill, the bottle spilled in the sink.”</td>
<td></td>
</tr>
<tr>
<td></td>
<td>“Even doubling the prescribed amount does not touch the pain.” (does not assume intentional over-medicating without evaluating for true ineffectiveness of current meds, need for adjunct therapy, etc.)</td>
<td></td>
</tr>
</tbody>
</table>

Health Belief Expectations

<table>
<thead>
<tr>
<th>Health Belief Expectations</th>
<th>Is there evidence to support/suggest that the patient’s medication non-compliance may be due to general beliefs or expectations about health and illness?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• “If he is meant to get better, it will happen.”</td>
</tr>
<tr>
<td></td>
<td>• “If I take the pills, it will show a lack of faith.”</td>
</tr>
<tr>
<td></td>
<td>Memory Deficit:</td>
</tr>
<tr>
<td></td>
<td>Is there evidence to support/suggest that the patient is forgetting to take medications, or forgetting that medications have already been taken resulting in non-compliance?</td>
</tr>
<tr>
<td></td>
<td>“I usually take one after lunch, but my daughter called, and I can’t remember if I took it.”</td>
</tr>
<tr>
<td></td>
<td>Pills found in chair, on table by cup, etc.</td>
</tr>
<tr>
<td></td>
<td>Incorrect pill counts</td>
</tr>
<tr>
<td></td>
<td>Signs of ineffective drug therapy</td>
</tr>
<tr>
<td></td>
<td>Functional Deficit:</td>
</tr>
<tr>
<td></td>
<td>Is there evidence to support/suggest that patient/caregiver non-adherence is due to functional deficits?</td>
</tr>
<tr>
<td></td>
<td>Fine motor/gross motor/mobility</td>
</tr>
<tr>
<td></td>
<td>Vision</td>
</tr>
<tr>
<td></td>
<td>Swallowing</td>
</tr>
<tr>
<td></td>
<td>Disorganization:</td>
</tr>
<tr>
<td></td>
<td>Is there evidence to support/suggest that the patient’s medication administration methods lack organization?</td>
</tr>
<tr>
<td></td>
<td>Bottle/pills in multiple locations</td>
</tr>
<tr>
<td></td>
<td>Unable to locate all medications</td>
</tr>
<tr>
<td></td>
<td>Reported administration methods vary from day to day (inconsistent)</td>
</tr>
<tr>
<td></td>
<td>Lack of established or predictable routines (sleep, meals, ADLs, etc.)</td>
</tr>
</tbody>
</table>

*May not affect patient’s ability to take medications, therefore may not impact MOC20. Referrals should be made based on patient need, state practice acts, and agency policy.

Patient Self-Management

### MY ACTION PLAN

**DATE:** ______

I __________________________ and __________________________

(name) and (name of clinician)

have agreed that to improve my health I will:

1. Choose one of the activities below:
   - Work on something that’s bothering me:
   - Stay more physically active!
   - Take my medications.
   - Improve my food choices.
   - Reduce my stress.
   - Cut down on smoking.

2. Choose your confidence level:
   - 10 VERY SURE
   - 9 SOMETHING SURE
   - 8 NOT SURE AT ALL

3. Complete this box for the chosen activity:
   - What:
   - How much:
   - When:
   - How often:

4. Follow-up:

   (Signature)

   (Signature of clinician)

---

### My Action Plan

1. **Goal:** Something I want to do __________________________

2. **Describe how:** __________________________

   **Where:** __________________________

   **When/How often:** __________________________

3. **Barrier(s):** __________________________

   **Plan to overcome barrier(s):** __________________________

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

   [___] [___] [___] [___] [___]

   - Totally Unconvinced
   - A Little Convinced
   - Somewhat Convinced
   - Very Convinced
   - Extremely Convinced

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

   [___] [___] [___] [___] [___]

   - Totally Unconvinced
   - A Little Convinced
   - Somewhat Convinced
   - Very Convinced
   - Extremely Convinced

6. **Follow-up:** __________________________
Patient Self-Management

### Patient Self-Hospitalization Risk Assessment

**Are You at Risk for Going to the Hospital?**

<table>
<thead>
<tr>
<th>Name:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>My Top Health Wish or Goal:</td>
<td></td>
</tr>
</tbody>
</table>

**Check all boxes that are true for you:**

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

My total number of checked boxes above is ______.  

<table>
<thead>
<tr>
<th>I’m interested in knowing more about services from:</th>
<th>I’m interested in knowing more about services from:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Therapy</td>
<td>Social Worker</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>Hospice Care</td>
</tr>
</tbody>
</table>

- [ ] I know how to call for help and have a “Call Me First” home poster.

<table>
<thead>
<tr>
<th>Patient Signature:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Health Signature:</td>
<td>Date:</td>
</tr>
</tbody>
</table>
To better manage my health and medications I will...

- Take this Personal Health Record with me wherever I go, including all doctor visits, emergencies or hospitalizations.
- Call my doctor or pharmacist if I have questions about my medications.
- Tell my doctors and pharmacist about all medications I am taking, including over-the-counter drugs, vitamins and herbal formulas.
- Know why I am taking each of my medications.
- Know how much, when and for how long I am to take each medication.
- Ask for help when I am uncertain about my health care goals.

Keep this record up to date if anything changes.

Hospital Discharge List

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

Doctor Appointments

<table>
<thead>
<tr>
<th>Date</th>
<th>Doctor</th>
<th>Reason</th>
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</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

Things I need to watch for

<table>
<thead>
<tr>
<th>Warning Sign</th>
<th>What I need to do</th>
</tr>
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<tbody>
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<td></td>
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</table>

Hospitalization Information

<table>
<thead>
<tr>
<th>Date Admitted: <em><strong>/</strong></em></th>
<th>Date Discharged: <em><strong>/</strong></em></th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital: ____________</td>
<td>____________</td>
</tr>
<tr>
<td>Reason: ______________</td>
<td>______________</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Date Admitted: <em><strong>/</strong></em></th>
<th>Date Discharged: <em><strong>/</strong></em></th>
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<tbody>
<tr>
<td>Hospital: ____________</td>
<td>____________</td>
</tr>
<tr>
<td>Reason: ______________</td>
<td>______________</td>
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<table>
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<tr>
<th>Date Admitted: <em><strong>/</strong></em></th>
<th>Date Discharged: <em><strong>/</strong></em></th>
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<tbody>
<tr>
<td>Hospital: ____________</td>
<td>____________</td>
</tr>
<tr>
<td>Reason: ______________</td>
<td>______________</td>
</tr>
</tbody>
</table>

Every time you talk with your doctor, use the Ask Me 3 questions to better understand your health:
1. What is my main problem?
2. What do I need to do?
3. Why is it important for me to do this?
Disease Management

CONGESTIVE HEART FAILURE ZONES for MANAGEMENT

**Green Zone: All Clear**
- Your Admission Weight: __________
- Your Goal weight: __________
- No shortness of breath
- No swelling
- No weight gain
- No chest pain
- No decrease in your ability to maintain your activity level

**Green Zone Means**
- Your symptoms are under control
- Continue taking your medications as ordered
- Continue daily weights
- Follow 3-4 salt diet
- Keep all your physician appointments

**Yellow Zone: Caution**
If you have any of the following symptoms:
- Increased weight (2-3 lbs. in one day or 4-5 lbs. in the past 5 days)
- Increased cough
- Increased swelling of legs, feet or ankles
- Increased shortness of breath with activity
- Increase in the number of pillows needed
- Anything else that bothers you

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

**Yellow Zone Means**
- Your symptoms indicate you need an adjustment of your medications

AGENCY NAME
PHONE NUMBER

**Red Zone: Medical Alert**
- Uncontrolled symptoms of shortness of breath, or shortness of breath at rest
- Uncontrolled chest pain
- Wheezing or chest tightness at rest
- Need to sit in a chair to sleep
- Weight gain of more than 5 lbs
- Confusion or mental status changes
**CALL YOUR PHYSICIAN IMMEDIATELY**

AGENCY NAME
PHONE NUMBER

AGENCY NAME
DIABETES EMERGENCY PLAN

**Green Zone: Great Control**
- Your Goal HbA1C: __________

- HbA1c is under 7
- Average blood sugars typically under 150
- Most fasting blood sugars under 120

**Call your physician if you are going into the YELLOW zone.**

**Yellow Zone: Caution**
- HbA1c between 7 and 9
- Average blood sugar between 160 — 210
- Most fasting blood sugars under 200

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

**Green Zone Means:**
- Your blood sugars are under control
- Continue taking medications as ordered
- Continue routine blood glucose monitoring
- Follow healthy eating habits
- Keep all physician appointments

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

**Red Zone Means:**
- You need to be evaluated by your physician. If you have a blood sugar over ___ follow these instructions.

**Call your physician**
Name: __________
Number: __________

**Call your physician**
Name: __________
Number: __________
## Self Management Plan for Heart Disease

**Name:** ____________________________  
**Date:** ____________________________

<table>
<thead>
<tr>
<th>Green Zone = “All Clear”</th>
<th>Green Zone Means:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• No shortness of breath</td>
<td>• Your symptoms are under control</td>
</tr>
<tr>
<td>• No swelling</td>
<td>• Continue taking your medications</td>
</tr>
<tr>
<td>• No weight gain</td>
<td>• Continue to follow your diet</td>
</tr>
<tr>
<td>• No decrease in your ability to maintain normal activity level</td>
<td>• Keep your Home Care Nurse appointments</td>
</tr>
<tr>
<td></td>
<td>• Keep physician appointments</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Yellow Zone = “Caution”</th>
<th>Yellow Zone Means:</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you have any of the following signs or symptoms:</td>
<td>• Your symptoms indicate that you may need an adjustment in your medications</td>
</tr>
<tr>
<td>• Increased weight (2-3 lbs, in one day or 4-5 lbs in the past 5 days)</td>
<td>• Call your Home Health Nurse and/or your physician</td>
</tr>
<tr>
<td>• Increased cough</td>
<td><strong>Agency Name</strong> 24 hour phone number is:</td>
</tr>
<tr>
<td>• Increased swelling of legs, ankles and/or feet</td>
<td><strong>Agency Phone Number</strong></td>
</tr>
<tr>
<td>• Increased shortness of breath with activity</td>
<td></td>
</tr>
<tr>
<td>• Chest Pain</td>
<td></td>
</tr>
<tr>
<td>• Increased number of pillows needed to sleep or need to sleep in a chair</td>
<td></td>
</tr>
<tr>
<td>• Anything else unusual that bothers you</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Red Zone = “Medical Alert”</th>
<th>Red Zone Means:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Unrelieved shortness of breath</td>
<td>This indicates that you need to be evaluated by a physician right away</td>
</tr>
<tr>
<td>• Unrelieved chest pain</td>
<td></td>
</tr>
<tr>
<td>• Wheezing or chest tightness at rest</td>
<td></td>
</tr>
<tr>
<td>• Chest pain not relieved or reoccurs after taking ____ Nitro tablets</td>
<td></td>
</tr>
<tr>
<td>• Mental changes</td>
<td></td>
</tr>
</tbody>
</table>

(Please notify your Home Care Nurse if you contact or go see your MD)
Care Transitions

Cross-Settings I BPIP

• Different care transition’s models
  – The Care Transitions Program®
  – Transitional Care Model© (TCM)
  – Better Outcomes for Older adults through Safe Transitions (BOOST)
  – Project Re-Engineered Discharge (Project RED)
  – IHI’s Transitional Home
  – State Action on Avoidable Rehospitalizations(STARR) Initiative

• Care Transitions and Coaching is focus of this package
Medicare Beneficiary Discharge Planning
REFERENCE LIST

Patient Choice
Section 423(b) of the Balanced Budget Act of 1997 requires that Medicare-certified home health agencies (HHAs) serve the beneficiaries in geographic areas and which are underutilized. In addition, the statute reflects knowledge of study that beneficiaries derive services from a particular HHA. Further, the statute requires that hospitals identify any HHAs or other entities with whom they have a financial interest or which have a financial interest in them. The intent of sections 1871(a) is to protect patient choice. (Medicare Appeal Act, 1997, No. 221/Friday November 30, 1997/Proposed Rule)

To qualify for Medicare
Home Health Services
- The patient is under the care of a physician (home maternity physician) and is an inpatient under care
- The patient requires skilled nursing, physical therapy, or speech therapy services, or has a continuing need for physical therapy on an intermittent basis. (If daily, then there is no re-visit to daily care)
- Services are provided to the patient's home
- Services must be reasonable and necessary
- The patient is homeless

Definition of homebound
Homebound means the condition of the patient that makes it impossible to leave home. When the patient does leave home, it requires a considerable and tiring effort.
Homebound Criteria:
- (2) Alarms from the home are infrequent or of short duration
- (3) Examples of infrequent or short duration absences
- Attendance at religious service
- Attendance at a significant family event
- Trip to barber or hairdresser
- To receive health care treatment
- To attend medical or dental services
- Consideration and tiring effort means the patient requires one of a supportive device (walker, cane, wheelchair), one of the transporters, it's reasonable to attend the services, and home care is medically contraindicated.

Definition of reasonable and necessary
Skilled services are reasonable and necessary if there is a reasonable potential of a complication or further acute episode.

Written, site, and available caregiver
Written notices are usually covered for a reasonable period of time (three weeks) or more as there remains a reasonable potential of a complication or further acute episode

Definition of necessary service
Skilled services encompass observation and assessment, teaching and training, performance of skilled treatments and procedures, or management and evaluation of the care plan.

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

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

CRITICAL PATIENT INFORMATION to include when transitioning patients between health care settings

☐ 1. Date and time of transfer
☐ 2. Patient name
☐ 3. Sex
☐ 4. Date of birth
☐ 5. Address
☐ 6. Insurance information, including documentation of prior authorization for transfer of care to the receiving healthcare provider and transportation payer
☐ 7. Medical Diagnosis
☐ 8. Treatment provided with timeframe
☐ 9. Clinical condition
☐ 10. Medical summary that includes history and physical with update for discharge disposition, including discharge and pre-discharge medical status
☐ 11. Recent reports of lab work, x-rays, EKG, and other relevant tests
☐ 12. Medications and treatments required by the patient (if applicable, include medications patient uses administered on the day of discharge)
☐ 13. Prescriptions
☐ 14. Access to care
☐ 15. Access to care
☐ 16. Follow-up therapy notes (if applicable)
☐ 17. Psychological history and summary
☐ 18. Summary of nursing care plan
☐ 19. Physician to order to transfer—spinal cord, bone, and tissue
☐ 20. Reason for discharge transfer
☐ 21. Patient destination
☐ 22. Current discharge plans, including discharge arrangements
☐ 23. Patient/family agreement to discharge
☐ 24. Discharge PRIS/PCD (if applicable)
☐ 25. List of personal effects, money, valuables (if transferring to another facility)
☐ 26. Any other required patient assessment documentation (MSDs/ABM/MDS/M293)
☐ 27. Sending and receiving facility transfer/discharge documents
☐ 28. Mode of discharge (transportation)
☐ 29. COBRA transfer form (if applicable)
☐ 30. Summary of patient education, assessment of learning and response to teaching provided during episode of care

## Discharge/Transfer Form

### Discharge Criteria

**Low Risk Discharge**
- Independent in ADLs
- Caregiver in the home and available to assist
- Lives alone with community support
- Independent with management of chronic disease
- Adherent to treatment plan
- Able to direct medical care
- Consistently followed by MDO/Therapist

**Moderate Risk Discharge**
- Lives alone with limited community support
- Requires assistance with medications
- Issues of health literacy
- History of mental illness
- Polypharmacy (greater than 7 meds)
- Requires temporary assistance with ADLs
- Requires assistance in:
  - Ambulating
  - Transferring
  - Around care
  - Management of oxygen and nebulizer

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

**If ≥ 2 then refer to home health agency**

### Discharge to Community

Refer to home care services for patients who reside in Adult Home or Assisted Living Facility

**Refer to home care services for:**
- Skilled nursing
- Observation and assessment
- Teaching and training
- Performance of skilled treatment or procedure
- Management and evaluation of a client care plan
  - AND/OR
  - Physical, occupational, and/or speech therapy
  - Medical social work
  - Home health aide service for personal care and/or therapeutic exercises
  - Telehealth Care Management

### Other Outpatient Referrals

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

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

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

PRO-00717318-07-11
# Discharge/Transfer Form

## NEW YORK STATE DISCHARGE PLANNING AT A GLANCE

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

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

### SKILLED SERVICES

- **Hospice Services**
- **Certified Home Health Agency (CHHA)**
  - **Medicare**
    - Homebound requirement
  - **Medicaid**
    - Commercial insurance
    - Requires skilled services: Nursing, PT, OT, ST, MSW, home health aide

### SKILLED OR NON-SKILLED SERVICES

- **Licensed Home Care Agency (LHCSA)**
  - **Medicaid or Private Pay**
    - No skilled care required (assist with personal care and activities of daily living (ADLs))
  - **Commercial Insurance**
    - Requires skilled services
  - Requires skilled non-skilled services: Nursing, PT, OT, ST, MSW, home health aide

### NON-SKILLED SERVICES

- **Home and Community-Based Services**
- **Medicaid Waiver AND Long Term Care Services**
- **Insurance (Long Term Care)**

### Types of Programs

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

### For Children (0-18 years)

- Care At Home Program

### Other Services provided at home:

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

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

- Patient’s pre-hospitalization functional ability
- Informal support—family, willing, available caregiver
- Cognition
- Patient’s current functional ability
- Prior home care services
- Multiple hospitalizations—high risk
- Chronic Illnesses
- Special Needs—assistive medical equipment
- Teachability/Understanding of illness

### To locate services within a specific NYS County access:

www.nyconnects.org

OR County-based point of entry (Central Assessment Unit) in County Department of Social Services

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

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

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

• Additional handout - PDF document of key resources your organization may want to use or modify
  – Many more tools and resources available - free
Cardiovascular Health Improvement Initiative

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

- Webinars including UP Networking
- LiveChat
- Discussion Forums
- MyHHQI Blog
- Social Networking
Questions?
Thank You!

mkevech@wvmi.org

www.HomeHealthQuality.org

This material was prepared by the West Virginia Medical Institute, the Quality Improvement Organization supporting the Home Health Quality Improvement National Campaign, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The views presented do not necessarily reflect CMS policy. Publication Number: 10SOW-WV-HH-MD-103013