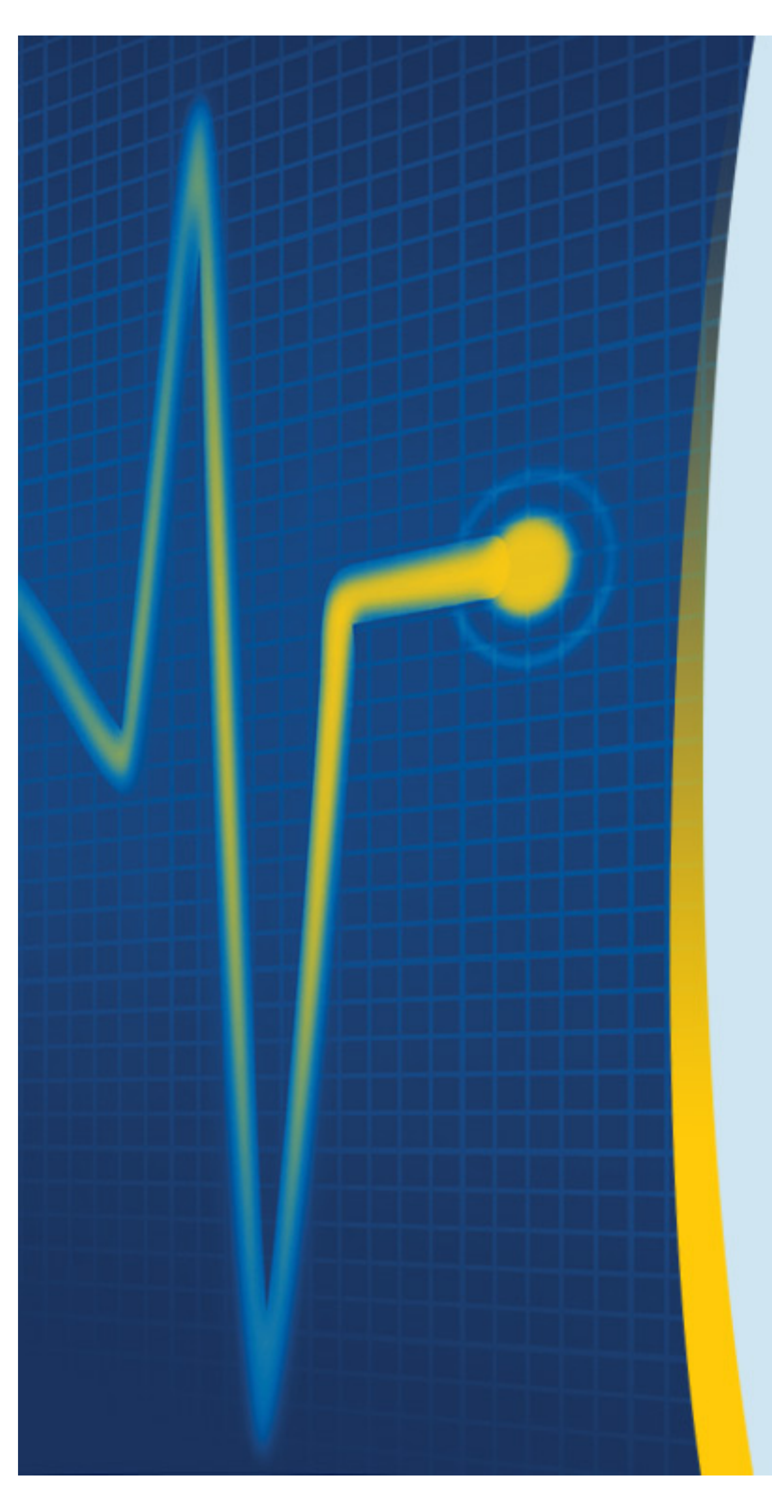


Bringing it Home with the PCMH:

Partnering with Home Health to Improve Quality and Patient Outcomes

September 16, 2013

About the Alliance

- 501(c)(3) non-profit research foundation
- Mission: To support research and education on the value home health care can offer to patients and the U.S. health care system. Working with researchers, key experts and thought leaders, and providers across the spectrum of care, we strive to foster solutions that will improve health care in America.
- *www.ahhqi.org*

Today's Speakers: Dr. Steven Landers

Steven H. Landers, MD, MPH
President, Chief Executive Officer
VNA Health Group
Steven.Landers@vnahg.org

Steven H. Landers, MD, MPH serves as the President and Chief Executive Officer of VNA Health Group, New Jersey's largest non-profit visiting nursing organization. Prior to his role at VNA Health Group, Dr. Landers directed home and community-based care services at the Cleveland Clinic as the Director of the Center for Home Care and Community Rehabilitation.

Today's Speakers: Beth Hennessey

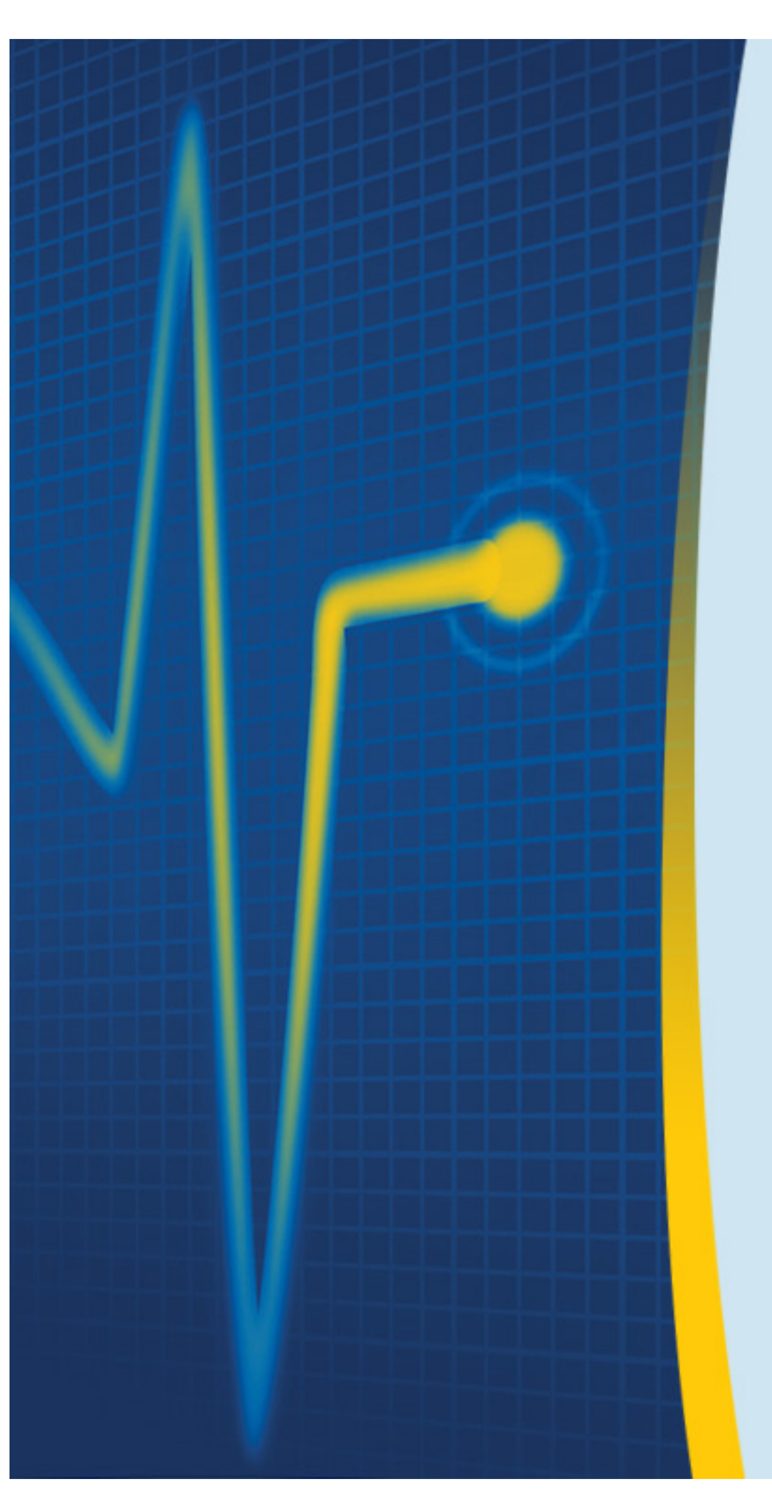
Beth Hennessey, RN, BSN, MSN
Executive Director, Integrated Care
Sutter Care at Home
hennesb@sutterhealth.org

Beth is the Executive Director at Sutter Center for Integrated Care. She leads the strategic planning and development of innovative care delivery approaches for sustainable, high quality, patient-centered care. Prior to joining Sutter, Beth and her colleagues developed the Home-Based Chronic Care Model™, which received national awards for excellence from the National Association of Homecare and Hospice (NAHC) and Modern Healthcare. Under her leadership the Home-Based Chronic Care Model evolved into the Integrated Care Model (ICM).

Today's Speakers: Paula Suter

Paula Suter, RN, BSN, MA
Director, Chronic Care Management
Sutter Care at Home
suterp@sutterhealth.org

Paula is the Clinical Director of Integrated Care Management (ICM) at the Sutter Center for Integrated Care. She has over 30 years of healthcare clinical and leadership experience across care settings including home care, acute care, intensive care, cardiac rehab, education, and research. Prior to joining Sutter, Paula co-developed the Home-Based Chronic Care Model™, which received national excellence awards from the National Association of Homecare and Hospice and Modern Healthcare.



The Challenge at Hand

Secret Weapons of Home Care

- Enhanced View of Patient and Caregivers
- Breaks Down Barriers to Care
- Strengthened Relationships
- Can Avoid Hazards
- Can Cost Less
- Often Desired More

Healthy at Home: Never More Relevant

Patient Centered Medical Homes

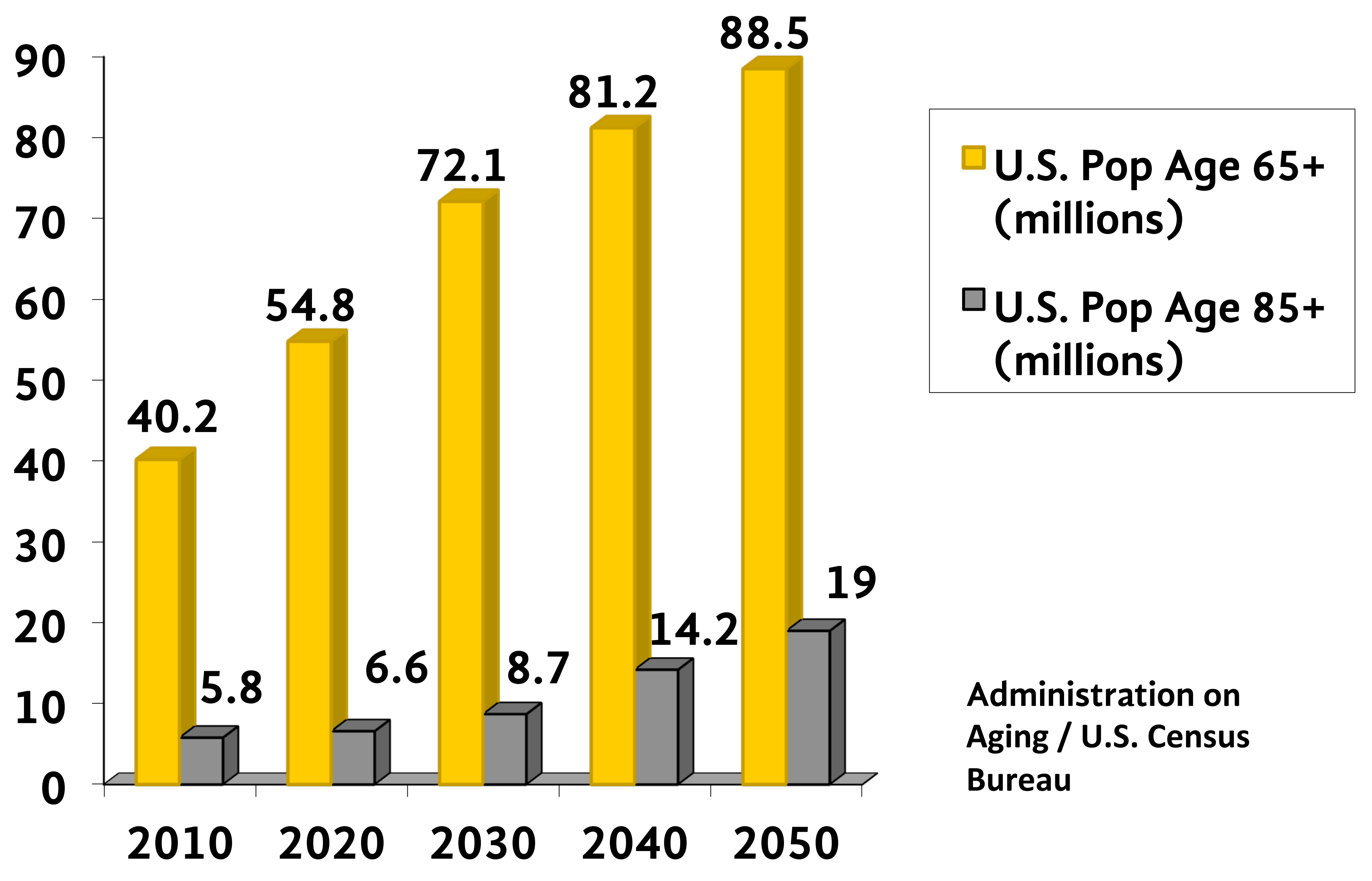
- Mindful clinician-patient communication
- Whole-person care
- Care is coordinated and/or integrated
- Quality and safety
- Enhanced access to care

Can't Forget Those In the Shadows…

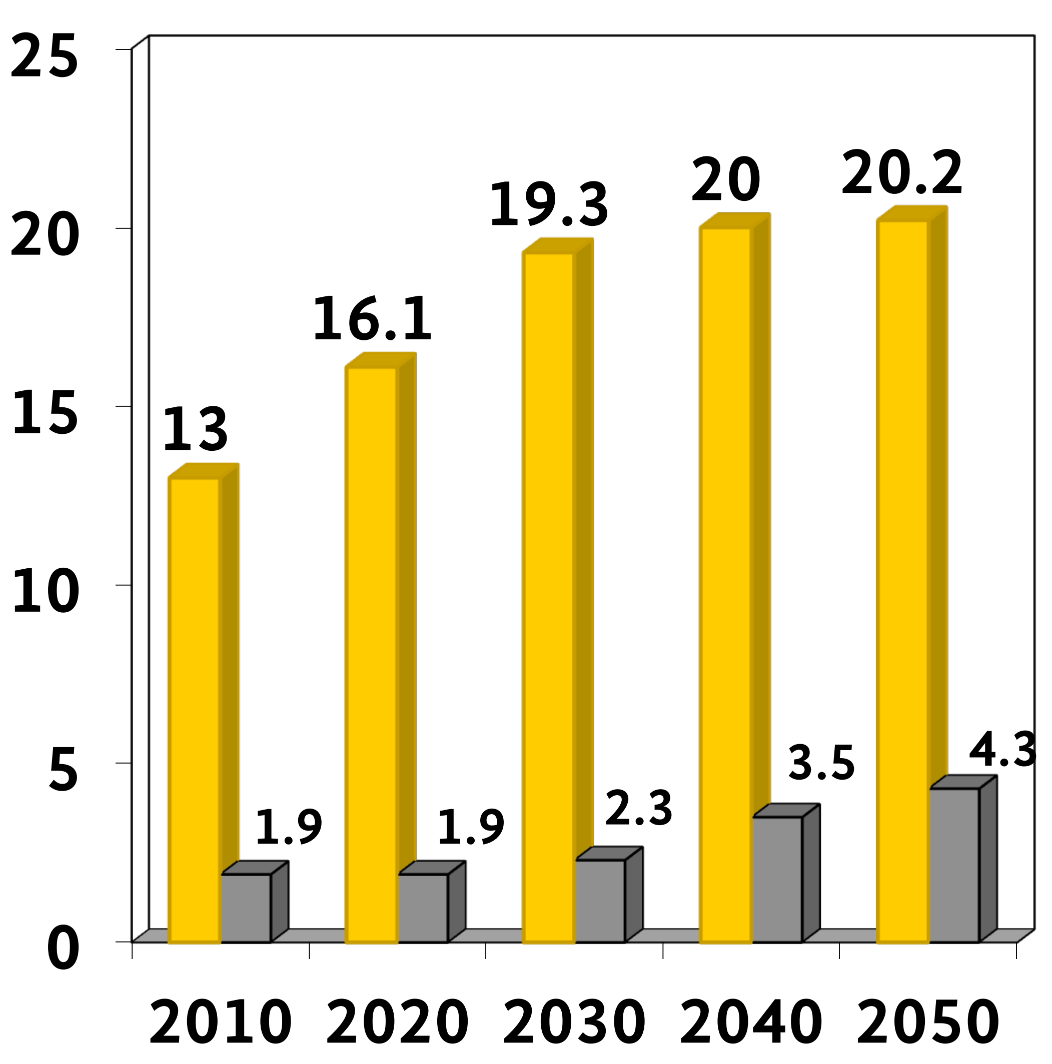
"Too Much Medical, Not Enough Home"

- Frail Elders & Disabled Persons
- Patients With Activity Limitations/Cognitive Impairment
- Transitioning Home From Complicated Hospitalizations & Nursing Facility Admissions
- Multiple Chronic Conditions/Frequent Fliers
- Mentally Ill

Demographics



The Whole Country is Boca

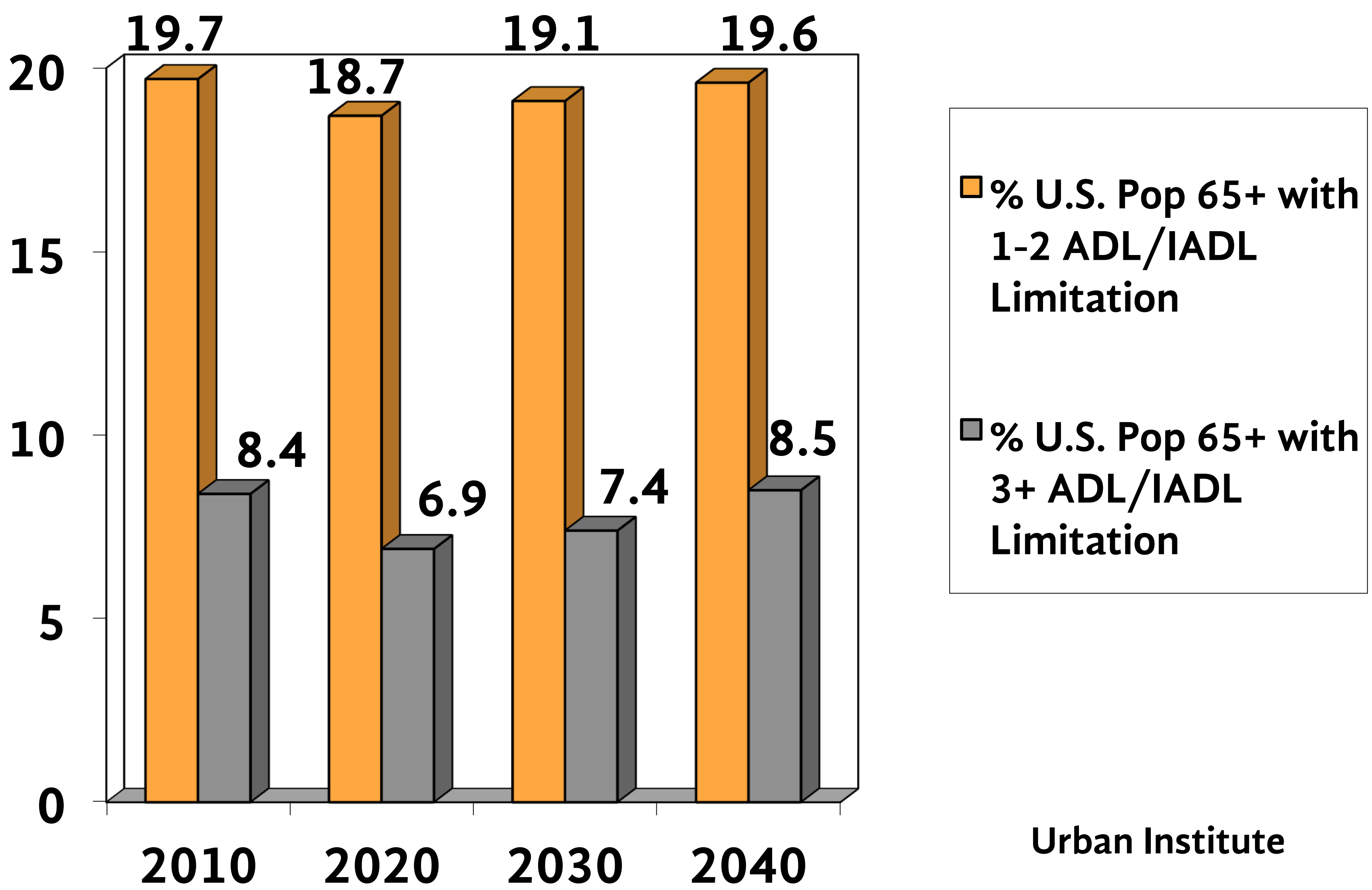


% U.S. Pop Age 65+ (millions)

% U.S. Pop Age 85+ (millions)

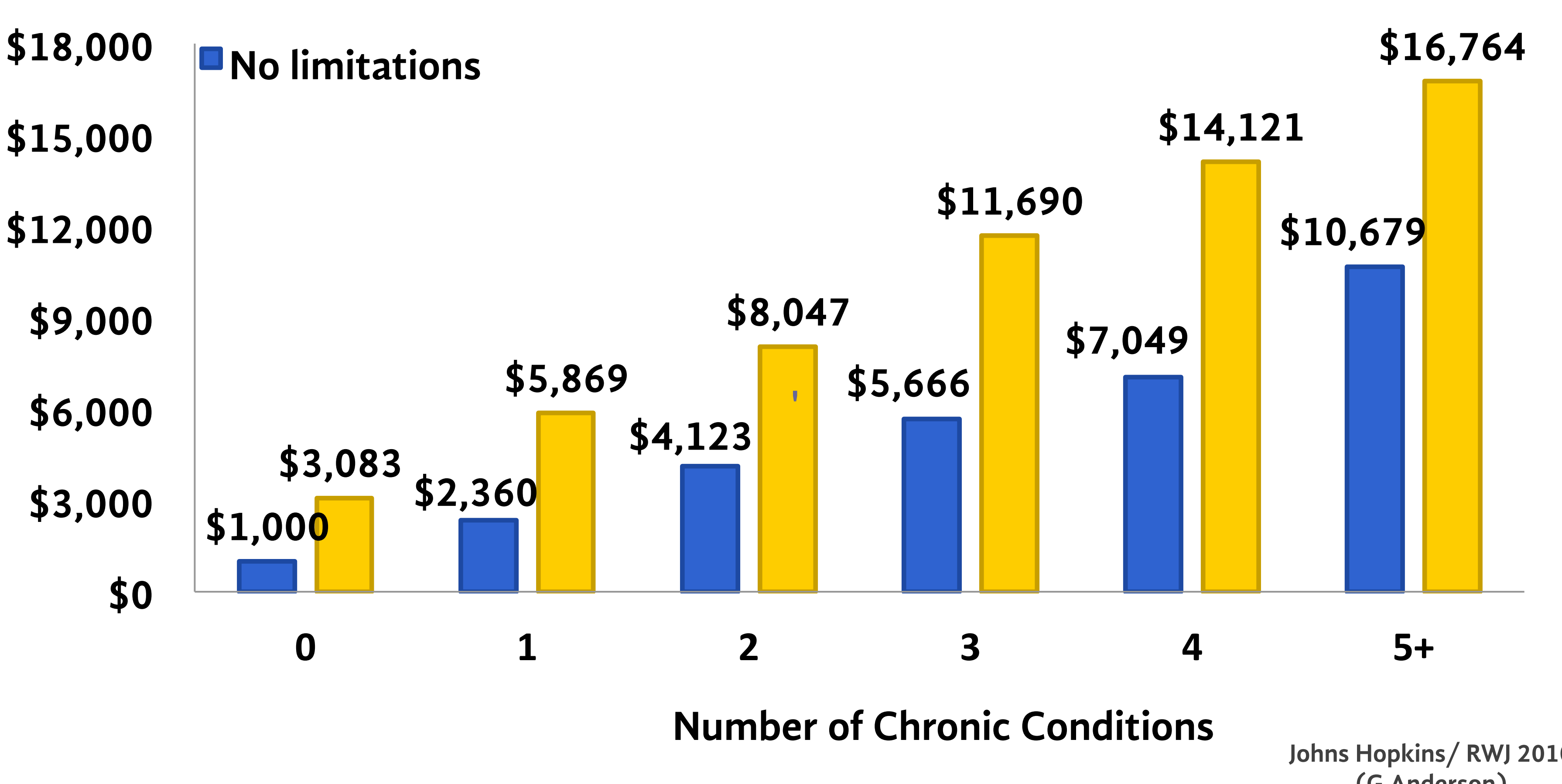
Administration on Aging / U.S. Census Bureau

Ponce De Leon is Still Looking…



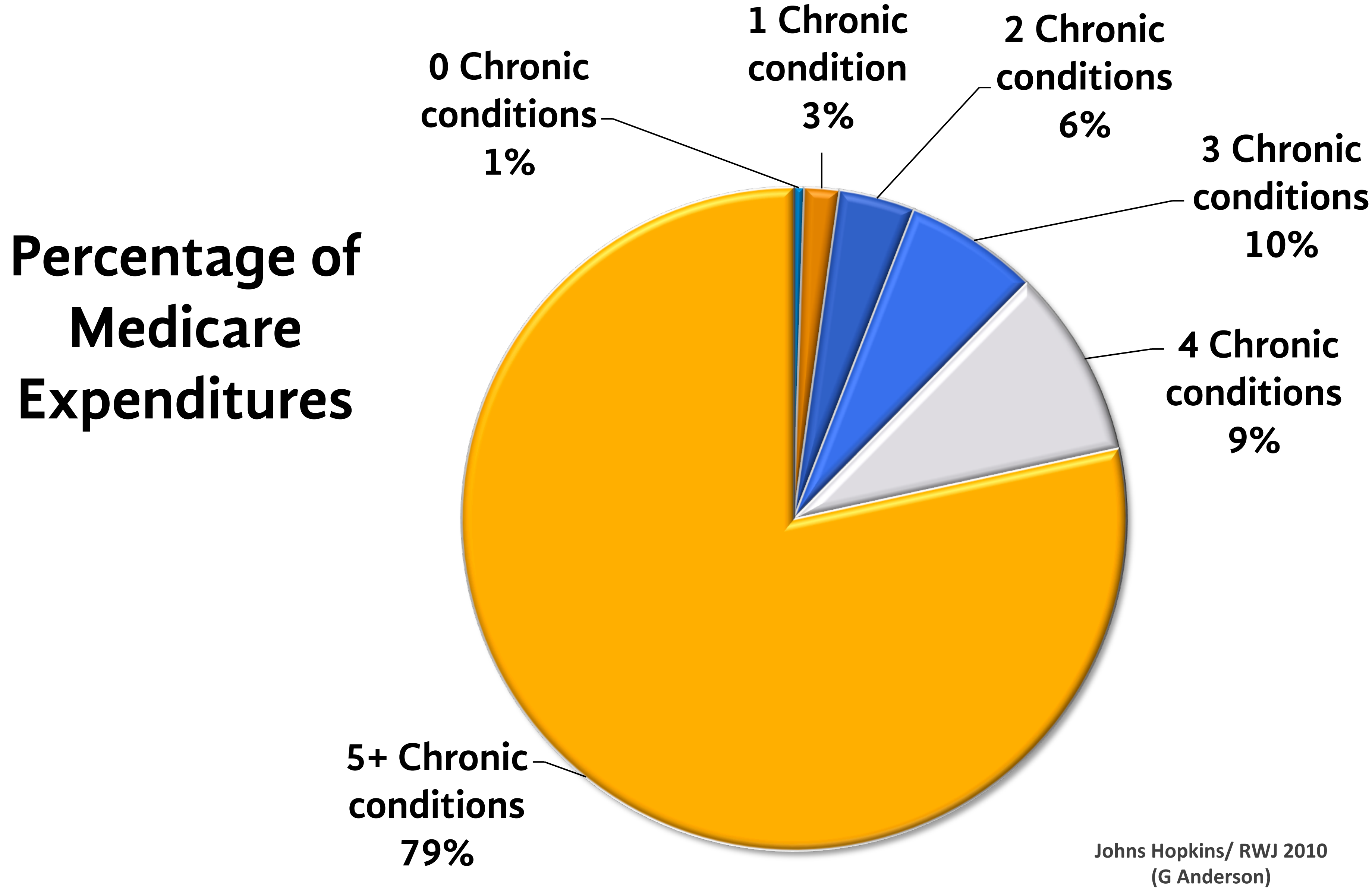
Where Does Money Go?

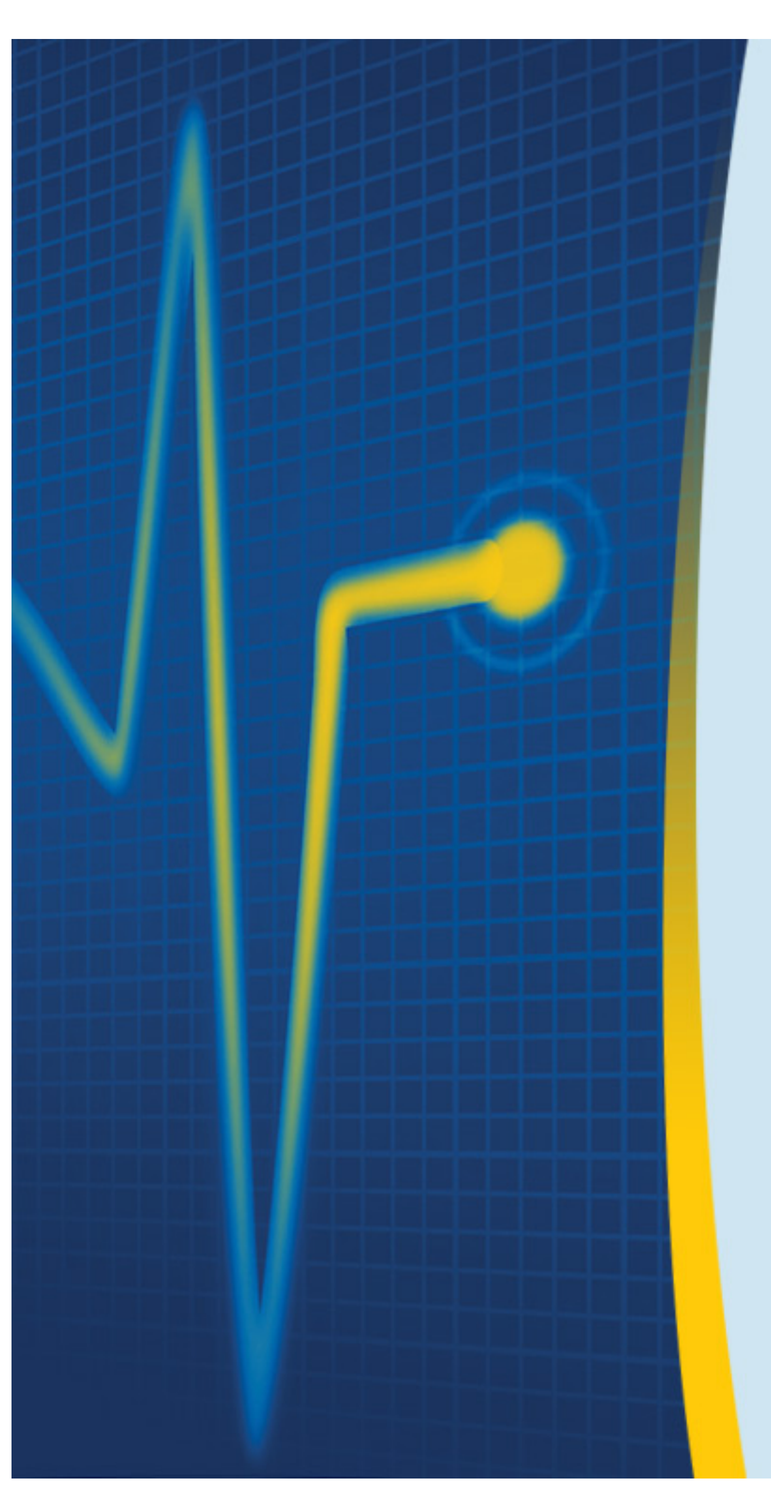
Spending Often Doubles for People With Chronic Illnesses and Activity Limitations



Johns Hopkins/ RWJ 2010
(G Anderson)

Lots of Suffering and Spending





Home Health as a Valued Partner in Meeting PCMH Milestones

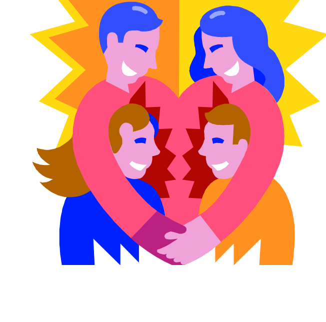
Home Health:
Improving Quality & Patient Experience

CLINICAL

OASIS (Clinical, Functional, & Service Measures)

Rehospitalization Rates

Transitions of Care



SATISFACTION

HHCAPS Survey

Patient Engagement

Employee Engagement

FINANCIAL

Productivity/ Efficiency

ICD 9/ ICD 10 Accuracy

INFORMATION SYSTEMS

EMR & PHR

Dashboard Communication

REGULATORY/ SAFETY

Face 2 Face

RAC/Probe Audits

Regulatory Surveys

living **in two worlds** at the same time is **challenging**

Fee For Service

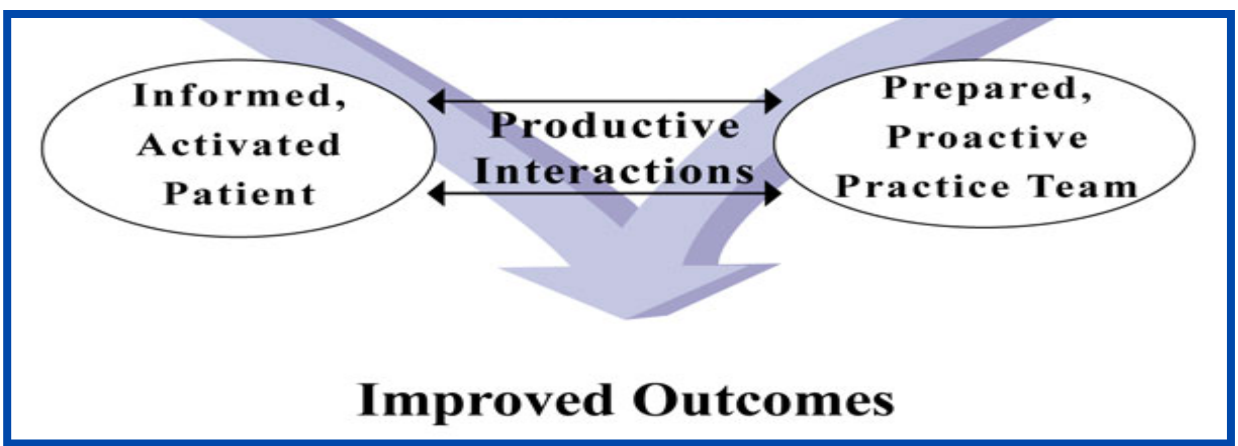
Value Based Population Reimbursement

Bottom Line:

Must define and continuously improve care delivery to achieve better health, better care, lower costs for today and for the future.

Improving Quality & Patient Outcomes

Applying Wagner's Care Model in Home Care Delivery Redesign



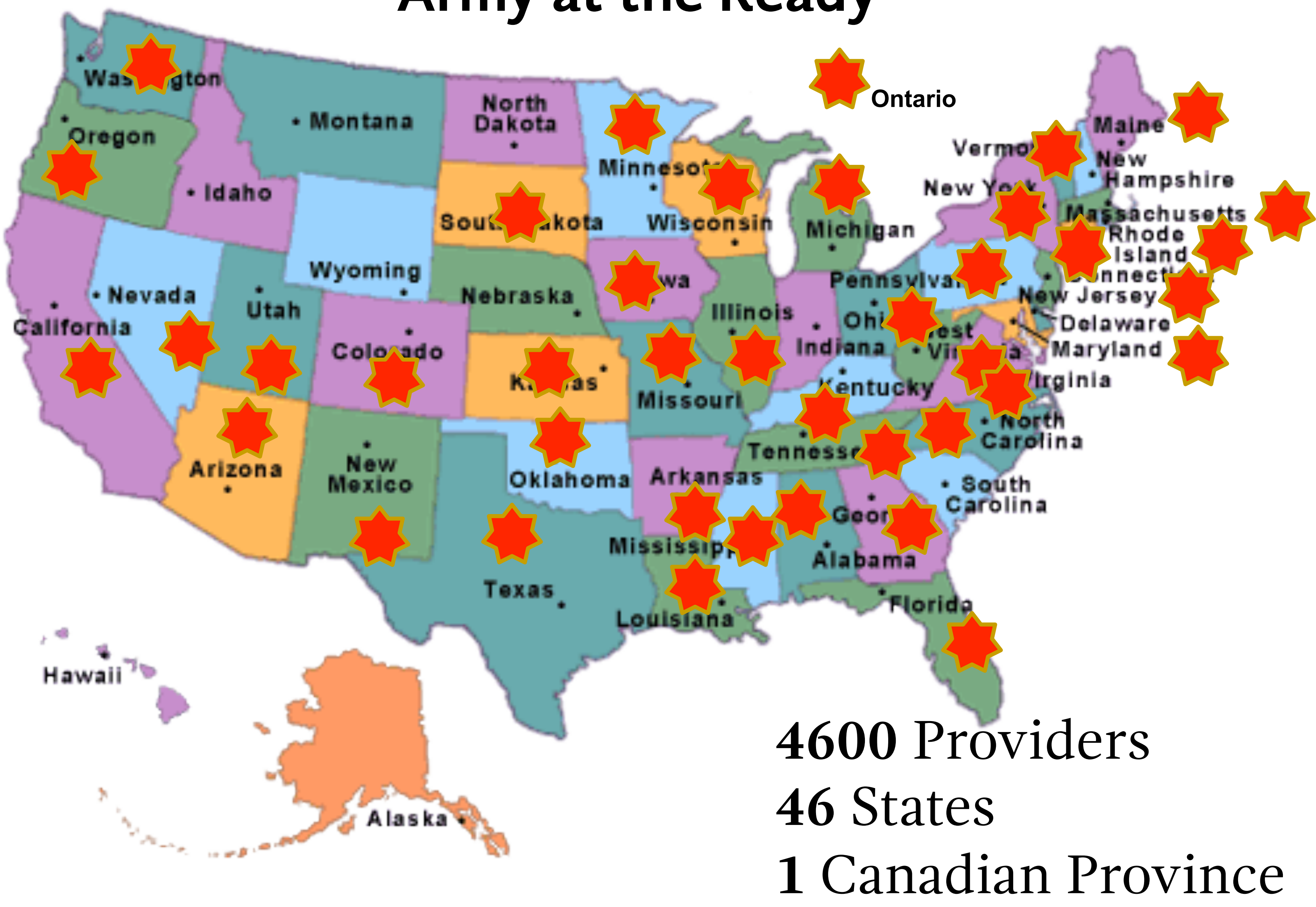
Incorporating Health Literate Care with Wagner's Model

By Howard K. Koh, Cindy Brach, Linda M. Harris, and Michael L. Parchman

ANALYSIS & COMMENTARY

A Proposed 'Health Literate Care Model' Would Constitute A Systems Approach To Improving Patients' Engagement In Care

Our Experience: Home Health Care Providers
"Army at the Ready"



4600 Providers
46 States
1 Canadian Province

Alignment of Efforts

PCMH Milestones		Home Health Services
1) **Care mgt for high risk pts:** *Job Description of care manager*	→	Core competencies for care manager
2) **Improve patient experience** *Patient Engagement*	→	Utilize universal health literacy principles for all written and verbal communication
3) **Care Coordination** *Transitions* *Meaningful data exchange*	→	Key transitions best practices Provider data exchange Patient data exchange

Care Manager Competencies

Patient Engagement/ Therapeutic Partnerships

Ability to identify/address patient barriers

Expert in care coordination- facilitates effective transitions

Knowledge of current evidence-based guidelines

Patient-activated adult education and health literacy

Communication skills & facilitation of behavior change

Patient Engagement: Getting Out of Our Comfort Zone

Where we tend to focus:

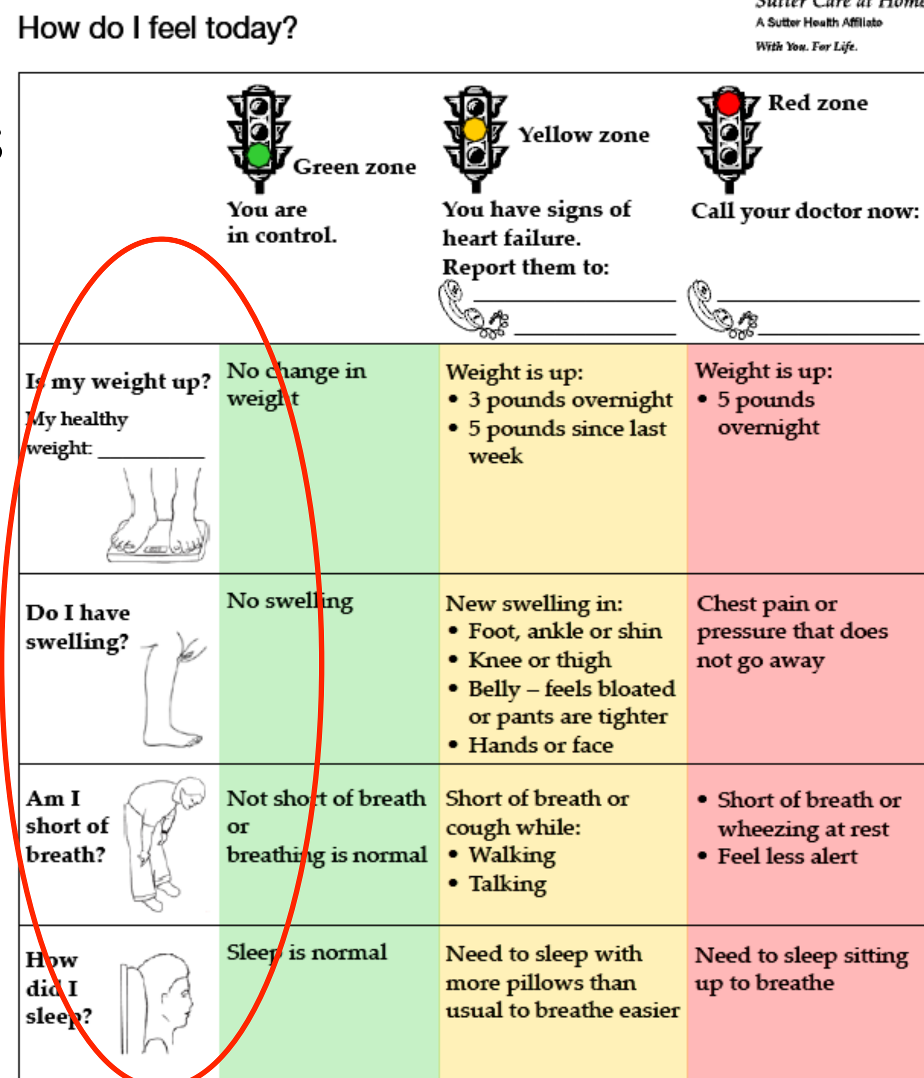
1. Adherence to clinical guidelines
2. Patient education
3. Directing

Where new focus is needed:

1. Using behavior change interventions
2. Building patient confidence
3. Guiding

Stoplight Form With A "Person-Centered" Universal Precaution Approach Applied

- First person
- Patient assessment drives navigation : design has the person "say and do"
- Font, layout, graphics consistent with health literacy and plain language principles
- Supports patient and caregiver engagement



Controlling heart failure at home

How do I feel today?

Sutter Care at Home
A Sutter Health Affiliate
With You. For Life.

	Green zone You are in control.	Yellow zone You have signs of heart failure. Report them to: ____________ ____________	Red zone Call your doctor now: ____________ ____________
Is my weight up? My healthy weight: ________	No change in weight	Weight is up: • 3 pounds overnight • 5 pounds since last week	Weight is up: • 5 pounds overnight
Do I have swelling?	No swelling	New swelling in: • Foot, ankle or shin • Knee or thigh • Belly – feels bloated or pants are tighter • Hands or face	Chest pain or pressure that does not go away
Am I short of breath?	Not short of breath or breathing is normal	Short of breath or cough while: • Walking • Talking	• Short of breath or wheezing at rest • Feel less alert
How did I sleep?	Sleep is normal	Need to sleep with more pillows than usual to breathe easier	Need to sleep sitting up to breathe

Patient Engagement in Care

Choose options here

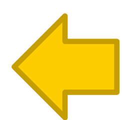
My plan for controlling COPD at home

Things I can do:

- **Ask "How do I feel today?"**
- **Stop smoking**
- **Take my medicine**
  Use my inhaler, oxygen or breathing treatment
- **Look for signs of infection:**
  - Change in cough and mucus
  - More short of breath or wheezing
  - Poor sleep or feeling tired
  - Fever
- **See your doctor**
- **Drink plenty of water**
  Drink at least 8 cups each day
- **Get exercise each day**
- **Have a plan for getting help**
- **Other ideas:**

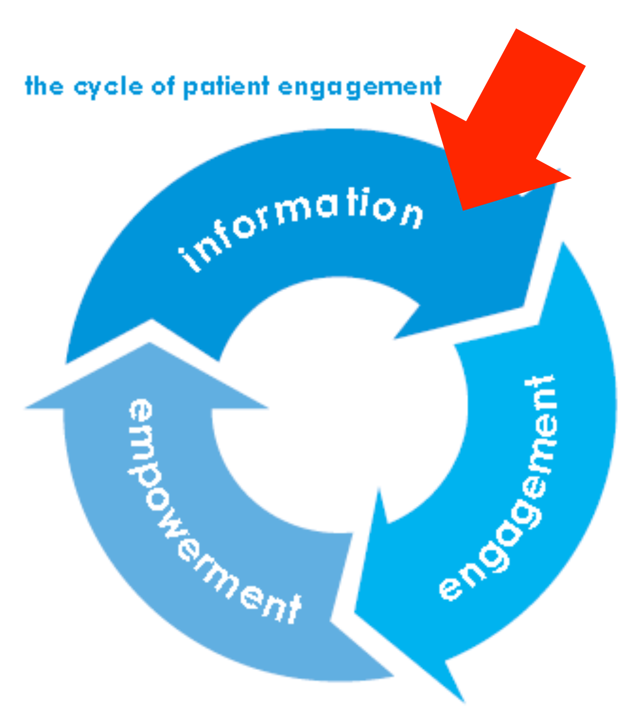
How I will do them:

Weigh myself 7 days in a row before I have my first cup of coffee



Write SMART goal here

Clear Information Increases Patient Engagement And Empowerment

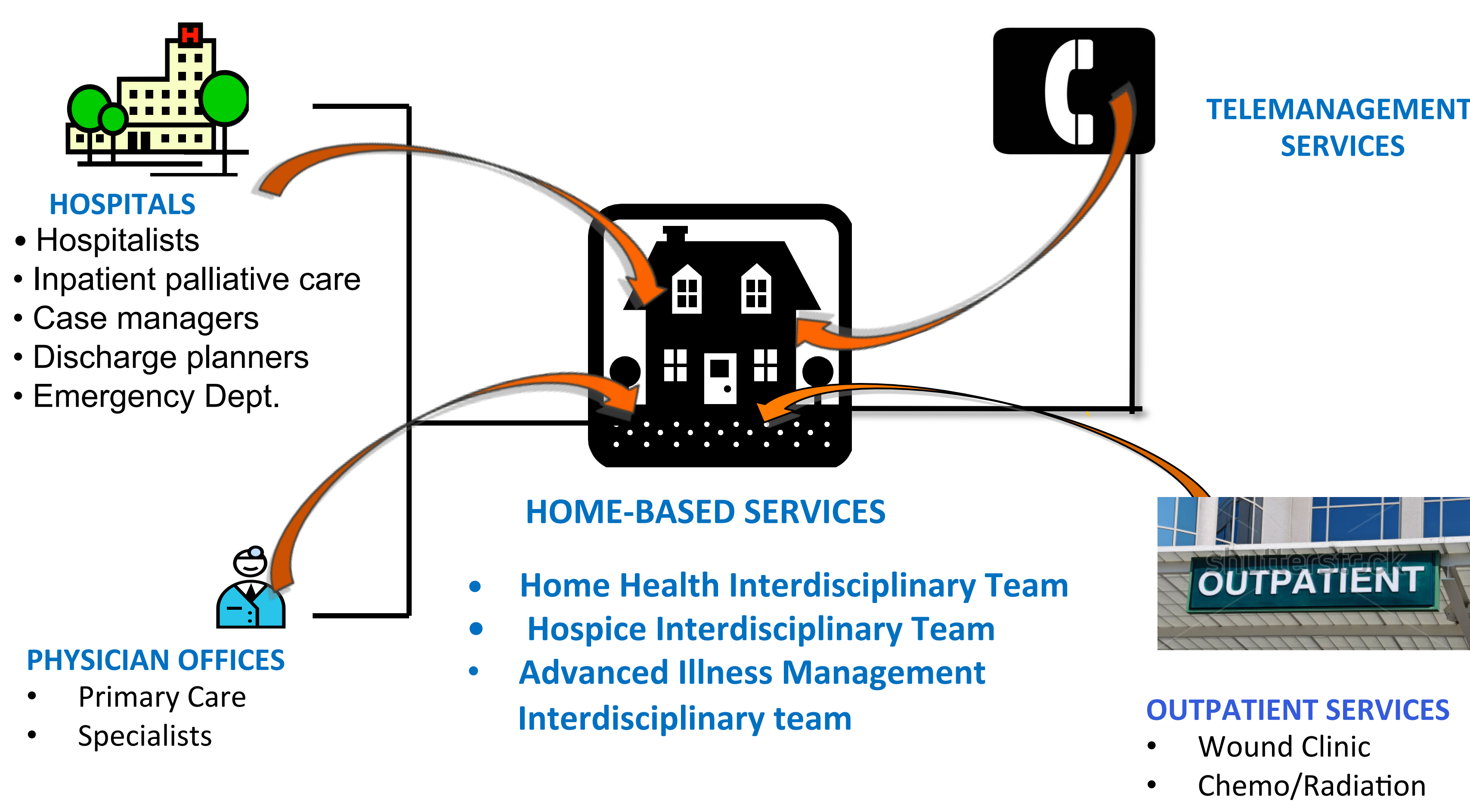


Information about one's health leads to greater patient empowerment and engagement; these, in turn, predict a desire for more health-related information.

Source: Empowerment and engagement among low-income Californians: Enhancing patient-centered care. 2012 Blue Shield of California Foundation Survey. September 2012

Alliance for Home Health Quality and Innovation

Care Transitions
Across Providers, Settings, and Time



Common Transition Best Practices
Home Health Competencies

Coleman	Naylor	Home Health
Med Mgt	Med Mgt	Med Mgt
Red flags	Red flags	Red flags
Follow up with MD	Follow up with MD	Follow up with MD

1. Personal Health Record / EMR/ Telemangement
2. Tools & support for pt/family to take an active role

Meaningful Data Exchange Across Providers , Settings, and Time

- Case Conferences
- Transitions of Care Notes
- New or change order requests of MD
- EMR Documentation
- Personal Health Record

Value of SBAR for Patients

How to give your doctor a quick, clear picture of your health problem

1. Say who you are: ______________________

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

2. Say what you are being treated for at this time: ______________________

____

Include:

- Names of medical problems
- Home health care services you have now
- Medical supplies you use (medication, oxygen, walker)

3. Say 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. Say what you need: ______________________

____

For example:

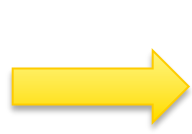
- To make an appointment
- Have a test
- More information

5. End the call by asking how to reach the doctor if you need more help: __________

Alignment of Efforts

PCMH Milestones | **Home Health Services**

4. Providing care management for high risk patients



4. -Thorough Medication reconciliation and drug-drug, drug allergy assessment
   -Early identification of risk
   -Interventions to mitigate risk

5. Improve patient shared decision making capacity

5. -Shared action plans
   - Access to remote monitoring data

6. Use of data to drive care improvements

6. -Reports to align goals across the continuum
   -Dashboard data

Providing care management for high risk patients

Medicare COP
Medication Reconciliation

484.55(c): Standard: Drug regimen review

“The comprehensive assessment must include a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects,

significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy.”

Required Assessments

Fall Risk Screening

Multifactorial Assessment

- Medication Review
- Visual Acuity Testing
- Gait and Balance Assessment
- Physical Assessment/ Functional Assessment
- Fall History
- Assessment of Fear of Falling

Depression Screening

(M1730) Depression Screening: Has the patient been screened for depression, using a standardized depression screening tool?

☐ 0 - No

☐ 1 - Yes, patient was screened using the PHQ-2©* scale. (Instructions for this two-question tool: Ask patient: "Over the last two weeks, how often have you been bothered by any of the following problems")

PHQ-2©*	Not at all 0 - 1 day	Several days 2 - 6 days	More than half of the days 7 – 11 days	Nearly every day 12 – 14 days	N/A Unable to respond
a) Little interest or pleasure in doing things	☐0	☐1	☐2	☐3	☐na
b) Feeling down, depressed, or hopeless?	☐0	☐1	☐2	☐3	☐na

☐ 2 - Yes, with a different standardized assessment-and the patient meets criteria for further evaluation for depression.

☐ 3 - Yes, patient was screened with a different standardized assessment-and the patient does not meet criteria for further evaluation for depression.

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Expanded Skill Sets –
Identification of Common Barriers in Our Population

Barrier identification in the hospital and in the home

- Limited literacy
- Personal assessment of health (additional evidence that patient may have limited literacy/ low self confidence)
- Support system/ Financial constraints
- Possible depression
- Complex medication regimen
- Cognitive impairments

Identification of “at risk” patients

Medication Management Risk Assessment Tool

Medication Regimen
- Number of medications, route, daily dose adjustments, high alert meds

Patient Behaviors
- Hoards d/cd meds, uses multiple pharmacies, shares meds with others, hx of non-adherence

Cognitive/ Physical barriers
- Cognitive deficits, limited literacy
- Low vision, swallowing difficulty, fall risk

High- Moderate-Low Risk

A Focus on Medication Management

- Assess for risk specific for med management
- Conduct targeted visit during first week for medication instruction/interventions
- Cues placed in EMR re: open-ended questions
- Patient medication lists that meet health literacy standards

Medicine schedule for: ______________________
(Name)

Medicine name, strength • Tape a pill or draw a picture of the medicine	Morning dose	Noon dose	Evening dose	Bedtime dose	As needed dose	Notes about medicine • What it is for • How to take it

Updated on ______________ Draft v.1/31/13 Page _____ of _____

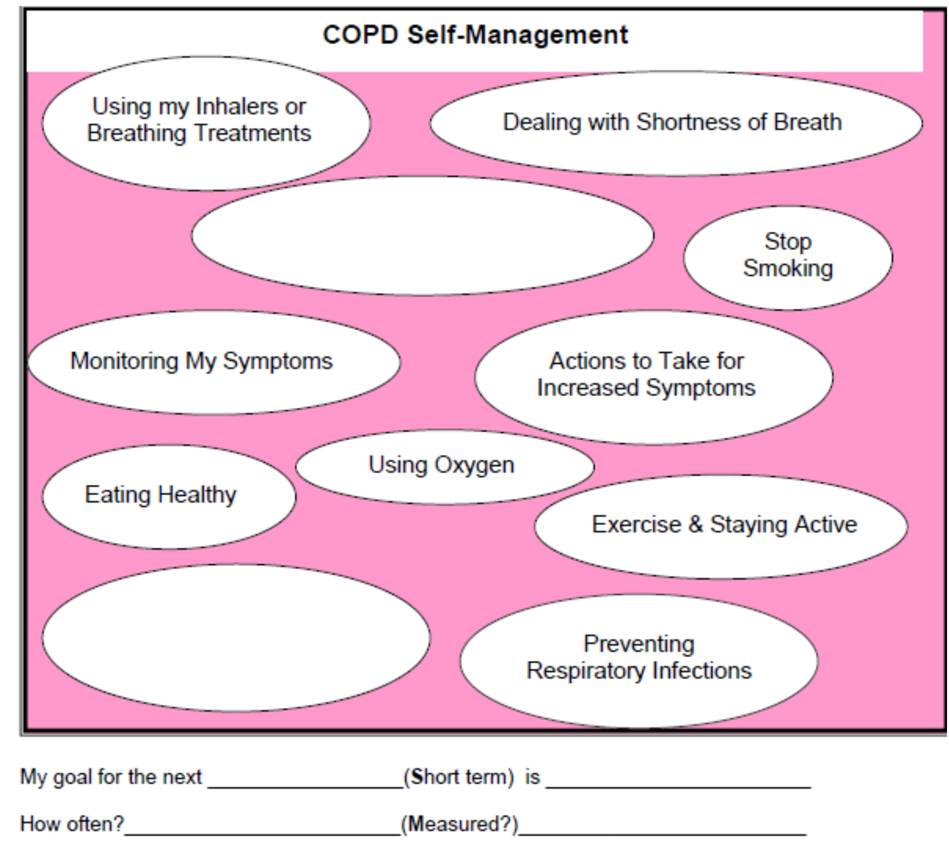
Improve patient shared decision making capacity

Provider skills to enhance patient motivation and confidence-building

- Active listening
- Assessing skill and confidence
- Eliciting change talk and supporting change
- Providing evidence and options for shared decision making conversations
- Structured goal setting including problem solving

Facilitating Choice in Daily Decisions Related to Health Behaviors

"These are some things you can do to help you achieve your long term goal. What would you like to work on?"



Building Self-Confidence (or Self-Efficacy) Through Goal Setting

1. Through social persuasion – having someone that believes they can do it – *offer hope*
2. Through providing mastery experiences

The most important method for improving a person's sense of self-efficacy is to allow opportunities for experiencing success by achieving goals

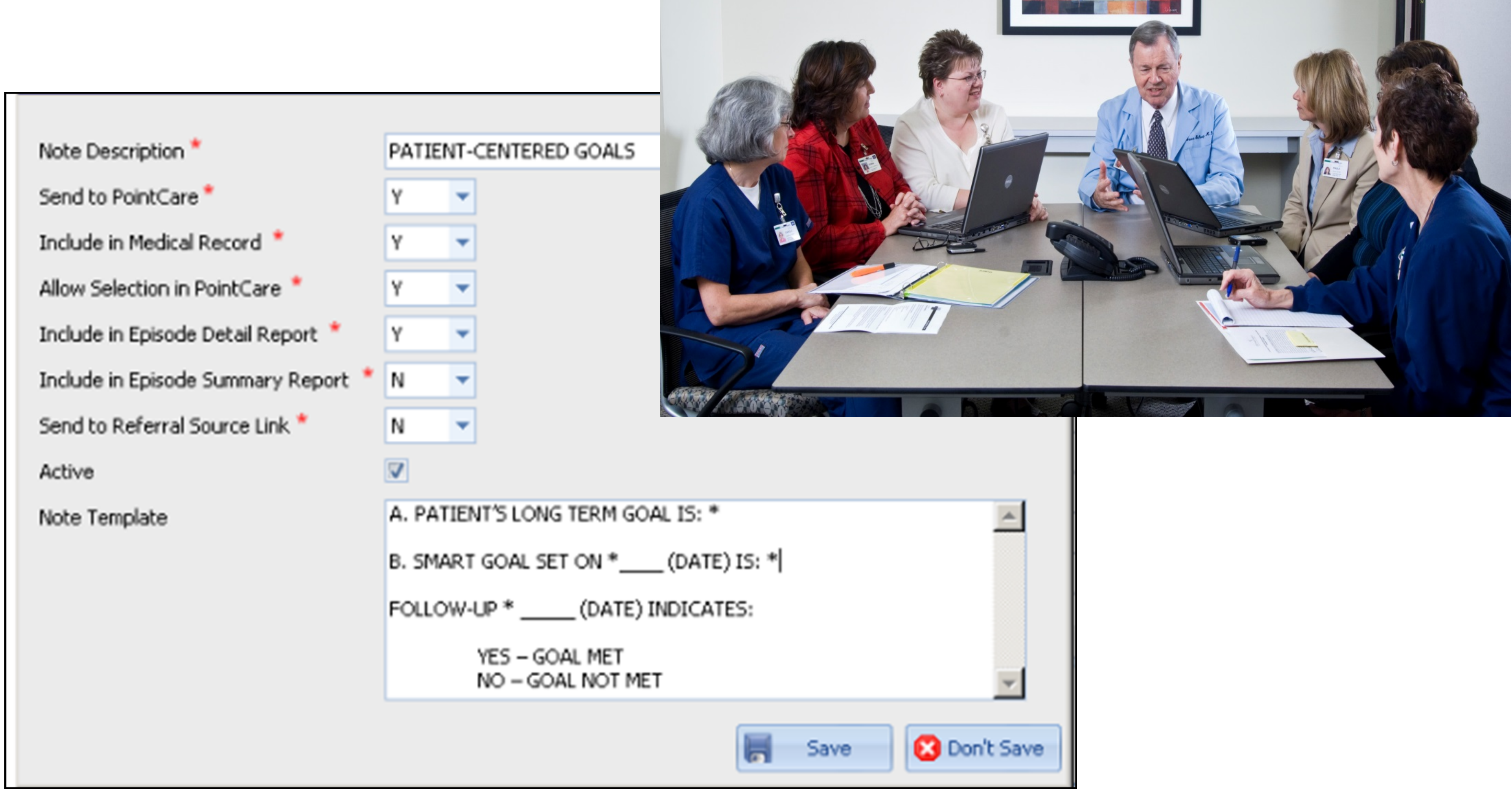
Goal Setting is Structured to Improve Patient Confidence with Condition Management

Identification of person-centered goal

Choices reviewed and SMART goal developed which ties condition management with patient personal goal

SMART goal structured for greatest potential for success

Patient-Centered Goal Front and Center



Improving Patient Shared Decision Making with Remote Monitoring

Glucose Logbook

Day	Morning(5-10)	Lunch(10-2)	Afternoon(2-4)	Dinner(4-8)	Bed(8-12)	Sleep(12-5)	Totals
6/24/2008							
6/23/2008							
6/22/2008							
6/21/2008							
6/20/2008							
6/19/2008				158			158
6/18/2008	155						155
6/17/2008	120	136					120 , 136
6/16/2008		142	115				142 , 115
6/15/2008	127	213	180	109	121		127 , 213 , 180 , 109 , 121
6/14/2008		200 , 151	194	121 , 138	149		200 , 151 , 194 , 121 , 138 , 149
6/13/2008							
6/12/2008	160		166				160 , 166
6/11/2008	129 , 154	154					129 , 154 , 154

Legend	
XXX	Fasting
XXX	Pre-meal
XXX	Post-meal

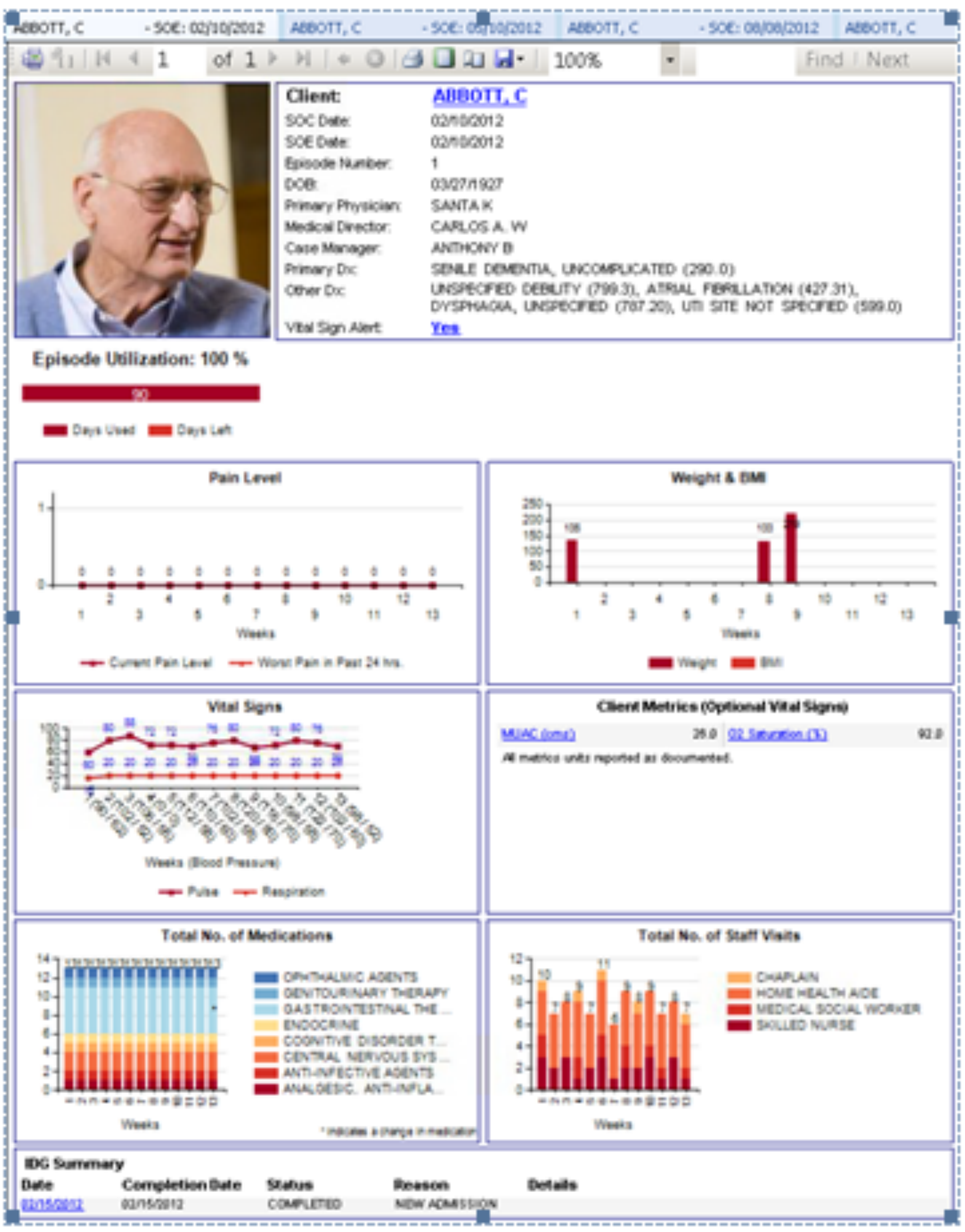
Use of data to drive care improvements

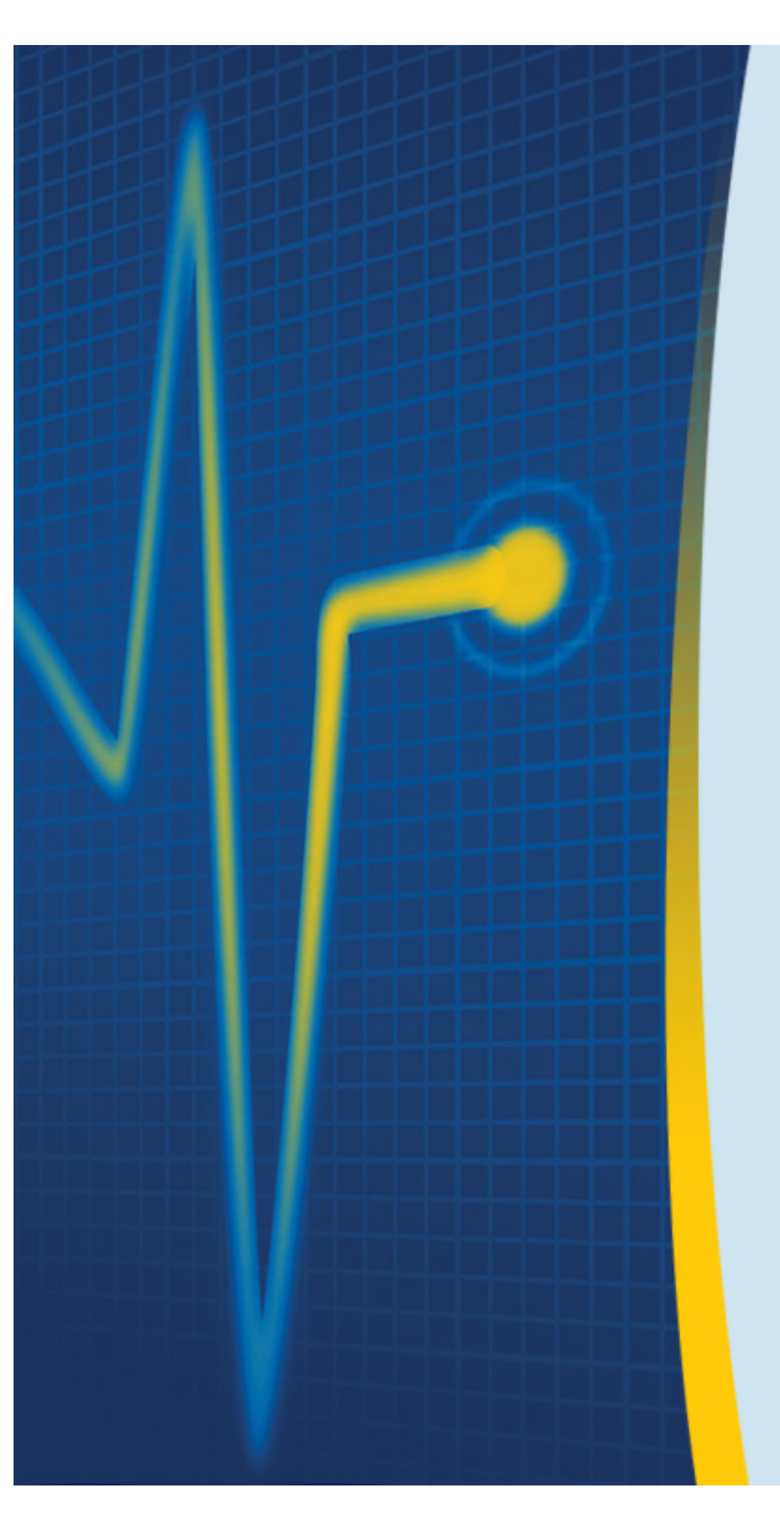
Use of Data to Guide Care Improvement: Benchmark Reports

Hospitalization Risk Factors (M1032)

Risk for Hospitalization: Which of the following signs or symptoms characterize this patient as at risk for hospitalization? (Mark all that apply.)	You				*SHP State Database*		SHP National Database	
	Indicated at SOC/ROC	Indicated at SOC/ROC & Hospitalized	% of All Patients Indicated	% with Risk and Hospitalized	*% of All Patients Indicated*	*% with Risk and Hospitalized*	% of All Patients Indicated	% with Risk and Hospitalized
Recent decline in mental, emotional, or behavior	2,540	586	10.6%	23.1%			14.3%	26.5%
Multiple hospitalizations (2 or more - past year)	8,709	2,435	36.2%	28.0%			39.2%	31.6%
History of falls (2 or more w/ injury - past year)	7,091	1,284	29.5%	18.1%			28.2%	22.8%
Taking five or more medications	19,972	3,893	83.1%	19.5%			84.9%	23.3%
Frailty indicators, e.g., weight loss, exhaustion	8,858	2,194	36.9%	24.8%			31.6%	27.2%
Other	1,704	343	7.1%	20.1%			16.6%	23.2%
None of the above	1,514	101	6.3%	6.7%			4.3%	10.1%

Client Progress Summary Report Projected During Multidisciplinary Case Conference





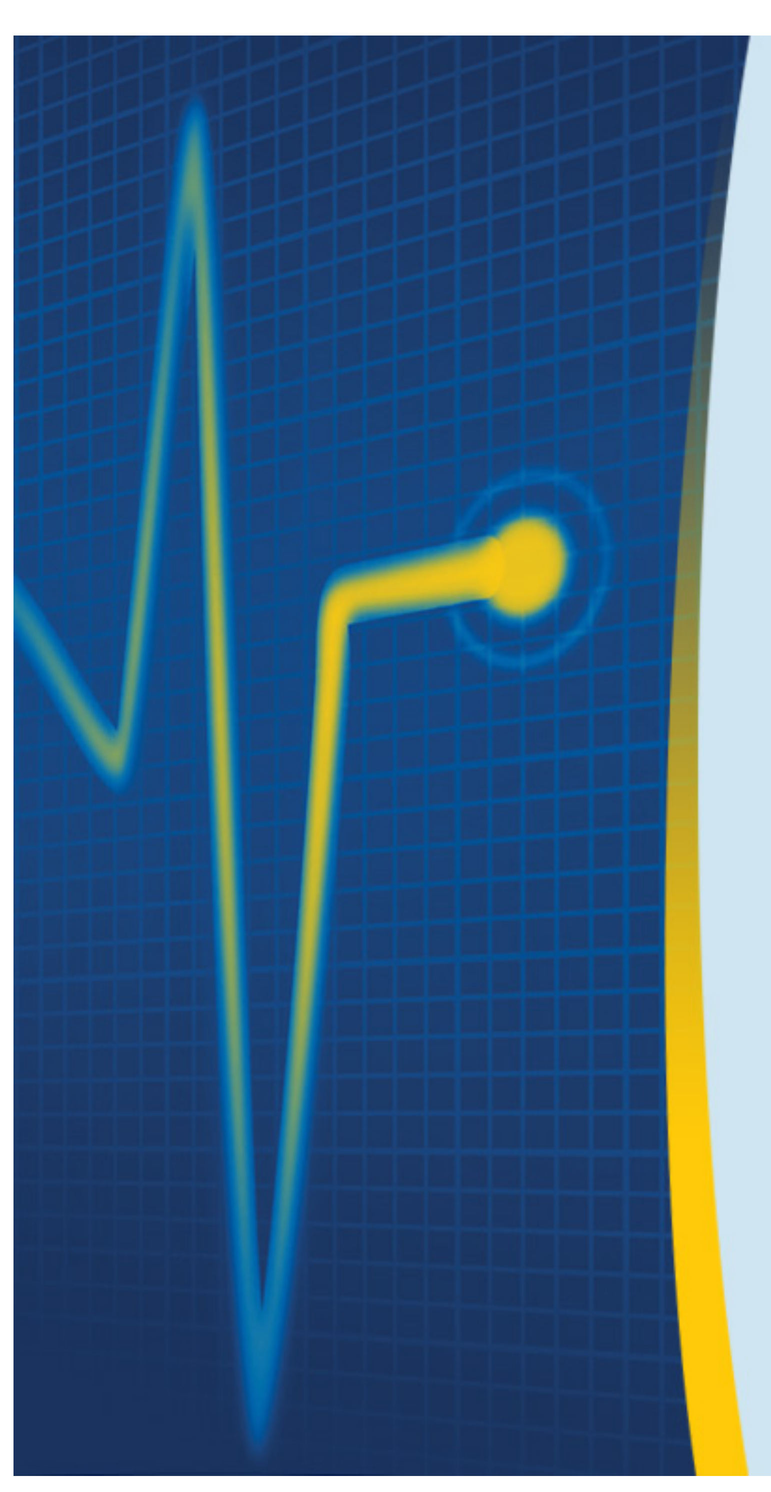
Home Health of the Future

Home Care Models

- Home Health
- Custodial Care
- Medical House Calls
- Hospital at Home
- Palliative, Hospice and Advanced Illness Models

Technology

- Inside Models and Stand Alone
- Fills “White Space”
- Substitutes for Marginal Visits
- Enhances Point of Care
- Improves Patient Experience, Caregiver Experience, and Access



Discussion

Thank You!

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