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  
[Email Address]

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

- **U.S. Pop Age 65+ (millions)**
  - 2010: 40.2
  - 2020: 54.8
  - 2030: 72.1
  - 2040: 81.2
  - 2050: 88.5

- **U.S. Pop Age 85+ (millions)**
  - 2010: 5.8
  - 2020: 6.6
  - 2030: 8.7
  - 2040: 14.2
  - 2050: 19

*Administration on Aging / U.S. Census Bureau*
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…

<table>
<thead>
<tr>
<th>Year</th>
<th>1-2 ADL/IADL Limitation</th>
<th>3+ ADL/IADL Limitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>19.7</td>
<td>8.4</td>
</tr>
<tr>
<td>2020</td>
<td>18.7</td>
<td>6.9</td>
</tr>
<tr>
<td>2030</td>
<td>19.1</td>
<td>7.4</td>
</tr>
<tr>
<td>2040</td>
<td>19.6</td>
<td>8.5</td>
</tr>
</tbody>
</table>

- % U.S. Pop 65+ with 1-2 ADL/IADL Limitation
- % U.S. Pop 65+ with 3+ ADL/IADL Limitation

Urban Institute
Spending Often Doubles for People With Chronic Illnesses and Activity Limitations

Where Does Money Go?

Number of Chronic Conditions

<table>
<thead>
<tr>
<th>Number of Chronic Conditions</th>
<th>No limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>$1,000</td>
</tr>
<tr>
<td>1</td>
<td>$3,083</td>
</tr>
<tr>
<td>2</td>
<td>$5,869</td>
</tr>
<tr>
<td>3</td>
<td>$8,047</td>
</tr>
<tr>
<td>4</td>
<td>$11,690</td>
</tr>
<tr>
<td>5+</td>
<td>$14,121</td>
</tr>
<tr>
<td>5+</td>
<td>$16,764</td>
</tr>
</tbody>
</table>

Johns Hopkins/ RWJ 2010
(G Anderson)
Lots of Suffering and Spending

Percentage of Medicare Expenditures

- 0 Chronic conditions: 1%
- 1 Chronic condition: 3%
- 2 Chronic conditions: 6%
- 3 Chronic conditions: 10%
- 4 Chronic conditions: 9%
- 5+ Chronic conditions: 79%

Johns Hopkins/ RWJ 2010
(G Anderson)
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

INFORMATION SYSTEMS
EMR & PHR
Dashboard Communication

FINANCIAL
Productivity/ Efficiency
ICD 9/ ICD 10 Accuracy

REGULATORY/ SAFETY
Face 2 Face
RAC/Probe Audits
Regulatory Surveys
living **in two worlds** at the same time is **challenging**

**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

1. **Care mgt for high risk pts:**
   - *Job Description of care manager*

2. **Improve patient experience**
   - *Patient Engagement*

3. **Care Coordination**
   - *Transitions*
   - *Meaningful data exchange*

### Home Health Services

- Core competencies for care manager
- Utilize universal health literacy principles for all written and verbal communication
- Key transitions best practices
- Provider data exchange
- Patient data exchange
Care Manager Competencies

- Ability to identify/address patient barriers
- Patient-activated adult education and health literacy
- Patient Engagement/Therapeutic Partnerships
- Communication skills & facilitation of behavior change
- Expert in care coordination- facilitates effective transitions
- Knowledge of current evidence-based guidelines
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

<table>
<thead>
<tr>
<th>Controlling heart failure at home</th>
<th>How do I feel today?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Green zone</strong></td>
<td><strong>Yellow zone</strong></td>
</tr>
<tr>
<td>You are in control.</td>
<td>You have signs of heart failure. Report them to:</td>
</tr>
<tr>
<td><strong>Red zone</strong></td>
<td><strong>Call your doctor now:</strong></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>If my weight up?</td>
<td>No change in weight</td>
</tr>
<tr>
<td>My healthy weight:</td>
<td>Weight is up:</td>
</tr>
<tr>
<td></td>
<td>• 3 pounds overnight</td>
</tr>
<tr>
<td></td>
<td>• 5 pounds since last week</td>
</tr>
<tr>
<td>Do I have swelling?</td>
<td>No swelling</td>
</tr>
<tr>
<td></td>
<td>New swelling in:</td>
</tr>
<tr>
<td></td>
<td>• Foot, ankle or shin</td>
</tr>
<tr>
<td></td>
<td>• Knee or thigh</td>
</tr>
<tr>
<td></td>
<td>• Belly – feels bloated</td>
</tr>
<tr>
<td></td>
<td>• or pants are tighter</td>
</tr>
<tr>
<td></td>
<td>• Hands or face</td>
</tr>
<tr>
<td>Am I short of breath?</td>
<td>Not short of breath or breathing is normal</td>
</tr>
<tr>
<td></td>
<td>Short of breath or cough while:</td>
</tr>
<tr>
<td></td>
<td>• Walking</td>
</tr>
<tr>
<td></td>
<td>• Talking</td>
</tr>
<tr>
<td>How did I sleep?</td>
<td>Sleep is normal</td>
</tr>
<tr>
<td></td>
<td>Need to sleep with more pillows than usual to breathe easier</td>
</tr>
<tr>
<td></td>
<td>Need to sleep sitting up to breathe</td>
</tr>
</tbody>
</table>

**Sutter Care at Home**
A Sutter Health Affiliate
With You. For Life.
Patient Engagement in Care

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:

Choose options here

Write SMART goal here

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

Care Transitions
Across Providers, Settings, and Time

HOSPITALS
- Hospitalists
- Inpatient palliative care
- Case managers
- Discharge planners
- Emergency Dept.

PHYSICIAN OFFICES
- Primary Care
- Specialists

HOME-BASED SERVICES
- Home Health Interdisciplinary Team
- Hospice Interdisciplinary Team
- Advanced Illness Management Interdisciplinary team

OUTPATIENT SERVICES
- Wound Clinic
- Chemo/Radiation
- Surgery Centers

TELEMANAGEMENT SERVICES
# Common Transition Best Practices

## Home Health Competencies

<table>
<thead>
<tr>
<th>Coleman</th>
<th>Naylor</th>
<th>Home Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Med Mgt</td>
<td>Med Mgt</td>
<td>Med Mgt</td>
</tr>
<tr>
<td>Red flags</td>
<td>Red flags</td>
<td>Red flags</td>
</tr>
<tr>
<td>Follow up with MD</td>
<td>Follow up with MD</td>
<td>Follow up with MD</td>
</tr>
</tbody>
</table>

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

4. Providing care management for high risk patients
5. Improve patient shared decision making capacity
6. Use of data to drive care improvements

Home Health Services

4. -Thorough Medication reconciliation and drug-drug, drug allergy assessment
   -Early identification of risk
   -Interventions to mitigate risk
5. -Shared action plans
   -Access to remote monitoring data
6. -Reports to align goals across the continuum
   -Dashboard data
Providing care management for high risk patients
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?”)

<table>
<thead>
<tr>
<th>PHQ-2®</th>
<th>Not at all 0 - 1 day</th>
<th>Several days 2 - 6 days</th>
<th>More than half of the days 7 - 11 days</th>
<th>Nearly every day 12 - 14 days</th>
<th>N/A Unable to respond</th>
</tr>
</thead>
<tbody>
<tr>
<td>a)</td>
<td>❑ 0</td>
<td>❑ 1</td>
<td>❑ 2</td>
<td>❑ 3</td>
<td>❑ na</td>
</tr>
<tr>
<td>b) Feeling down, depressed, or hopeless?</td>
<td>❑ 0</td>
<td>❑ 1</td>
<td>❑ 2</td>
<td>❑ 3</td>
<td>❑ na</td>
</tr>
</tbody>
</table>

☐ 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.

*Copyright© Pfizer Inc. All rights reserved. Reproduced with permission.
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
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?”

COPD Self-Management

- Using my Inhalers or Breathing Treatments
- Dealing with Shortness of Breath
- Stop Smoking
- Actions to Take for Increased Symptoms
- Using Oxygen
- Exercise & Staying Active
- Preventing Respiratory Infections
- Monitoring My Symptoms
- Eating Healthy

My goal for the next (Short term) is __________________________
How often? (Measured?) __________________________
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
## Glucose Logbook

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

### 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)

<table>
<thead>
<tr>
<th>Risk for Hospitalization:</th>
<th>Indicated at SOC/ROC</th>
<th>Indicated at SOC/ROC &amp; Hospitalized</th>
<th>% of All Patients Indicated</th>
<th>% with Risk and Hospitalized</th>
<th>% of All Patients Indicated</th>
<th>% with Risk and Hospitalized</th>
<th>% of All Patients Indicated</th>
<th>% with Risk and Hospitalized</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recent decline in mental, emotional, or behavior</td>
<td>2,540</td>
<td>586</td>
<td>10.6%</td>
<td>23.1%</td>
<td>14.3%</td>
<td>26.5%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Multiple hospitalizations (2 or more - past year)</td>
<td>8,709</td>
<td>2,435</td>
<td>36.2%</td>
<td>28.0%</td>
<td>39.2%</td>
<td>31.6%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>History of falls (2 or more w/ injury - past year)</td>
<td>7,091</td>
<td>1,284</td>
<td>29.5%</td>
<td>18.1%</td>
<td>28.2%</td>
<td>22.8%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Taking five or more medications</td>
<td>19,972</td>
<td>3,893</td>
<td>83.1%</td>
<td>19.5%</td>
<td>84.9%</td>
<td>23.3%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Frailty indicators, e.g., weight loss, exhaustion</td>
<td>8,858</td>
<td>2,194</td>
<td>36.9%</td>
<td>24.8%</td>
<td>31.6%</td>
<td>27.2%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>1,704</td>
<td>343</td>
<td>7.1%</td>
<td>20.1%</td>
<td>16.6%</td>
<td>23.2%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>None of the above</td>
<td>1,514</td>
<td>101</td>
<td>6.3%</td>
<td>6.7%</td>
<td>4.3%</td>
<td>10.1%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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!

Teresa L. Lee, J.D., M.P.H.
Executive Director
tlee@ahhqi.org
www.ahhqi.org