Home Care Medicine Pearls

**Ordering Home Health:** Patient must have skilled need and meet Medicare’s definition of home bound. A Face to Face visit documenting this must be done within 90 days before or 30 days after the start of care.

**Ordering DME** (Patient must meet medical necessity): Examples of Medicare covered DME: Patient lifts (e.g. Hoyer lift), hospital bed, support surfaces (Level 1 (APPB, Foam, Gel overlays), Level 2 (low air loss), Level 3 (Clinitron (rare in home)), manual wheelchair, Pressure reducing seat cushion for wheelchair, electric wheelchair, powered scooters, walker, cane, oxygen, nebulizer, CPAP/BPAP, ventilators (and all supplies including replacement trachs), bedside commode, lift chair (lift mechanism), Glucometer, enteral nutrition supplies and equipment (G-tubes), ostomy supplies, orthotics/prosthetics, therapeutic shoes, suction machines; Learn how to change trachs and G-tubes (both are billable). PEG tubes can be removed in the home with traction (they have an internal silicon bumper) and replaced with balloon G-tubes. I always teach caregivers how to change G-tubes so they can do it in an emergency (calling us first to take them through it).

**DME Not covered under Medicare:** transport wheelchair, shower chair, grab bars, raised toilet seat, stair lifts, Support stockings; Medicare will pay for home health agencies to administer IV fluids and IV antibiotics in the home but will not pay for the fluids or the antibiotics. Medicaid will often pay for home IV antibiotics. We try to order once a day IV antibiotic such as Ceftriaxone, Moxifloxacin, Ertapenem). Generally a medical provider has to be present for the first dose if patient has not had the antibiotic in the recent past.

**Foley catheters:** We have home health agencies change Foley catheters monthly and as needed. We leave urine cups with orders for Urinalysis/Urine culture in all homes with a Foley catheter to be used as needed for signs/symptoms of UTI.

**Wound care supplies:** Supplied by home health agency if involved. If patient does not qualify for home health can order wound care supplies under Medicare Part B through companies such as Byrum. This most often happens when wounds are stable and family has been taught wound care and home health discharges.

**Supplies covered by Medicaid but not Medicare:** Diapers, Chucks, Gloves

I never deny any services. I tell patients and families they can have anything they want but I cannot necessarily get it for them for free (i.e. through insurance). They may have to pay out of pocket. If they desire things like aides to continue after home health discharges or continuous Physical Therapy, etc. I tell them they can have it but they need to pay for it.

**Community resources:** can find these by talking to local social workers at home health agencies, Area Agencies on Aging or non-profit social service agencies:

- Transportation services
  - Wheel chair accessible vans--$
  - Ambulance: BLS $$; ALS $$$
- Homemaker services: Covered by state and private duty
- Respite Care
- Home maintenance services (ramps, grab bars, etc.)
- Meals on wheels
Ancillary Resources (vary by community): Portable X-ray, Ultrasound, EKG, lab, etc.

Other professional home services: Podiatry, Optometry, Dentistry, Audiology, Beautician

Environmental Assessment: This can be for safety but also to get to know the patient better (e.g. pictures, religious items, cleanliness, odors, etc). An example of a home safety assessment that can be done by families/caregivers that was created in partnership by the Administration on Aging and the American Occupational Therapy Association can be found at: http://rebuildingtogether.org/wp-content/uploads/2012/06/RT-Aging-in-Place-Safe-at-Home-Checklist.pdf.

“Fridge biopsies”: house calls provide direct access to what patients are eating such as availability and types of food (e.g. sodium, sugar and fat content)

End-of-Life Care: Most house call programs have an annual mortality rate between 20-25%. House call providers should have a high index of suspicion to start hospice care. There is much palliative care in home care medicine. Discussing goals of care early is critical to honoring patients’ wishes and quality end-of-life care. The only thing I virtually always insist on in home care medicine is for my hospice patients to have comfort medications in the home (e.g. Morphine for pain and trouble breathing, Lorazepam for anxiety or terminal agitation, drying agent such as Atropine drops, Tylenol suppositories and sometimes Haldol for nausea/agitation and a constipation medication). I use the analogy we need to have auto insurance in case of an accident and we need to have comfort medications in case of suffering. In both cases I hope auto insurance is never needed and comfort meds are never needed but they need to be available if needed.

Wound care: “If dry wet it and if wet dry it.” Learn wound care supplies in different categories. Learn how to stage and to surgically debride wounds which is billable. Home health agencies often have wound care nurses and can get wound care supplies into the home and teach families/caregivers wound care.

Preparing for visit: I typically go over the patient’s chart the day before the visit to make sure I have all needed supplies and can give instructions if needed (patient in bed to review wound, patient needs to fast, call family member if needed for history ahead of visit). Patients are called 1-2 days ahead of visit with 2 hour window. I also call on the way so they are ready and tell them to have ALL medications out including OTC meds they are using and any vicious dogs put away (this is very rare—usually pets add to the visit). Assisted Living Facilities are called ahead to have patient in the room, medication list available and caregiver report so time is not wasted trying to find them.

Desire patients to be on the “perfect” medication: The perfect medication is always the least amount of medication that gets the desire result. Significant patient improvement comes much more frequently from lowering medication than adding medication. Become comfortable at weaning down or weaning off medication that may no longer be needed. Many of our patients have some unintentional weight loss that may allow for lowered hypertension, heart failure and diabetes medication. Patients can often be weaned off Proton pump inhibitors (do not stop suddenly has can gave rebound hyperacidity). If patients have been on antidepressants or anti-seizure medication for a long time without any problems an attempt can be made to wean off after discussing risks/benefits. If weaning off does not work at least you know definitively they need the medication. Alzheimer’s medications may no longer be benefitting the patient. Cholesterol medications may be able to be weaned down.
Phlebotomy: Home-limited patients can be difficult to draw blood from and it is not uncommon to draw blood from the lower legs (medical lower leg, ankle area/foot). We minimize time the tourniquet is on.

Patient Assistance Fund: We have been very successful at receiving donations for a patient assistance fund to help patients afford health related services or equipment they could not afford. We have used it for things like transportation, medicine, glasses, utilities, wound care supplies, medical equipment, etc.

Home Care Medicine is extremely rewarding and emotionally challenging. We often find ourselves between rocks and hard places having no good options but having to determine what is the least bad option. The good thing for our patients, families and caregivers is they have a caring house call provider to help them through these challenging times. In these challenging circumstances home care providers need to set limits. We are their medical provider not their family or personal caregivers (usually—sometimes we do become their family). They need to understand we cannot be two places at once nor can we solve all their problems (especially non-medical) in the home.

If any comments, corrections or additions please email Thomas.Cornwell@cadencehealth.org