HOSPITAL/HOME HEALTH

SHARED EXPECTATIONS
Section 1
Improving Systems of Care
## SECTION 1

### Improving Systems of Care (Hospital & Home Health)

<table>
<thead>
<tr>
<th>Action</th>
<th>Practice</th>
<th>Measure or Quality Domain</th>
</tr>
</thead>
</table>
| Monthly Cross-Setting Quality Improvement Meetings - Participants | Hospital convenes monthly quality improvement meetings to identify opportunities to improve transitions in care  
Home health agencies send administrative and clinical representatives to participate |  
- Frequency & Total number of cross-continuum meetings per year  
- Number of post-acute and community based providers engaged  
- Participation (attendance) by organization or agency  
- CMS Hospital Discharge Planning Conditions of Participation: *Know the capabilities of post-acute providers* |
| Monthly Cross-Setting Quality Improvement Meetings – Data Sharing | Hospital and home health agencies measure unadjusted all cause 30-day return to acute care (ED, readmission)  
Each provider presents most recent 30-day readmission data  
Each provider presents run chart of past 12 months of readmission data  
Each provider shares additional data, such as: Number of days between discharge and readmission, Hours between discharge and first home visit |  
- Monthly return to ED rate per provider  
- Monthly 30-day readmission rate per provider  
- Number (%) of providers furnishing requested data each meeting |
| Monthly Cross-Setting Quality Improvement Meetings – Transition and Readmission Reviews | Discuss problematic transfers  
Discuss all past month readmissions  
Identify system or process issues to address  
Propose interventions to address root cause of issue(s)  
Establish follow-up timeframe  
Identify responsible party |  
- CMS Discharge Planning Conditions of Participation requirement to review root causes of readmissions to identify opportunities for improvement |
Section 2
Screening & Referral
## SECTION 2
### Screening and Referral (Hospital)

<table>
<thead>
<tr>
<th>Action</th>
<th>Practice</th>
<th>Measure or Quality Domain</th>
</tr>
</thead>
</table>
| Enhanced screening              |hospital staff utilize a “whole-person” readmission or needs assessment to identify clinical, social, functional needs in post-hospital setting  
hospital staff will fax or digitize those assessments and share with the next provider(s) of care (eg. PCP and home health agency)|% of patients screened with standard tool for “whole-person” post-hospital readmission risks and needs  
% of assessments sent to the next provider(s) of care  
CMS Hospital Discharge Planning COPS: assess patients for post-hospital needs, using standard assessment tool |
| Collaborative assessment        |If a patient is considered at-risk of readmission, but hospital staff are not certain of home health eligibility, collaborate with agency liaisons to assess the patient prior to formal referral  
If a patient was initially evaluated for SNF or thought to require 24h care but has chosen to go to the home setting, the hospital will flag that patient for a same-day or next-morning visit to the home care agency |Reduce missed referrals of patients with home health care needs who failed to have referral prior to discharge  
Hospital HCAHPS question 19 “did hospital staff talk with you about whether you would have the help you needed when you left the hospital?” |
| Referral – patient communication |Hospital staff communicate to patients and caregivers the specific findings of their readmission risk / needs assessment  
Hospital staff communicate to patients and caregivers that a referral to home health is being placed to address the patient’s specific post-hospital needs and risks |HCAHPS – “During this hospital stay, staff took my preferences and those of my family or caregiver into account in deciding what my healthcare needs would be when I left.”  
HCAHPS- “During this hospital stay, did doctors, nurses, or other hospital staff talk with you about whether you would have the help you needed when you left the hospital?” |
Section 3
Pre Discharge Transitional Planning
### SECTION 3

**Pre-Discharge Transitional Care Planning (Hospital & Home Health)**

<table>
<thead>
<tr>
<th>Action</th>
<th>Practice</th>
<th>Measure or Quality Domain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-discharge care plan collaboration</td>
<td>⑨ Hospital invites home health agency clinical liaison to participate in discharge planning meetings</td>
<td></td>
</tr>
<tr>
<td></td>
<td>⑨ Hospital allows home health liaison to establish face to face contact with patient/caregiver upon acceptance to initiate contact prior to discharge home</td>
<td>Pre-discharge contact identified as a best practice for transitional care programs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• # of home health referrals /month</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• # of initiated episodes/month</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• % of referred episodes that started</td>
</tr>
<tr>
<td>ACO member identification</td>
<td>⑨ Hospital (ACO) identifies patient as ACO member</td>
<td>Measure TBD</td>
</tr>
<tr>
<td></td>
<td>⑨ ACO lets agency know if patient is high risk, and if so, how</td>
<td></td>
</tr>
<tr>
<td></td>
<td>⑨ ACO lets agency know if other longitudinal care managers are involved and provides contact info</td>
<td></td>
</tr>
<tr>
<td>High risk medication review</td>
<td>⑨ Identify any difficult to obtain medications, (not in stock, pre-auth required, costly)</td>
<td>Noted as best practice for transitional care programs (CCTP, STAAR, INTERACT, WellTransitions, BCPI)</td>
</tr>
<tr>
<td></td>
<td>⑨ Primary team to identify lower-cost options if potential barriers identified</td>
<td></td>
</tr>
<tr>
<td></td>
<td>⑨ Hard-copy prescriptions for controlled substances will be provided prior to discharge</td>
<td>Measure TBD</td>
</tr>
<tr>
<td></td>
<td>⑨ Hospital to consider bedside delivery of medications prior to d/c</td>
<td>(manual collection of % home health patients who filled all prescriptions)</td>
</tr>
<tr>
<td>Certification and equipment review</td>
<td>⑨ Hospital completes Face to Face form</td>
<td>CMS Hospital Discharge COPs requiring hospitals to make arrangements for...</td>
</tr>
<tr>
<td>Such as: face to face, wound vac, wound</td>
<td>⑨ Hospital clearly identifies what equipment / materials are required</td>
<td>• % of referrals with completed F2F form</td>
</tr>
<tr>
<td>dressings, tube feeds, IV antibiotics, picc</td>
<td>⑨ Hospital staff will ensure needed equipment has been ordered</td>
<td>• other measures TBD</td>
</tr>
<tr>
<td>placement, ostomy supplies, oxygen,</td>
<td>⑨ Hospital staff will provide name of DME provider(s) to home health staff</td>
<td></td>
</tr>
<tr>
<td>hospital bed, etc.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Section 4
Day of Transfer
### SECTION 4
**Day-of-Transfer Processes (Hospital & Home Health Agency)**

<table>
<thead>
<tr>
<th>Action</th>
<th>Practice</th>
<th>Measure or Quality Domain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-discharge clinical assessment</td>
<td>⑨ Hospital staff documents updated set of vitals, cognitive status, pain within 4 hours of discharge ⑩ If pain present, medicate patient prior to discharge home</td>
<td>• Measure TBD, possibly manual audit of % home health patients with documented vitals within 4 of hours of discharge</td>
</tr>
</tbody>
</table>

#### Essential Information Elements

*Hospital provides standardized and prioritized information to home health agencies containing transitional care elements of most relevance to home health providers assuming care*

Elements per [Hospital to Home Health Transfer Document](#) include:
- Patient and Alternate contact info.
- Primary caregiver
- Diagnoses, identify those that are new
- Most recent vitals including cognitive status and pain
- Readmission risk/needs assessment
- Medication dose, route, indication
- Allergies, intolerances to medications
- PT/OT/RT/SLP/Nutrition/SW recs
- Equipment needs & whether ordered,
- Tubes/lines/drains/wound information, eg PICC, IV, pleurex, wound vac, G or J tube, JP drain, etc.
- Wound care instructions, supplies
- PCP name, number
- Specialist(s) name(s), number(s)
- Date(s) of appointment(s)
- Code Status/MOLST

| Specific Point of Contact | Hospital provides point of contact (CM, floor resource nurse, hospitalist) who can answer post- discharge questions ⑨ ACO provides point of contact to coordinate regarding care plan | Best practice as per Transitions of Care Consensus Policy Statement-v |

---

*Best practice transitional care information is defined by the information elements needed by “receiving” providers*

- Measure TBD, possibly elements of the CCD as via LAND/SEE IMPACT?
- As per CircleBack, % home health staff who stated they had all the information they needed to assume care of the patient
Section 5
Initial Review and Confirmation of Care Plan (Home Health Agency)
# SECTION 5
Initial Review and Confirmation of Care Plan (Home Health Agency)

<table>
<thead>
<tr>
<th>Action</th>
<th>Practice</th>
<th>Measure or Quality Domain</th>
</tr>
</thead>
</table>
| Timely Contact              | ⑨ Initial within 24h of discharge if ACO patient  
⑨ Non-high risk or ACO contact <48h                                                                                                           | • % of ACO patients with initial contact <24h of discharge                                                  |
| Confirm & Clarify Plan of Care | ⑨ If nurse identifies questions or discrepancies in plan of care, medications, supplies, the following steps will be taken the same business day: call hospital point of contact, call ACO point of contact, and /or call PCP to resolve  
⑨ Agency will notify ACO point of contact weekly of care plan discrepancies remain unresolved | Measure TBD, examples:  
• % of episodes initiated with care plan discrepancies identified by home health agency  
• % of first attempts at calling hospital point of contact successful  
• % of first attempts at calling ACO point of contact successful  
• % of patients with no care plan discrepancies after second post discharge visit |
| Medication Review & Reconciliation | ⑨ Perform in-home review of all medications, visualizing all medications throughout home  
⑨ Identify discrepancies in prescribed medication regimen  
⑨ Identify potential drug-drug interactions  
⑨ Contact hospital, ACO and/or PCP to clarify medication issues                                                                 | • ACO Measure-12  
• In-home medication reconciliation complete within x days of discharge  
• Medication issues clarified within x days of discharge  
• Complete medication reconciliation list sent to PCP within x days of discharge |
| Assess Patient Needs        | ⑨ Ability to perform self-care  
⑨ Understanding of conditions, symptoms and red-flags  
⑨ Medication teaching  
⑨ Fall Risk                                                                                                                                   | • ACO-13 (falls)  
• ACO-18 (depression)  
• ACO-14 (Flu)  
• ACO-15 (pVax) |
| Patient and Caregiver Teaching | 9. Personal Health Record  
9. Review readmission risks and plan for mitigating risks  
9. Medication teaching w/ teach-back  
9. Red flag symptoms with teach back  
9. Pain management plan  
9. Chronic disease self-management  
9. “Call me first” teaching | Measures TBD |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Advanced Directives</td>
<td>9. Determine if patient has Advanced Directive and/or MOLST form</td>
<td></td>
</tr>
</tbody>
</table>
| Care Coordination / Case Conference | 9. If discrepancies persist in care plan or patient remains high risk, Home Care staff will initiate a case conference with primary physicians and specialists to coordinate plan  
9. ACO will initiate case conferencing if desired | |
Section 6
Change in Clinical Status & Transfer of Care (Home Health Agency)
<table>
<thead>
<tr>
<th>Action</th>
<th>Practice</th>
<th>Measure or Quality Domain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transfer to “Home” (End Episode)</td>
<td>⑨ Agency adheres to OPT-IN practices including: • Known medications • Understand self management role • Know symptoms to monitor • Know who to all • When next appointment(s) are • Connection with community services ⑨ Agency will notify ACO point of contact that episode is over ⑨ Agency will notify PCP that episode is over</td>
<td>Measures TBD, may include • Total length of episode • % of episode recerts</td>
</tr>
<tr>
<td>Transfer to Skilled Nursing Facility (Change in clinical status)</td>
<td>⑨ If a non-emergent change in clinical status is observed, agency will contact ACO point of contact to discuss whether SNF-level of care is indicated (via 3-day waiver, or after recent discharge, etc)</td>
<td>Measure TBD, may include • Number of home health patients transferred to SNF past month (quarter)</td>
</tr>
<tr>
<td>Transfer to Hospice</td>
<td>⑨ If indicated, agency will work with PCP and ACO to refer patient to hospice</td>
<td>Measure TBD, may include • # of patients referred from HH to hospice past month (quarter)</td>
</tr>
<tr>
<td>Transfer to ED/hospital</td>
<td>⑨ Agency will send ED the following: • Advance Directives/MOLST • Most recent medication list • Home Health Agency Contact ⑨ ED to call HH contact to discuss alternatives to admit, if indicated</td>
<td>Adapted from INTERACT</td>
</tr>
</tbody>
</table>