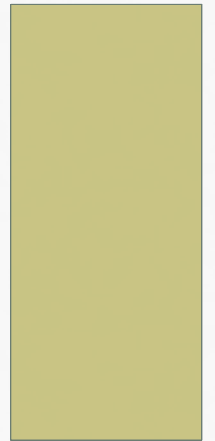
# HOSPITAL/HOME HEALTH

SHARED EXPECTATIONS



# Section 1
# Improving Systems of Care

| SECTION 1<br>Improving Systems of Care (Hospital & Home Health) | | |
|---|---|---|
| *Action* | *Practice* | *Measure or Quality Domain* |
| Monthly Cross-Setting Quality Improvement Meetings - Participants | ⑨ Hospital convenes monthly quality improvement meetings to identify opportunities to improve transitions in care<br>⑨ Home health agencies send administrative and clinical representatives to participate | • Frequency & Total number of cross-continuum meetings per year<br>• Number of post-acute and community based providers engaged<br>• Participation (attendance) by organization or agency<br>• CMS Hospital Discharge Planning Conditions of Participation[i]: *Know the capabilities of post-acute providers* |
| Monthly Cross-Setting Quality Improvement Meetings – Data Sharing | ⑨ Hospital and home health agencies measure unadjusted all cause 30-day return to acute care (ED, readmission)<br>⑨ Each provider presents most recent 30-day readmission data<br>⑨ Each provider presents run chart of past 12 months of readmission data<br>⑨ 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<br>• Monthly 30-day readmission rate per provider<br>• Number (%) of providers furnishing requested data each meeting |
| Monthly Cross-Setting Quality Improvement Meetings – Transition and Readmission Reviews | ⑨ Discuss problematic transfers<br>⑨ Discuss all past month readmissions<br>⑨ Identify system or process issues to address<br>⑨ Propose interventions to address root cause of issue(s)<br>⑨ Establish follow-up timeframe<br>⑨ Identify responsible party | • CMS Discharge Planning Conditions of Participation requirement to review root causes of readmissions to identify opportunities for improvement |

## Section2
## Screening & Referral

| **SECTION 2**<br>**Screening and Referral (Hospital)** | | |
|---|---|---|
| *Action* | *Practice* | *Measure or Quality Domain* |
| Enhanced screening | ⑨ Hospital staff utilize a "whole-person"[ii] readmission or needs assessment to identify clinical, social, functional needs in post-hospital setting<br>⑨ 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<br>• % of assessments sent to the next provider(s) of care<br>• CMS Hospital Discharge Planning COPS: assess patients for post-hospital needs, using standard assessment tool |
| Collaborative assessment | ⑨ 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<br>⑨ 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<br>• 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 | ⑨ Hospital staff communicate to patients and caregivers the specific findings of their readmission risk / needs assessment<br>⑨ 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."<br>• 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<br>Pre-Discharge Transitional Care Planning (Hospital & Home Health) | | |
|---|---|---|
| *Action* | *Practice* | *Measure or Quality Domain* |
| Pre-discharge care plan collaboration | ⑨ Hospital invites home health agency clinical liaison to participate in discharge planning meetings<br>⑨ Hospital allows home health liaison to establish face to face contact with patient/caregiver upon acceptance to initiate contact prior to discharge home | *Pre-discharge contact identified as a best practice for transitional care programs*<br><br>• # of home health referrals /month<br>• # of initiated episodes/month<br>• % of referred episodes that started<br>• |
| ACO member identification | ⑨ Hospital (ACO) identifies patient as ACO member<br>⑨ ACO lets agency know if patient is high risk, and if so, how<br>⑨ ACO lets agency know if other longitudinal care managers are involved and provides contact info | • Measure TBD |
| High risk medication review | ⑨ Identify any difficult to obtain medications, (not in stock, pre-auth required, costly)<br>⑨ Primary team to identify lower-cost options if potential barriers identified<br>⑨ Hard-copy prescriptions for controlled substances will be provided prior to discharge<br>⑨ Hospital to consider bedside delivery of medications prior to d/c | *Noted as best practice for transitional care programs (CCTP, STAAR, INTERACT, WellTransitions, BCPI)*<br><br>• Measure TBD<br>• (manual collection of % home health patients who filled all prescriptions) |
| Certification and equipment review<br><br>Such as: face to face, wound vac, wound dressings, tube feeds, IV antibiotics, picc placement, ostomy supplies, oxygen,, hospital bed, etc. | ⑨ Hospital completes Face to Face form<br>⑨ Hospital clearly identifies what equipment / materials are required<br>⑨ Hospital staff will ensure needed equipment has been ordered<br>⑨ Hospital staff will provide name of DME provider(s) to home health staff | *CMS Hospital Discharge COPs[iii] requiring hospitals to make arrangements for…*<br><br>• % of referrals with completed F2F form<br>• other measures TBD |

# Section 4
# Day of Transfer

| SECTION 4<br>Day-of-Transfer Processes (Hospital & Home Health Agency) | | |
|---|---|---|
| *Action* | *Practice* | *Measure or Quality Domain* |
| Pre-discharge clinical assessment | ⑨ Hospital staff documents updated set of vitals, cognitive status, pain within 4 hours of discharge<br>⑨ If pain present, medicate patient prior to discharge home | • Measure TBD, possibly manual audit of % home health patients with documented vitals within 4 of hours of discharge |
| Essential Information Elements<br><br>*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:<br>⑨ Patient and Alternate contact info.<br>⑨ Primary caregiver<br>⑨ Diagnoses, identify those that are new<br>⑨ Most recent vitals including cognitive status and pain<br>⑨ Readmission risk/ needs assessment<br>⑨ Medication dose, route, indication<br>⑨ Allergies, intolerances to medications<br>⑨ PT/OT/RT/SLP/Nutrition/SW recs<br>⑨ Equipment needs & whether ordered,<br>⑨ Tubes/lines/drains/wound information, eg PICC, IV, pleurex, wound vac, G or J tube, JP drain, etc.<br>⑨ Wound care instructions, supplies<br>⑨ PCP name, number<br>⑨ Specialist(s) name(s), number(s)<br>⑨ Date(s) of appointment(s)<br>⑨ Code Status/MOLST | *Best practice transitional care information is defined by the information elements needed by "receiving" providers*<br><br>• Measure TBD, possibly elements of the CCD as via LAND/SEE IMPACT?<br>• As per CircleBack[iv], % home health staff who stated they had all the information they needed to assume care of the patient |
| Specific Point of Contact | ⑨ Hospital provides point of contact (CM, floor resource nurse, hospitalist) who can answer post- discharge questions<br>⑨ ACO provides point of contact to coordinate regarding care plan | *Best practice as per Transitions of Care Consensus Policy Statement[v]* |

# Section 5
# Initial Review and Confirmation of Care Plan  (Home Health Agency)

| **SECTION 5**<br>**Initial Review and Confirmation of Care Plan (Home Health Agency)** | | |
|---|---|---|
| *Action* | *Practice* | *Measure or Quality Domain* |
| Timely Contact | ⑨ Initial within 24h of discharge if ACO patient<br>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<br>⑨ Agency will notify ACO point of contact weekly of care plan discrepancies remain unresolved | *Measure TBD, examples:*<br>• % of episodes initiated with care plan discrepancies identified by home health agency<br>• % of first attempts at calling hospital point of contact successful<br>• % of first attempts at calling ACO point of contact successful<br>• % 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<br>⑨ Identify discrepancies in prescribed medication regimen<br>⑨ Identify potential drug-drug interactions<br>⑨ Contact hospital, ACO and/or PCP to clarify medication issues | • ACO Measure-12<br>• In-home medication reconciliation complete within x days of discharge<br>• Medication issues clarified within x days of discharge<br>• Complete medication reconciliation list sent to PCP within x days of discharge |
| Assess Patient Needs | ⑨ Ability to perform self-care<br>⑨ Understanding of conditions, symptoms and red-flags<br>⑨ Medication teaching<br>⑨ Fall Risk | • ACO-13 (falls)<br>• ACO-18 (depression)<br>• ACO- 14 (Flu)<br>• ACO-15 (pvax) |

| | ⑨ Home Safety evaluation<br>⑨ Physical Therapy<br>⑨ Occupational Therapy<br>⑨ Speech Language Pathology<br>⑨ Nutritionist, nutritional support<br>⑨ Home Health Aide<br>⑨ Medical Social Worker<br>⑨ Behavioral Health<br>⑨ Depression screen<br>⑨ Pain assessment<br>⑨ Readmission risk assessment<br>⑨ Assess social supports<br>⑨ ASAP referral<br>⑨ Flu and Pvax status | |
|---|---|---|
| Patient and Caregiver Teaching | ⑨ Personal Health Record<br>⑨ Review readmission risks and plan for mitigating risks<br>⑨ Medication teaching w/ teach-back<br>⑨ Red flag symptoms with teach back<br>⑨ Pain management plan<br>⑨ Chronic disease self-management<br>⑨ "Call me first" teaching | Measures TBD |
| Advanced Directives | ⑨ Determine if patient has Advanced Directive and/or MOLST form | |
| 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<br>⑨ ACO will initiate case conferencing if desired | |

# Section 6
# Change in Clinical Status & Transfer of Care (Home Health Agency)

| SECTION 6<br>Change in Clinical Status & Transfer of Care (Home Health Agency) | | |
|---|---|---|
| *Action* | *Practice* | *Measure or Quality Domain* |
| Transfer to "Home" (End Episode) | ⑨ Agency adheres to OPT-IN practices including:<br>• Known medications<br>• Understand self management role<br>• Know symptoms to monitor<br>• Know who to all<br>• When next appointment(s) are<br>• Connection with community services<br>⑨ Agency will notify ACO point of contact that episode is over<br>⑨ Agency will notify PCP that episode is over | *Measures TBD, may include*<br>• Total length of episode<br>• % of episode recerts |
| Transfer to Skilled Nursing Facility (Change in clinical status) | 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) | *Measure TBD, may include*<br>• Number of home health patients transferred to SNF past month (quarter) |
| Transfer to Hospice | ⑨ If indicated, agency will work with PCP and ACO to refer patient to hospice | *Measure TBD, may include*<br>• # of patients referred from HH to hospice past month (quarter) |
| Transfer to ED/hospital | ⑨ Agency will send ED the following:<br>• Advance Directives/MOLST<br>• Most recent medication list<br>• Home Health Agency Contact<br>⑨ ED to call HH contact to discuss alternatives to admit, if indicated | *Adapted from INTERACT* |