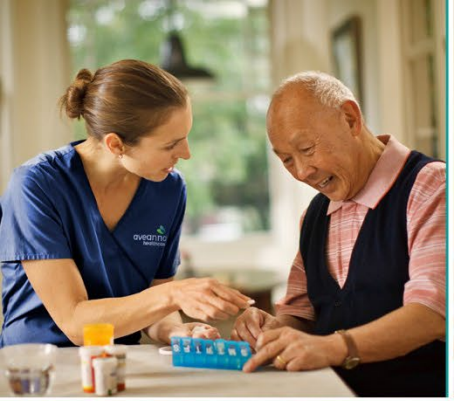
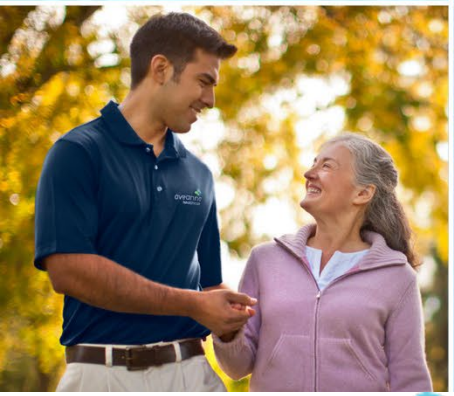


Home Care Collaboration

Abby Rimmert
Branch Manager
Brightstar Care

Sara Gillespie
Account Executive,
Aveanna Home Health



aveanna home health

BrightStar Care®
HOME CARE | MEDICAL STAFFING

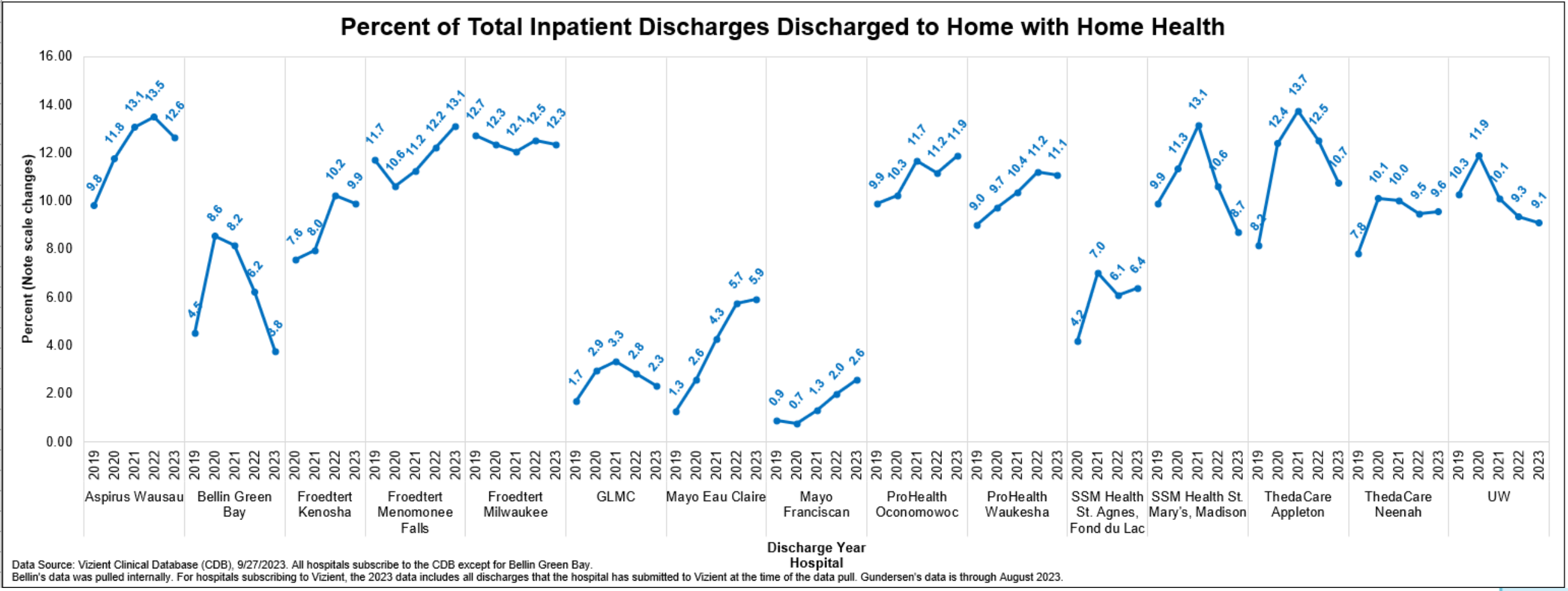
LA CROSSE MEDICAL HEALTH SCIENCE CONSORTIUM

Presentation Outline

- In-home services can prevent rehospitalization rates
- Home care options are important to integrate into the discharge discussion
- Different home care services can collaborate

Presentation Outcomes

- Benefits of supportive home care and home health
- Navigation process for determining least restrictive setting
- Collaboration possibilities for safe transitions upon discharge

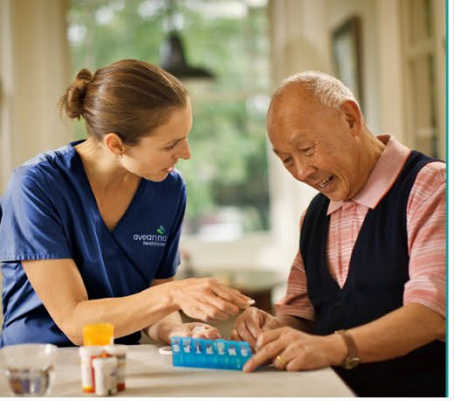


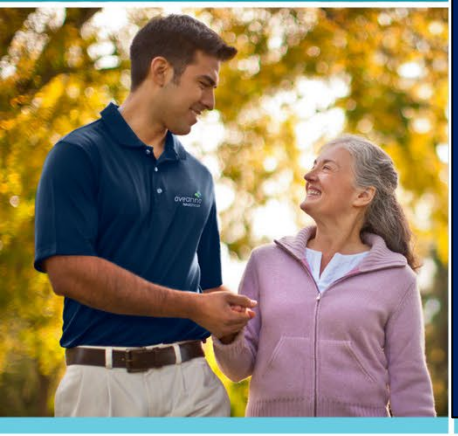
Data Source: Vizient Clinical Database (CDB), 9/27/2023. All hospitals subscribe to the CDB except for Bellin Green Bay.
Bellin's data was pulled internally. For hospitals subscribing to Vizient, the 2023 data includes all discharges that the hospital has submitted to Vizient at the time of the data pull. Gundersen's data is through August 2023.

AVG % for Home with Home Health

12.4	Froedert Milwaukee
12.2	Aspirus Wausau
11.8	Froedert Menomonee Falls
11.5	Theda Care Appleton
11.0	ProHealth Oconomowoc
10.7	SSM Health St Mary's
10.2	UW

9.4	ThedaCare Neenah
8 .9	Froedert Kenosha
6.3	Bellin Green Bay
5.9	SSM Fon du lac
4.0	Mayo Eau Claire
2.6	GLMC
1.5	Mayo Franciscan





What is Medicare Home Health?

What is Medicare Home Health?

What does Medicare Cover?

Medicare part A covers home health services with no out-of-pocket cost to the patient. Home health services covered under the Medicare benefit include: **Skilled Nursing, Physical Therapy, Occupational Therapy, Speech Therapy, Medical Social Worker, and Home Health Aide**

How to Qualify for Medicare Part A Home Health Benefit

If patients meet the following three conditions, Medicare will pay for home health services:

1. A person who is homebound
2. A person who has a **skilled need**
3. A person who is under the care of an allowed provider who authorizes their home health care plan

***Patient doesn’t need a qualifying stay to receive Home Health services.

Homebound Status DEFINED & REFINED

Defined: Homebound – Permanently bounded, unable to leave home

Refined:

- Infrequent/short absences are allowed
- An individual does not have to be bedridden
- Conditions must meet the homebound criteria

Allowed Absences:

- Visiting a barber or a salon
- Attending a celebration such as a wedding or graduation
- Dialysis
- Healthcare appointments
- Adult day care
- Church
- Family lunch
- Leaving the home to be able to live – visits to the grocery store, bank, post-office, etc.

Homebound Status

Criteria One

The patient must either:

- Because of illness or injury**, need the aid of supportive devices** such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the **assistance of another person** in order to leave their place of residence

OR

- Have a condition such that leaving their home is medically contraindicated

If the patient meets one of the Criteria One conditions, then the patient must ALSO meet two additional requirements defined in Criteria Two.

Criteria Two

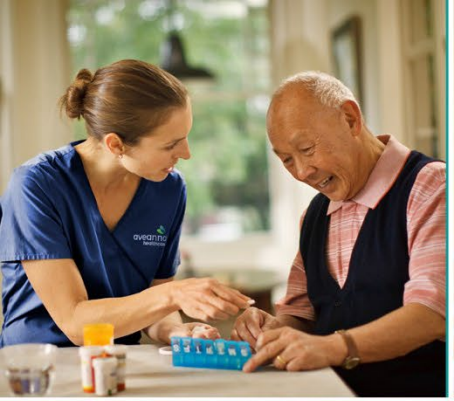
- A normal inability to leave home must exist

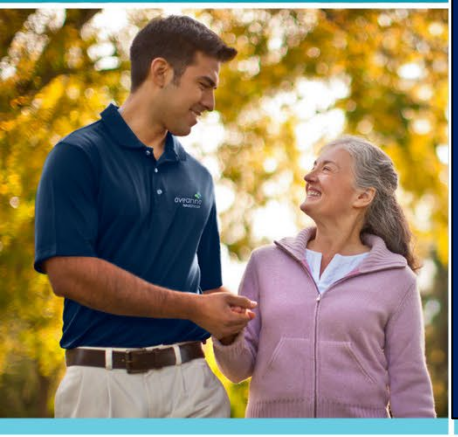
AND

- Leaving home must require a considerable and taxing effort and be infrequent in nature and of short duration.

Provider's must "open the door" to homebound status*

1. A patient with arteriosclerotic heart disease of such severity that they must avoid all stress and physical activity.
2. A patient paralyzed from a stroke who is confined to a wheelchair or requires assistance to walk.





Home Health Services Defined

Therapies

Physical Therapy:

Increased weakness

Balance deficits

Increased pain

Decreased mobility

Recent fall(s)

Endurance deficits

Occupational Therapy:

Trouble with personal care (bathing, dressing, etc.)

Incontinence

Visual deficits

Decline in cognition

Shortness of breath

Speech Therapy:

Speech deficits

Swallowing deficits

Trouble expressing or understanding thoughts or ideas

Aphasia, apraxia, dysphagia

Memory and recall deficits

OT cannot initiate services without the need for nursing, physical therapy, or speech therapy.

What is Skilled Nursing?

Observation and Assessment

- New medical diagnosis – i.e., newly diagnosed with CHF or COPD
- New medication or new dosage
- Pain Management
- Acute/Exacerbated Conditions (COPD, CHF, HTN)
  - Vital signs out of normal range

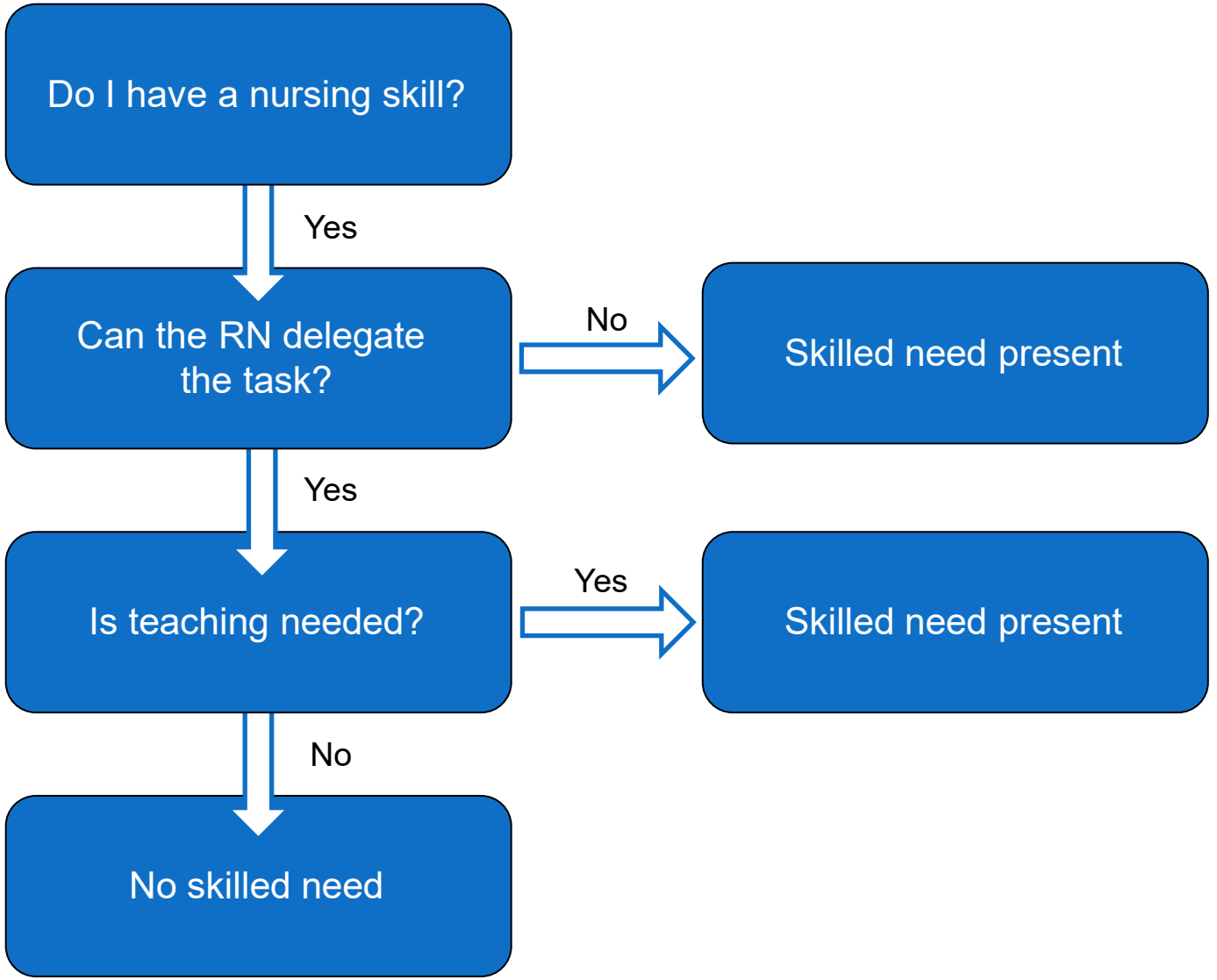
Teaching and Training

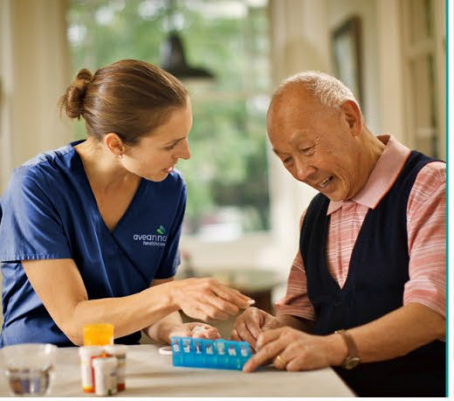
- How to manage the treatment regimen
- Impacts patient's functional loss, illness, or injury
- Unsuccessful teaching will cease to be reasonable and necessary
  - Lack of understanding of current illness or diagnosis
  - Difficulty managing current medications
  - New prescription for O2

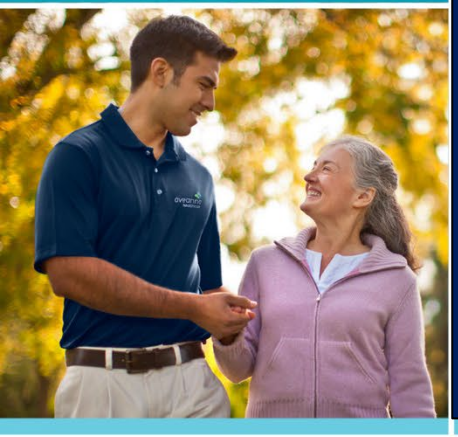
Hands-On Care

- Medication Administration (B12 injections, IV)
- Tube Feedings
- Aspiration
- Sterile Irrigation
- Catheter Placement
- Wound Care **with exception*

Skilled Need Decision Tree







What is Home Care

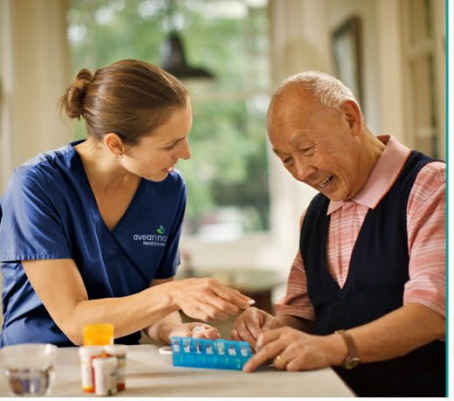
What is Home Care?

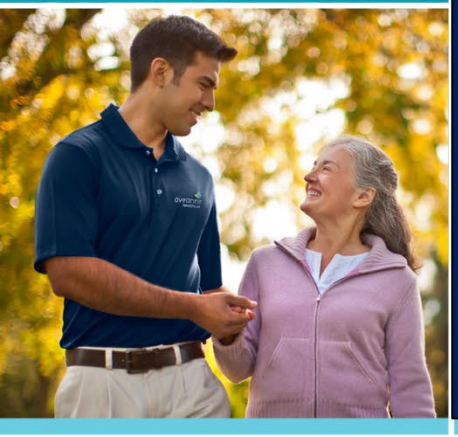
What is Home Care?

Home care is ***supportive care*** provided by a professional caregiver in the individual home where the patient or client is living.

Individuals that could benefit from Home Care?

- Companionship or need 24/7 supervision
- Assistance w/personal cares
- Housekeeping/laundry assistance
- ADL assistance
- Transportation needs
- Maintain independence (Age in place)
- Short/Long-term care
- Family burnout





Home Care Services Defined

Services Defined

- **Home Health Aide**
- **Skilled Nursing (Long-term)**
- **Vital observation/checks and reminders**
- **ADL's:**
  - Meal delivery/prep and shopping
  - Light housekeeping
  - Bill paying/money management
  - Companionship/Community access
  - Transfers/ROM assistance
  - Transportation
  - And much more!

Does the patient have an in-home need post discharge?

ADL assistance
Household duties
Companionship
Medication
Observation-Checks-Reminders

Yes

Make referral to:
Supportive Homecare

- Light housekeeping
- Laundry
- Meal prep
- Grocery Shopping
- Bathing
- Nursing
- Exercise
- Paying bills
- Playing cards
- Playing games
- Conversation
- Appointment companionship
- 1hr of service-24/7 care

Nursing

Is the need long term?
Patients need CANNOT improve
Patient is at baseline

Yes

Is the need short term?
Patients need CAN improve back to baseline

Yes

Therapy
Physical-Occupational-Speech

Can you answer YES to all of the following?

- Are patient's outings of short duration and infrequent in nature?
- Does patient require aid of supportive device or the assistance of another person when leaving home?
- Does patient need to exert a considerable and taxing effort when leaving home?

No

Yes

Make referral to:
Home Health

Skilled Nursing need due to:

- **Hospitalization**
- **New/exacerbated condition**
- **Change in med in 60 days**
- **New med in last 30 days**
- **Caregiver education**
- **Treatment of illness or injury that must be performed by a nurse such as:**
  - Medical administration (other than oral)
  - Wound care
  - Urinary catheter care
  - IV therapy
  - Parenteral/Enteral nutritional support
  - Diabetic care
  - Unstable INR's

PT, OT, or ST need due to:

- **Recent marked decline in functional status (e.g., speech, ambulation, strength, endurance)**
- **Recent falls, fractures, stroke**
- **Need for home maintenance program to maintain current level of function**
- **Shortness of breath, decreased mobility, balance & endurance deficits**

****Please note: Referrals must be ordered by an allowed practitioner and the patient must have had a face-to-face encounter with a practitioner within 90 days prior to the start of care or within 30 days after the start of care. The encounter must be related to the primary reason the patient requires home health services.*

- If patient has a skilled need but also could benefit from additional assistance, consider making a referral to both Home Health and Supportive Home Care
- Services can be provided any place the patient calls home (Assisted living, Independent living, Apt, House, etc.)
- ****Homebound status is Medicare Criteria – Medicaid or Commercial insurance policies *may not* require patient to be homebound in order to utilize skilled home health services.
- If a patient in a Wisconsin Family Care MCO, reach out to patient's Interdisciplinary Team to provide authorization for any service including Home Health, Therapies, and Supportive Home Care.

La Crosse Medical Health Science Consortium

Developed by the La Crosse Medical Health Science Consortium's Transitions in Care Committee - August 2021

Combining in-home services:

Families find that a combination of supportive home care and home health is beneficial for their loved ones. Health professionals address clinical and rehab needs, while personal/supportive home care aides assist personal caregiving and household chores.

Services	Home Health Services	Supportive Home Care
Skilled Nursing • Medical Tests • Wound Care • Injections • Observation & Assessment	⊕	⊕
Therapy – PT, OT, ST	⊕	
Monitoring of Health Status (SN, HHA & Therapy)	⊕	
Medical Social Worker	⊕	
Home Health Aide	⊕	⊕
Medication		
Observation/Checks & Reminders		⊕
Education/Reconciliation	⊕	
Administer (IV or Injection)	⊕	
Pain Management	⊕	

Services	Home Health Services	Supportive Home Care
Activities of Daily Living (ADL)		
Meal delivery/prep & shopping		⊕
Light Housekeeping		⊕
Bathroom needs/Incontinence A		⊕
Incontinence care	⊕	⊕
Assist with Bill Paying and Money Management		⊕
Companionship/Community Access		⊕
Transportation		⊕
Personal Hygiene (hands on/cues) • Dressing, Bathing, Grooming, Laundry		⊕
Transfers • Total body: Full Body or Sit-To-Stand lift • Assistance: Slide board, pivot transfer with use of a gait belt or simply stand-by to prevent falls		⊕

= Policies may vary

⊕ = Service is provided

Payment Options	Home Health Services	Supportive Home Care
Medicare Part A	⊕	
Commercial Insurance	⊕	🍃
Private Pay		⊕
Long Term Care Ins		🍃
Medicaid (Family Care)	⊕	🍃
Military (VA, etc.)	⊕	🍃

🍃 = Policies may vary ⊕ = Service is covered

Myrtle

Diagnosis: Joint Surgery
Age: 68

Background

- Fell down 10 steps
- Laid on floor for 2 days
- Broken hip and arm – surgery and rehab

Discharged

- Declined SNF
- Home with no services

One week later daughter visited & observed:

- Meds not being taken
- No showering due to fear of falling
- Not eating
- Not ambulating well

Follow up clinic appointment

- Daughter inquired about home services
- Referral was sent to home health and SHC

Outcome

- Home Health started in home PT/OT.
- Supportive Care started HHA 24/7
- No more falls
- No hospitalization since her last fall.

Resource PAGE

ADRC (Aging, Disability and Resource Center)
Options Counselors
608.785.5700

La Crosse Medical Health Science Consortium Resources
www.lacrosseconsortium.org
Contact e-mail on home page

Questions?