VNAA BLUEPRINT FOR EXCELLENCE

BEST PRACTICES
TO IMPROVE DISCHARGE TO COMMUNITY

Training Slides
April, 2017
Why Take Action to Help Patients Stay Home?

- Better patient care and patient experience
- Home Health Compare / Star Ratings
- 2017 Conditions of Participation
- IMPACT ACT – Potentially Preventable Readmission and Discharge to Community
- Payers want it: value-based purchasing, ACO
- Reimbursement
Thank you

Joint VNAA-AHHQI
Discharge to Community
Work Group
VNAA Blueprint for Excellence

Best Practice Information, Case Studies, Resources and more information

Vnaablueprint.org

Chapters of interest:

- Discharge to Community
- Reducing Readmissions
- 5-Star Best Practices
- IMPACT Act Resources
- Improving the End of Life Continuum
About the VNAA Blueprint

- Expert recommendations from VNAA member Work Groups
- Based on available evidence (see references and resources tabs)
- Work in progress – knowledge continues to evolve
- Identifies multiple options for improvement
- Blueprint is used in conjunction with Clinical Pathways, accreditation, electronic tools, regulatory compliance and other requirements for home health agencies
- Users identify strategies that work in their organization, given size, workforce availability, caseload, customer needs
What is Discharge to Community (DTC)?

- IMPACT Act requires CMS to calculate the rate of readmissions to hospitals or long term care hospital facilities for the 31 day period after discharge from home health
- High performance is based on no unplanned rehospitalizations and no death in the 31 days following discharge
- DTC is a risk-standardized rate of Medicare FFS patients who are discharged to the community following a HH episode
- DTC is an opportunity to partner with community organizations to ensure smooth handoffs to the community, and is also an opportunity to partner with hospitals
DTC is related to prevention of readmissions, but also focuses on supporting patients through caregiver and community resources.

- No magic bullets; limited evidence on effective DTC approaches
- Evidence on preventing readmissions: multi-faceted interventions more effective than single element strategies
- No studies address long term stay in the community after home health
- Improved continuum of home health, palliative care and hospice may reduce unwanted emergency and hospital use and increase DTC
What should home-based care organizations do?
Factors related to readmissions:

- Early / inappropriate hospital discharge
- MD referral direct to Emergency Room
- Lack of reimbursement to follow up after HH discharge
- Caregivers don’t know what to do or can’t manage
- Difficulty tracking readmissions especially after HH discharge
- Challenging to identify high risk patients
- Unclear evidence on effective interventions
- Lining up effective community supports
• Develop relationship with and recommend a visiting physician / APRN practice for patient home visits
• Ensure patients have confirmed relationships with primary and specialty care
• Confirm appointments and other follow up planned after home health discharge
• Use teachback to ensure patients and caregiver understand who to contact after discharge from hospital and home health
Prepare patients and caregivers to stay in the community with collaborative planning process and validating pt/caregiver understanding

Make a social work referral early after home health admission

Identify comprehensive social needs: food, transportation, financial means, caregiver capability and ensure a plan is in place before home health discharge

Identify community based organizations willing to partner with the HHA on nutrition, caregiving assistance, transportation, and other resources that can help prevention readmissions during and after the home health episode.
Develop referral programs and processes to assist in identifying and referring patients eligible for palliative care

Consider developing an agency-level palliative care program

Work with hospital partners to develop collaborative palliative care program

See also VNAA's Blueprint module on Improving the Continuum of Care at the End of Life
Improving the Continuum: Facilitate Transition to Hospice

- Assess clinical eligibility for hospice
- Train home health staff on having discussions with patients and families about hospice
- Offer hospice RN or social work visit during HH stay
- Engage home health social worker to review options with the patient and family when an extended home stay seems unlikely
- See also VNAA's Blueprint module on Improving the Continuum of Care at the End of Life
During the HH Episode:

- Assess and address risk factors
- Engage patients and caregivers in plan of care and management
- Ensure effective medication management
- Prioritize functional status
- Identify and alert physicians to cognitive changes
**Top Tip:** Make sure patients and caregivers know what to do if they have problems. For example, use Zone Tools to discuss possible clinical issues and ‘call me first’ posters or information to remind the patients to contact the nurse HHA they are having a true emergency.
HH measures used in Star Ratings, Home Health Compare, IMPACT Act

New: home health is accountable for readmissions during the HH episode and after HH discharge – including admission to long term care hospital

Potentially preventable readmission (PPR) and discharge to community (DTC) are claims based IMPACT Act Measures new in 2017

What Should HHAs Do?

Understand definitions and time frames used measures: all cause, preventable readmissions, 30 day, 60 day

Recognize interrelationships between measures: pain, function, experience are all related to readmission

Partner with other organizations also accountable for readmission and discharge planning: physicians, hospitals, ACOs
New in 2017:

• Discharge to community (DTC): assesses successful discharge to the community from HHA, with successful discharge to the community including no unplanned rehospitalizations and no death in the 31 days following discharge.

• Potentially Preventable Readmission (PPR): risk-standardized rate of unplanned, potentially preventable readmissions for patients (Medicare fee-for-service beneficiaries) in the 30-days after a home health discharge.

• Readmission during the HH episode is a factor in Medicare Star Ratings for Home Health.
Hospital Readmission Resources

- Agency for Healthcare Quality and Research – Preventing Avoidable Re-admissions
- Agency for Healthcare Quality And Research - Interventions to Prevent Readmissions for People with Heart Failure
- CMS Guide to Preventing Readmissions among Racially and Ethnically Diverse Medicare Beneficiaries
- Center for Health Care Quality and Payment Reform – Preventing Readmissions
- HHQI Fundamentals of Reducing Acute Care Hospitalizations - tools and patient education
Staying in the Community Resources

- Aging and Disability Resource Centers (ADRCs) are a program of the Federal Administration for Community Living.
- U.S. Administration on Aging
- Aging / Area Agencies on Aging Finder Tool
- Eldercare Locator
- Nutrition.gov and specific nutrition resources for seniors.
- The Senior Corps
- Supplemental Nutrition Assistance Program (SNAP)
- National Association of Area Agencies on Aging (N4A)
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