McLaren NORTHERN MICHIGAN

Physician Office-Home Health Partnership

Reducing Readmissions/Improving Care

VitalCare
Clinical Excellence. Caring Professionals.
Affiliated with McLaren Northern Michigan

VitalCare

- Part of McLaren Health System
  - Will be rebranded January first as McLaren Homecare and Hospice

McLaren HOME CARE & HOSPICE

  - Home Health, Hospice, Home Medical Equipment, Adult Day Center, Private duty
    - Two hospice residences (Petoskey, Cheboygan)
    - 3 Medical equipment retail stores (Petoskey, Gaylord, Cheboygan)

VitalCare - Home Health

- Service area:
  - Emmet, Charlevoix, Cheboygan, Antrim, Otsego, Presque Isle, Montmorency. Cities of St. Ignace and Alpena.
  - Goal for expansion to Traverse City Feb 1st
- Services: Skilled nursing, PT, OT, SLP, MSW, HHA
  - Specialty services: Telehealth (HF/COPD), Palliative NP, CRNI, CWOCN

Home Health Services

- Provide education/monitoring
- Support for family & caregivers
- Evaluate and educate on home safety
- Help with early detection of complications
- Rehab
- Placement if necessary

Who Qualifies?- Medicare

1. Under the care of a physician
   - who reviews and signs the plan of care, ongoing follow up
2. Requires SKILLED, INTERMITTENT care from:
   - RN, PT, ST

   OR
   - Ongoing care from OT
   - May also require MSW, HHA-(Cannot stand alone)

3. Homebound
   - Leaves home other than for medical care infrequently and requires a taxing effort to leave home
4. Face to face- must have seen NP or physician 90 days prior to HH admission or 30 days after for reason referral to HH was made

Physician Directed Care

- CMS is using incentives to promote physician directed care:
  - PCMH's/ACO's/CCM/TCM
  - Communication requirements (Admit communication and ongoing from agency staff)
  - Documentation requirements (Face to face, CCM documentation)
  - Public reporting quality/customer service

Partnering with Home Health

- Physicians can benefit from home health by:
  - Eliminating unnecessary visits to office
  - Breaking ED cycle
  - Increase pt satisfaction
  - Proactive case management
  - Patient data
  - Holistic care with HH team (environmental assessment, multiple discipline team)

Patient Selection

- Educational deficits
  - Disease education, injections, glucometer use, Pleurx, wound care, infusions, tube feedings, trach., ostomy patients, safety
- Mobility deficits
  - W/C bound, gait, mobility, falls, new walker
- Medication Reconciliation and Education
  - Instructing on changes/assessment of efficacy

Patient Selection

- Ensure orders are followed
  - Changes occurring during physician office visit
  - D/C from hospital or ECF
- Short term assessment of unstable condition

Benefits of home health

- Telehealth for monitoring of heart failure/COPD
- Wound experts
  - Photo's for assessment
  - Recommend best practice treatments
  - Monitor for infections
- Fall prevention
  - Home therapy for patients at risk

Benefits of home health

- Placement evaluation
  - Patient manage at home independently?
  - Medical social work
    - Placement/Behavioral modification
    - Counseling, emotional support through alternate living arrangements or additional support at home
- On initial assessment each discipline has to make contact with physician or designee to discuss plan of care (fax or phone)

Home Health/Physician Partnership

- **COMMUNICATION**
  - Communicate the goal of the referral?
    - What is physicians goal? Any information physician would like us to evaluate and report?
    - Parameters for notification?
    - Provide accurate medication list
    - PRN meds with parameters are helpful
- HH Compare – National Quality Metrics
  - Quality items and Customer Service Scores

Home Health Benefits Video

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THANK YOU!

- Questions???