Right Care, Right Time, Right Place

The Relationship Between ALF, Home Health and Hospice

Why will collaboration become more important?

Collaboration will become more important as Healthcare Systems switch to Value Based Care.

We will have an increased need to improve and understand the importance relationship of AL state rules and Home Health/Hospice Regulations and CoPs.
Dummies Guide
Shift From Fee for Service to Value Based Care

I’m Not an Expert….
But Trying To Be

No Longer Fee For Service

• Value-based healthcare is a healthcare delivery model in which providers, including hospitals and physicians, are paid based on patient health outcomes.

... Value-based care differs from a fee-for-service or capitated approach, in which providers are paid based on the amount of healthcare services they deliver.
The Road to Value Based Care

Our Mileage May Vary – But The Journey is Unavoidable

The Shift By US Health Care Organizations Toward VBC is a lot like taking a road trip to never before visited destination via never before traveled roads.

The Journey From FFS is Unavoidable

Pressure to Reduce Cost & Improve Quality

- When the market shifts further toward Value, those not ready may be left behind, while those on their road trip may be well positioned.
- Some markets in the US health care have already adopted value based models.
- Some are still test driving
- Some have not started the road trip.
Healthcare’s New Mantra

The Right Care, in the Right Place, At the Right Time

Where does ALF fit into all of this?

Healthcare systems need post acute providers more now than ever. What do Healthcare systems understand that post-acute providers need to understand?
Hospital Systems - 30 Day Mortality Rates

- Readmission and death rates are measured within 30 days, because readmissions and deaths after a longer time period may have less to do with the care received in the hospital and more to do with other complicating illnesses, patients' own behavior, or care provided to patients after hospital discharge.
As the population ages, the ratio of older adults to working-age adults, also known as the old-age dependency ratio, is projected to rise.

Today, there are 6 working age adults for every retirement-age person.

By 2020, there will be about three-and-a-half working-age adults for every retirement-age person.

By 2060, that ratio will fall to just two-and-a-half working-age adults for every retirement-age person.

United States is Just Beginning to See Baby Boomers Reach Old Age
Demographics Also Predict Greater Need for Facilities Care Due to Lack of At-Home Caregivers

Figure HH-4. Growth in living alone


Note: This figure uses a person weight to describe characteristics of people living in households. As a result, estimates of the number of households do not match estimates of housing units from the Housing Vacancy Survey (HVS). The HVS is weighted to housing units, rather than the population, in order to more accurately estimate the number of occupied and vacant housing units.

<table>
<thead>
<tr>
<th>Location</th>
<th>Daily Move ins</th>
<th>Annual Move ins</th>
</tr>
</thead>
<tbody>
<tr>
<td>Boise</td>
<td>18</td>
<td>6570</td>
</tr>
<tr>
<td>Meridian</td>
<td>11</td>
<td>4015</td>
</tr>
<tr>
<td>Nampa/Caldwell</td>
<td>7</td>
<td>2673</td>
</tr>
<tr>
<td>Total</td>
<td>36</td>
<td>13,258</td>
</tr>
</tbody>
</table>

- Does anyone still live in Portland, Seattle or California?
What Is An ACO?

- An accountable care organization is a healthcare organization that ties payments to quality metrics and the cost of care. ACOs in the United States are formed from a group of coordinated health-care practitioners.

- Both formal and unformal ACOs are being formed.

- You will see more partnerships even amongst post acute providers

Top Management Focus Areas for ACOs

<table>
<thead>
<tr>
<th>Objective</th>
<th>Percent of ACOs with Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevent hospital readmissions</td>
<td>58%</td>
</tr>
<tr>
<td>Manage chronic conditions</td>
<td>56%</td>
</tr>
<tr>
<td>Prevent ED visit and inpatient admissions</td>
<td>54%</td>
</tr>
<tr>
<td>Integrate post-acute care</td>
<td>35%</td>
</tr>
<tr>
<td>Integrate mental health care</td>
<td>18%</td>
</tr>
<tr>
<td>Improve end-of-life care assessment</td>
<td>16%</td>
</tr>
<tr>
<td>Improve pharmacy or medication adherence</td>
<td>14%</td>
</tr>
<tr>
<td>Improve patient engagement</td>
<td>12%</td>
</tr>
<tr>
<td>Provide palliative care</td>
<td>11%</td>
</tr>
<tr>
<td>Avoid overuse of specialty care/redundant imaging &amp; diagnostics</td>
<td>10%</td>
</tr>
</tbody>
</table>

Soon there will be an exit sign on hospitals.

Hospitals will be for the sickest of the sick.
Shouldn't The Continuum of Care Model Change?
Why Is This Exciting Times for Post Acute Providers?

Modern Hospice Company are increasing in intensity of care for their patients

- Hospice is a Medical Model!
Continuous Care Definition

Nursing care may be covered on a continuous basis for as much as 24 hours a day during periods of crisis as necessary to maintain the patient at home.

A period of crisis is a period in which patient requires continuous care to achieve palliation or management of acute medical symptoms. Think of continuous care as being the same as inpatient hospital criteria, except the goal is to prevent hospital admission.

A minimum of 8 hours of care by the hospice team will occur in the home. Need not be continuous SW and Chaplain time not counted. Update plan of care accordingly.

Order: Admit to hospice with Continuous Care due to _____, as evidenced by _______________. Not required but recommended by NHPCO.

Recent Admission

• Patient arrives in the ED with family. Family is overwhelmed in the home, patient is dehydrated due to uncontrollable vomiting. Family wants patient admitted. ED Physician is considering writing an order to admit to hospital due to uncontrollable vomiting.
  • Instead: Physician calls Treasure Valley Hospice. On call RN arrives in ED, explains to patient/family the support system and acute symptom control that can be provided in the home.
    • Patient goes home with continuous care hospice and avoids the hospitalization. Hospice team works with patient/family over the course of the next several days with NG tube, suction and anti-nausea medication for symptom control and develops a plan for when patient is stabilized. Patient converts to routine hospice care two days later. (A two-day hospitalization was avoided).
## Pepper Report – Q4 FY 17: No GIP or Continuous Home Care

### The National Trend vs. The Treasure Valley

<table>
<thead>
<tr>
<th>The National Trend</th>
<th>The Treasure Valley</th>
</tr>
</thead>
<tbody>
<tr>
<td>44%</td>
<td>98.3% of patients received no GIP or Continuous Home Care</td>
</tr>
</tbody>
</table>

### Measures Under Development Or Consideration For Hospice

- Access to levels of hospice care
- Claims-based Transitions from Hospice Care, Followed by Death or Acute Care
Live Discharges

- MedPAC suggests that although some level of live discharges from hospice may be appropriate, providers with substantially higher rates of live discharge than their peers may have potential quality issues, such as inability to meet patient and caregiver needs.

So, if there is going to be an increase in ALF admissions with Hospice...

What do we all need to know....
Importance of Understanding Regulations and CoPs

Partnerships are important to provide quality of care at end of life.

We only die once – we get one chance to do it right.
Contracts with Home Health or Hospice

Must have a contract in place

- Any rules that apply to an agency providing services in the building
- Describes coordination of care with the AL Staff
  - Provide copies of care plan and updates
  - Provide copies of notes
  - Delineation of Responsibilities

Contracts Should Include

- Professional liability insurance
- Helps to assure only Qualified Staff are being used (Licensed, passed background check, trained in infection control and abuse reporting)
- Establish criteria for when resident is no longer appropriate for Facility and each entity’s role in ensuring a smooth transition
Coordination of Care

<table>
<thead>
<tr>
<th>Nursing Task</th>
<th>Facility Nurse</th>
<th>HH Nurse</th>
<th>Both</th>
</tr>
</thead>
<tbody>
<tr>
<td>90 day assessments</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Available to staff by telephone</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Changes of condition</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Resident and facility staff Education</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Recommendations</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Follow-up on recommendations</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Delegation meds, cares</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Medication Orders</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Self Administration Assessments</td>
<td></td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

Medications

- Delivery
- Education
- Monitoring
- Delegation

Cares-No bathing by home health aide

Supplies/Equipment

Staffing

Scheduling of appointments, labs, testing and other follow up

Ensuring visit notes and referrals are returned to facility in a timely manner

Be Clear on Who is Doing What
Hospice or HH Residents may require increased needs as their health conditions progress –

Are you prepared to deal with these issues according to the Rules?

Are you prepared to increase your staffing to care for these needs regardless of financial implications?

Are you aware of what the outside agency can provide you and what they are suppose to provide you?

Are you willing to accept the responsibilities for those needs?

And More To Think About

- Admission Agreement – refer to IDAPA 16.03.22.220.01-09
- Services Provided (…coordination of outside services)
- Include acceptable admission information
- Include information about admission, discharge and transfers
- Include information about how emergencies will be handled
- Include staffing patterns and qualifications of staff on duty
- Admissions and care congruent with 16.03.22.152.05 a-h
When Limiting the Number of Providers

Must be in the ALF’s admission agreement

- These are our contracted providers
- ALF can’t make changes in the middle of care.
  - Example, if you are not happy with the care you cannot say “we do not allow this company in our facility until the care has been discharged.”
- You must provide a 30 day notice to all patients in your facility if you are taking agencies off of your list of contracted providers.
- There is a contract example on the Licensing and Certification website.
- Avoiding Fraud and Abuse situations “Kickbacks” and “Anti Trust Laws.”
  - If there is suspicion a call will be made to the OIG

Should include:

Fraud and Abuse Guidance

1.) Home Health Agencies cannot pay for referrals

2.) Cannot offer (furnish) or receive free services to/from referral sources.

- Free services = paying for referral
- Free/discounted clinical staff
- Paying ALF to rent unnecessary space
  - Must be charged at market value for services and paid accordingly
Coordination of Services/Care is Common Theme

Both entities are being cited.

Document, document, document .... Conversations, etc.

Federal Regulations and State IDAPA rules require the coordination of services provided by the FACILITY and the Outside Agency –

- Failure to Coordinate these services could result in Core deficiencies for the FACILITY and
- Possible Condition level citations for the Agency.

Best Practices

Outside agency verbally checks in and checks out with Nurse.

Facility Nurse should be reading notes and not just filing notes. Must have the outside agencies notes and POC.

Comfort kits should not be ordered until needed.

Facility staff can destroy medications. Outside agency can witness.

Outside agency can delegate to facility

- Document and sign off on training
- Facility cannot train each other following that training.
Before Sending a Patient to the Hospital

- Not necessary to “automatically” send patient to the ER.
- Contact outside agencies for an assessment
- Okay to use Bed-Side X-Ray if Appropriate
- Obtain documentation from Outside Agency (Medical Director, PA or NP)
  - We have consulted with agency staff and reviewed tests/results and have determined that the patient’s care can be managed in their current setting.

Everyone’s Goal Is To Keep Resident at Home

- Hospice may need to “treat” more than they would in a home in the community.
- Best Practice: Outside agencies would utilize a wound nurse and not just “any RN.”
- Care Conferences Goal:
  - What do we need and how do we get it?