Working with Physicians of Home Care Clients: Strategies to Prevent Unnecessary or Avoidable Hospitalizations

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Learning Objectives

Participants will be able to:

• Identify common medically related causes of unscheduled hospitalizations

• Describe processes and incentives that exist in medical offices and after hours on-call systems that promote hospitalizations

• Overcome barriers to communication between doctors and home health agencies
Learning Objectives (cont)

• Increase use of home care referrals as a substitute for hospital admission from emergency departments
• Improve hospital discharge documentation sent to home health agencies to reduce re-hospitalizations
• Implement processes to have at home care client homes physician orders for paramedics to “DO NOT HOSPITALIZE”
<table>
<thead>
<tr>
<th></th>
<th>Hospitalized</th>
<th>Urgent (ER)</th>
</tr>
</thead>
<tbody>
<tr>
<td>US</td>
<td>28</td>
<td>21</td>
</tr>
<tr>
<td>MN</td>
<td>28</td>
<td>24</td>
</tr>
</tbody>
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From: [www.medicare.gov/hccompare](http://www.medicare.gov/hccompare), 3/22/07 update


This data is from the most recent Home Care Compare reports. Clients covered by the Medicare home care benefit excluding those enrolled in Medicare Advantage or Special Needs Programs. In other words, clients covered by Medicare PPS. Agencies receive roughly $2,000 - $3,000 per 60 days, primarily to help clients stay out of the hospital, but fail 28% of time. Rate is not even per 60 days, as only hospitalization prior to discharge (average length of stay about 30-45 days) are counted. Urgent medical care rates represent primarily ER visits.
### Rates of Hospitalization – Large HHAs

<table>
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<tr>
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<tr>
<td>HealthEast</td>
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<td>North Mem</td>
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<td>Integrated</td>
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<tr>
<td>Allina</td>
<td>28</td>
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<td>MN</td>
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These are the largest HHA agencies in MN, based upon # of Medicare clients discharged. Note that the hospitalization rates vary modestly and are at or below the state rate. Thus the rates at smaller agencies must be relatively higher, unless risk adjustments (differences in client populations) offset unadjusted rates.
Rates of Hospitalization – Last 6

<table>
<thead>
<tr>
<th></th>
<th>Hospitalized*</th>
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<tbody>
<tr>
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<td>65%</td>
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<tr>
<td>Wilder</td>
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<tr>
<td>MN</td>
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</tbody>
</table>

* Risk adjusted

This list is the last 6 agencies alphabetically (quasi-random sample). Except for Wilder, all are outside Twin Cities area and all are relatively small compared to the prior list. Hospitalization rates vary more widely, even after risk adjustment. White Earth data represents a somewhat different model for home care, that is more long-term than most post-acute care based agencies.
A graphical representation of the data from 6 randomly selected agencies. Note the lack of pattern of hospital vs. urgent care. Sometimes both relatively high or low. One or the other might be higher.
Why Is This Important?

“Some inpatient hospital care may be avoided if the home health staff is doing a good job at checking your health condition at each visit to detect problems early. They also need to check how well you are eating, drinking, and taking your medicines, and how safe your home is. Home health staff must coordinate your care. This involves communicating regularly with you, your informal caregivers, your doctor, and anyone else who provides care for you.”

~http://www.medicare.gov/HHCompare/  

From CMS Web page seen when comparing HHA’s outcomes graphically. This describes CMS viewpoint on what HHAs are or should be doing to prevent hospitalizations.
Basic skilled home care plans help patients recover from acute illness. Attention is primarily focused on previously identified illnesses, prescribed medications, and standard rehabilitation of weak or painful muscles and joints.

More advanced home care plans will identify external factors, rarely recognized by MD, that influence success at home, including physical environment and caregiving.

The most challenging activity in home health is recommending and implementing enhancements to pre-determined care plan that led to the home care referral. This includes changing medications from what has been prescribed, adding types of services provided by skilled HHA or other organizations, and even working to move patient to higher level of care.
The intrinsic, biological issues are a common cause of hospitalization for chronic diseases such as CHF and COPD and multi-factorial conditions such as unsteadiness of gait. Often this is not the primary diagnosis for which the patient was admitted, so the first task may be recognition of the risk of hospitalization from such problems. Preventing hospitalizations for primarily biological causes typically focuses on early recognition of loss of homeostasis, the maintenance of physiological and psychological stability. Often adjustments in medication doses can return the patient to baseline.
Causes of Avoidable Hospitalization: Biology and Environment:

Problem: Accident with injury

Need: Anticipate Accidents
    Accident Prevention
    Injury Prevention
    Home Management of Injury

HHA Response:
    Improve client ability to avoid accidents
    Improve environment to reduce injury
    Communicate with MD
    Manage injuries at home

Biology and environment interact to cause accidents, only some of which cause injury. In home care, one of the most common reasons for hospitalization is injury sustained from falls. HHAs can likely reduce this by considering fall risk and including fall risk reduction plans routinely. Improvement in home safety can both reduce accidents and/or reduce injuries. Some injuries will not be preventable. Intensive home evaluation and management after injury can prevent hospitalization. For example, a patient who does not have a fracture (or with a non-surgical fracture such as pelvic or spinal compression) may be able to avoid ER evaluation – a home X-ray (available easily in the TC) and increased post-fall visits may allow a client to recover at home from even a temporarily immobilizing injury. A key aspect of injury prevention and post-injury management is liberal use of rehab, even when no ortho or neuro dx is present on admission.
The problems with medications and iatrogenic injuries in hospitals is a national cause. Possibly the most common cause of hospitalization in home care clients is related to adverse responses to the medical care prescribed. The programs to reduce unnecessary medication in nursing homes, due to regulations, are equally applicable in home care. Excellent resources regarding particularly unsafe medications and common side effects of most classes of medication can be found on the MDH Web site. Best way to find such resources is to search the site for “F329”. I believe that there is value in having a medical director or pharmacist review at least high risk medication profiles (e.g. more than 12 drugs or for clients with repeated hospitalizations), as is done for all nursing home residents.
Causes of Avoidable Hospitalizations: Incomplete / Inadequate Care Plan

Problem: Predictable or observable problems not addressed thoroughly
Need: Recognize all problems/issues
   Anticipate likely future problems
   Home management or NH placement
HHA Response:
   Comprehensive, multi-disciplinary assessments
   Communicate with MD
   Implement new care plan

In my experience, HHA miss significant opportunities to reduce hospitalizations by failing to recognize or advocate for useful additions or corrections to medical care plans. This is especially true for clients who are receiving minimal or no outpatient medical care – who are using ERs and hospitalization more often the primary care visits. Guideline supported medications may be under-utilized, such as aspirin and ace-inhibitors for DM, ace inhibitors and beta blockers for CHF, inhalers for COPD. Lab monitoring of side effects of medications may be missed. In many cases, the home care plan prescribed on admission fails to consider the other home and community-based services that may be needed to keep someone at home. In some cases, aggressive advocacy to move a client to a more supported living environment or to get significant hours of extended care is an important tool to avoid hospitalization. More the most high risk patients, easily recognized by the frequency of prior hospitalization, all HHA disciplines, including SW and dietician should have an opportunity to evaluate the client. Some sort of team collaboration, ideally with an interdisciplinary team meeting, should be available to sort out recommendations.
Communicating with Physicians

Almost always a challenge!

1. Identify the physician in charge of home care plan oversight
2. Learn best means and times to communicate for routine info
3. Establish process for urgent communication
4. Plan each communication – using standard format

Although there is a way for physicians to be reimbursed for time communicating with home care staff, through Care Plan Oversight, the billing is cumbersome and very rarely used. Thus, physicians consider such communication as a free service they provide, which has lower priority than reimbursed care.

Often, when patients leave the hospital or NH for home care, they change physicians. The referring MD may not be the one following the patient. HHA should clarify who is responsible for ongoing communication at the time of admission and get that right on the 485.

Some doctors prefer phone mail, some fax, some direct calls, and many “please don’t bother me” unless critical. HHA should maintain communication protocols for referring physicians, so each case manager doesn’t have to figure it out for each case. A different protocol is typically needed for urgent issues, such as with a client with a significant change in condition or a panic lab value.

Written or verbal communication should be formatted for ease of use by the physician.
How to Organize Communication with Physicians

1. State problem
2. Provide background Info
3. Summarize assessment
4. Make recommendation

This type of format organizes the information to transmit and simplifies the physician’s ability to accept or modify recommendation. This process requires preparation prior to calling a physician, but it may take less time than back and forth messaging to clarify or provide more information. Remember, the physician is often uncertain what to do for a patient that hasn’t been seen recently; the home care staff recommendation, if clearly made, will almost always be accepted. If the home care staff person doesn’t know what to do, a discussion with a colleague, supervisor or medical director may be appropriate before communicating to the physician.
Simple Communication Example

• Problem: Anticoagulation, INR now 3.5
• Background: 72 y.o. with a-fib. On 5 mg. Coumadin. Last INR 3.1 one week ago (on same dose). No bleeding symptoms.
• Assessment: Over-anticoagulated
• Recommend: Reduction to 4 mg. Recheck in one week

A simple example. Remember, the physician shouldn't need to pull medical records to figure out what the patient’s diagnosis is, what prior treatment or labs and needs to know if the client is symptomatic. A recommendation is important, as the HHA staff person has knowledge of the patient’s ability to manage the intervention (e.g. med change). Think about when follow-up should occur regarding this problem or need for changes in frequency of visits.

The AAHCP has a booklet with communication templates to enhance disease specific discussions between home care staff and physicians. See resources at end of presentation.
Preventing Hospitalization from ER

- Know when your clients go to ER
  - Teach clients to call HHA before or after 911
  - Identify HHA within hospital medical record
  - Provide client with way to inform ER that they are your client
- Define who should communicate with ER (7 X 24 X 365) when client is there
- Promote “observation” rather than admission
- Be able to do urgent, post-ER visits (same day)

Sometimes urgent MD evaluation is needed, but hospitalization is usually only a better alternative than return home if surgery, multiple hospital-based tests, or ICU care are needed. Once client goes to ER, preventing hospital admit requires knowing the client is there and having someone from HHA (24 hours a day) who can communicate with ER staff. Very often evaluations can be completed in less than 24 hours and client can go home if immediate nursing/therapy follow-up can assure implementation of new care plan that results from ER visit.
Improving Communication From Hospitals

Better knowledge allows better care plans

• Liaison visit in hospital pre-discharge
• Request discharge summary
  – To be sent home with patient
  – To be sent to HHA
• Medication reconciliation
• Direct access to hospital EMR?

Too often HHA work in information vacuums, with little knowledge of pre-admission hospital care. Although expensive to organize pre-admission liaison visits, they are likely to reduce the number of home visits/episode to offset such a cost in Medicare PPS. Ideally, such pre-admission visits would be covered by private insurers. With or without such visits, it is critical to get discharge summaries. Medication lists should from hospital records and home review should be reconciled. It should be increasingly possible for HHA to have access to hospital EMRs, even if outside the same health care organization – but advocacy for such arrangements may be needed at state level. There is little justification for hospital based agencies to have exclusive access from a technical or security standpoint. If HHA medical directors are on staff of referring hospitals, that may be a method to gain such access.
Honoring Client Preference for “Do Not Hospitalize”

- Empower clients to use EMS without transport
- EMS system needs MD order to avoid hospitalization for patient unable to communicate
- Standard forms – put in admit packets
- Post on refrigerator

No one who has a pre-defined desire to stay at home, even if it means life-prolonging therapy is forgone, should have to go to the hospital when EMS is called. Clients who can speak can take advantage of EMS benefits (e.g. evaluation and help getting into bed or relieving pain) without transport. Clients who are too ill to speak when EMS is called must have such a preference documented and signed by MD. Such forms should be filled out on every client and posted prominently in the home. The standard forms used by each county’s EMS system have options from all care to comfort care only.
Resources

• HH QIO ACH Project:
  – http://www.hhqualitycampaign.org/e-bulletin/index.htm

• AAHCP print resources:
    – Booklets for physicians
    – Communication templates for HHA staff
Summary

• Hospitalization among home care clients is too common
• Variety of causes and HHA strategies can reduce rates
• Communication with MD is common to all strategies
• Work with ERs, hospitals, and EMS systems (with MD involvement) to prevent hospitalization
Thanks to Stratis Health for this opportunity to present on the important topic of working with physicians to reduce unnecessary and avoidable hospitalizations.

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