



SPARTANBURG REGIONAL HOME HEALTH

OPICP CONFERENCE

ORGANIZATION OVERVIEW

- Hospital-based, Medicare-certified Home Health Agency
- Serving Spartanburg County for 30 years – population 293,542 (2014 U.S. Census Bureau)
- Services: Nursing, PT, OT, ST, MSW, aides, infusion therapy, telehealth, certified wound nurse, behavioral health nursing, chronic disease management
- Other programs: ImPACT, partnerships with 12 Assisted Living Facilities and 4 Independent Living Facilities
- 2014 Stats:
 - Total annual visits (all disciplines) - 58,352
 - Total annual admissions - 2828
 - Average daily census - 487
 - FTE's - 91

CHALLENGES

- Identifying a standard process
 - Understanding the “why” behind the rework
- Attending and listening to referring physician feedback
- Embracing the barriers

OPICP TEAM MEMBERS

- Anita Butler- VP Post-Acute Services
- Dr. Garrett Snipes- Home Health Medical Director
- Phyllis Osborne- Home Health Director
- Linda Edmond- Population Health Program Manager
- Jill Greene- Post-Acute Chief Nursing Officer
- Patricia Stimac- Post-Acute Director of Quality
- Karla Lamb- Director of Post-Acute Referral Center and Case Management
- Sherry Eison- Post-Acute Director of Education
- Leslie Wolfe- Home Health Nursing Manager
- Odette Ray- Home Health Rehab Director
- Vickie State- Home Health Compliance Officer
- Melissa Weaver- Home Health Assisted Living Program Manager
- Julie Owens- Home Health Intake Nurse
- Lindley Ewing- Home Health Insurance Case Manager
- Gracie Williams- Health Informatics Manager
- Tara Johnson- Health Informatics Home Health Specialist
- Teresa Dawkins- Health Informatics QA Technician Supervisor
- Beth McKelvey- Processor Insurance Claims
- Lynn Henderson- Corporate Director of Health Informatics
- Susan Bullman- Systems Analyst Information Services



OPICP TEAM MEMBERS



BASELINE MAP

BARRIERS

- Physician knowledge of face-to-face requirements
 - Physician goal/regulatory alignment
- Contact lead for physician practices and hospitals
- Intake process
- Extensive process change
- Time allotment to role change
- Dedicated SOC review
- Fax line
- EPIC conversion
 - Cost



FUTURE STATE MAP

INITIATIVES LIST

- Develop and implement physician education- CME offering
- Redesign and standardize intake process
- Develop and implement start of care and weekly case review
- Develop physician practice lead
- Develop cross functional team to “own” face-to-face and plan of care certification
- Ensure uniform computer access for all staff

THE REFERRING PHYSICIAN EDUCATIONAL INITIATIVE

TAKING THE MESSAGE TO DOCS

FIRST STEP: “LISTENING TOUR”

- Key practices, physician leadership of hospitalist group and primary care groups
- Lessons learned:
 - Educational barriers related to:
 - home health eligibility
 - role/importance of home healthcare
 - referral patterns for home health agencies
 - home health certification requirements

THE INITIATIVE

- Physician education in their work setting
 - CME credit
- Components of the presentation designed to address learning opportunities:
 - Home health in a changing healthcare system
 - Home health eligibility
 - Home health certification basics
 - Referral development

PHYSICIAN EDUCATION



Regional Home Health:

Your new "best friend" in the management of complex patients?

HOME HEALTH IN A CHANGING HEALTHCARE SYSTEM

- Goal: Educate physicians in changing healthcare environment- projecting into the future
 - Changes in payment methodology -Move from volume-based to value-based care
 - Medicare Spending per Beneficiary (MSPB)
 - Cost analysis of post-acute discharge setting
 - Highlighting cost and care management benefit of home healthcare

HOME HEALTH IN A CHANGING HEALTHCARE SYSTEM

- Discharge patterns to post-acute settings
 - home health agencies are key to controlling cost and managing outcomes
- Social determinants of care
 - home health agency flexibility for addressing the holistic patient
- High-risk patient management in risk bearing healthcare systems
- Seven Essentials of Engaged Intervention to achieve the Triple Aim (Better Care, Healthy People, Healthy Community)

HOME HEALTH ELIGIBILITY

- Goal: Educate the physician of home health eligibility criteria
 - Homebound status
 - Under the care of a physician
 - Skilled need
 - Face-to-face encounter requirements

HOME HEALTH CERTIFICATION BASICS

- Goal: Educate the physician regarding home health certification requirements
 - Development of pocket card

HOME HEALTH CERTIFICATION BASICS



***4-Question model for successfully certifying Home Health services through documentation:**

Plan: Home Health Evaluation

1. What is the skilled need?

Example: Skilled Nurse for teaching, monitoring heart failure, telemonitoring of weight, etc., PT for energy conservation and reconditioning

2. What is the structural impairment?

Example: Heart failure with recent decompensation

3. What is the functional impairment?

Example: Dyspnea with exertion and cognitive deficits due to delirium

4. What is the activity limitation?

Example: Restricted mobility, supervision in ADLs

Physicians can bill for the time spent in certifying patients for Home Health — Codes: G0180 AND G0179. See CR 9119 for details.

*Dr. Harry Feliciano, "Efficiently and Effectively Communicating Information to Satisfy the Home Health Face-to-Face Requirement," May 30, 2013, <http://palmgba.com/gbd/2013/05/efficiently-and-effectively-communicating-information-to-satisfy-the-home-health-face-to-face-requirement/>.

HOME HEALTH CERTIFICATION BASICS



Home Health Care

**Providing Excellence
in Health**

For referrals please call 864-560-CARE.

REFERRAL DEVELOPMENT

- Goal: Maintaining the pulse of the agency:
 - Ongoing relationship development
 - Regular scheduled education offerings to physician practice (CME)
 - Population health management
 - Physician practice liaison
 - Post-acute navigator

WHAT DO WE HOPE TO ACHIEVE

- Increased engagement of physicians through education
 - Home health in a changing healthcare system
 - Home health eligibility
 - Home health certification basics
 - Referral development
 - *Happy physicians*
- “Clean” , efficient intake process

CONTROL PLAN - METRICS

- Percent of clean referrals on admission
- Percent of clean claims accepted on initial submission
- Percent of billing error edits due to face to face needs

LESSONS LEARNED PROCESS BENEFITS

- Physicians do not understand:
 - Role of home health
 - Home health eligibility
 - Home health certification requirements
- Work and rework prevents valuable work
 - Streamline cross functional workflow

SUPPLY CHAIN MESSAGES

- Home health regulatory requirements are challenging and can be prohibitive to patient referrals
 - Face-to-face documentation
 - Plan of care certification
 - Physician orders

CONFERENCE AGENDA

TIME	DETAILS	SPEAKER
7:30 AM	Registration & Continental Breakfast	All
9:00 AM	Welcome	Joe Johnson Ed Sanchez
9:20 AM	OPICP Process	Kathy Merrill Annette Zwerner
9:40 AM	Carolina's Healthy@Home: Physician Practice Template Implementation	Kimber Walters Jennifer Piracci Lynne Bailey
10:10 AM	Break	All
10:30 AM	UFL Shands: Hospital Procedures & Measure Improving F2F Documentation	Chris Montrowl
11:00 AM	Encompass – Dallas: Improved MAC Relationship	Bud Langham
11:30 AM	Encompass – Tulsa: Measures installed to Improve Performance	Kelly Shearrer
12:00 PM	Spartanburg: Physician Education to Improve Documentation Integrity	Karla Lamb Dr. G. Snipes
12:30 PM	Break	All
12:45 PM	Lunch & Pilot Projects Exposition	All
2:30 PM	Results	Dr. Feliciano
2:50 PM	Best Practices/Lessons Learned/Needs Panel Discussion	Pilot Representatives
4:00 PM	Questions?	Dr. Feliciano
4:30 PM	Adjourn	Dr. Feliciano

