HEALTHPRO® HERITAGE

SELECTING A STRATEGIC HOME HEALTH PARTNER

Safe Transitions

Selecting a strategic Home Health Agency (HHA) is a critical component in providing improved care coordination, greater efficiency across all settings, achieving optimal patient outcomes, reducing hospitalizations, and lowering overall medical costs.

STEPS TO ENSURE YOU HAVE THE RIGHT PARTNER

1. Review the HHA quality measures on home care compare
    a. Compare those to state and national averages as well as other HHAs in the market
    b. Overall quality of patient care Star Rating and Quality Measure (QMs) ratings of 3.5 or greater
        i. How well does the HHA compare with the following QMs:
            1. Managing daily activities
            2. Managing pain and treating symptoms
            3. Treating wounds and preventing pressure
            4. Preventing harm
            5. Preventing unplanned discharges
        ii. Review patient survey results
        iii. These items should help you to narrow based on reported quality of services provided
2. Schedule a meeting with your potential HHA partner
    a. Prior to the meeting, have your HHA potential partner complete the **Application for Home Health Preferred Provider List** for your center
    b. Review the below listed best practices for a home health agency partnership to identify

BEST PRACTICES FOR A HOME HEALTH AGENCY PARTNERSHIP

1. HHA Nurse Liaison to be present on-site prior to discharge for a warm hand-off of the patient
2. Start of care within 24 hours of discharge (all services within 72 hours)
3. HHA providing regular updates after the transition has occurred on the patient's progress and barriers
    a. HHA to prepare scorecard on all SNF referred patients and progress
        i. Start Lag
        ii. Anticipated D/C date
        iii. Services provided and progress
        iv. 30 and 60 day readmissions
        v. LOS
4. Ensure care coordination items are completed
    a. Initial PCP visit is completed by day 7
    b. Medication reconciliation has occurred
    c. 6-7 days of week of coverage in the first week – on-site, telephonically or by Bluetooth monitoring system of vitals
    d. DME has been delivered, set up, and the patient/caregiver is educated on its use
    e. Community resources have been initiated and/or completed
    f. Any HH refusals who need therapy or nursing services to be reported
        i. Is the HHA willing to contract with the SNF or Outpatient therapists to provide continuity of care to ensure acceptance of services?
5. Readmission reduction protocols are in place
    a. Health literacy with teach back methods are carried over from acute and post-acute settings
    b. Medication management with rehab and nursing is continued
    c. PCP is notified of any slight changes in condition – using interact care paths
    d. Ensure communication plan from HHA to SNF partner if readmission to acute is likely

6. Communicate planned discharges from HH and next level of care planned, if applicable

If you are a senior living community or CCRC with Assisted and/or Independent Living:

7. HHA rep/liaison attends weekly caseload reviews for those on HH
8. Formal Quarterly review of the scorecard and partnership
    a. Review medicare.gov Five-Star Ratings prior to this meeting

If the HHA is hospital or health system owned or affiliated:

9. Have the same discussions and be a true partner – be candid