HOME NURSING AGENCY
Part of UPMC

Home Health

Improving Patient Outcomes & Reducing Readmissions

Benefits of Home Health Care

- Scientific evidence proves **people heal more quickly, are healthier, happier and live longer at home**.

- **Improves patient outcomes and reduces costly acute care re-admissions** by:
  - **Proactively addressing health or safety concerns** before they become a crisis.
  - **Improving compliance** with medication regimens and attendance at medical appointments.
  - **Reducing fall events** by providing assistance with mobility, incontinence, and exercise programs as well as ensuring ongoing home safety.
  - **Educating patients** to promote self-management of their conditions.

HNA Home Health

DISTINGUISHED

- **National Recognition as a Home Care Elite Top Agency for 11 consecutive years,** indicating we are a top 25% performer in the nation, which is especially impressive considering that we care for patients of all acuity levels.
- A 9.41/10 ranking that **referral sources would recommend us to their patients**.
- **99% of customers would recommend us** to others.
- **4 Star rating** by CMS.

Home Health Clinicians are a Valuable Resource

- The home health team serves as the "**eyes and ears**" of the physician while in the patient's home.

- **One-on-one time** presents the opportunity to provide in-depth health coaching to improve patient compliance and promote self-management.

- The **multidisciplinary approach** helps patients get the right care, at the right place, at the right time – every time.

By combining expert clinicians, innovative systems, access to our continuum of care, and a commitment to exceptional service, we are able to consistently deliver top quality care in the home.

A Multidisciplinary Approach to Meet Patient's Unique Needs

- **Registered nurses** provide highly skilled care, proactively address health or safety concerns before they result in an unnecessary hospitalization, educate patients to enable self-management of their health, and serve as the "eyes and ears" of the physician in the home.

- **Physical therapists** provide advanced rehabilitative therapy in the home in order to improve and restore a patient's mobility, independence, and safety.

- **Occupational therapists** focus on ensuring the patient can independently perform activities of daily living, such as eating, dressing, and bathing, through energy conservation and use of adaptive equipment in order to remain safely at home.

- **Speech therapists** work with individuals who need speech, language, communication, and swallowing training after a stroke, surgery, or other condition.

- **Home health aides** help with personal care and activities of daily living when skilled services are also provided.

- **Specialty services** are also provided by advanced-practice nurses, wound-ostomy specialists, social workers, nutritionists, and psych nurses.

Specialty Programs

- Orthopedic
- Balance & Fall Prevention
- Cardiopulmonary
  - Congestive Heart Failure (**CHF**)
  - Chronic Obstructive Pulmonary Disease (**COPD**)
  - Myocardial Infarction (**MI**),
  - Hypertension and other vascular diseases
- Diabetes
- Infusion/IV
- Wound

Our programs utilize a multidisciplinary approach, best practice protocols, and proprietary disease management guides to help educate patients, promote self-management of their conditions, and optimize clinical outcomes.

Partnering with Hospitals and Skilled Nursing Facilities

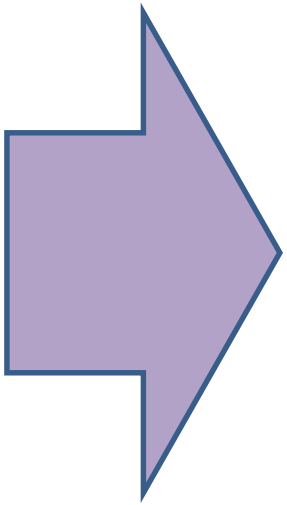
- **Care Transitions** best practices are implement AFTER the home health referral and can be initiated prior to discharge.
  - Goals are to help patients understand their plan of care and transition to home safely after facility discharge.

- The **ED U-Turn** is a collaborative health care program with hospital emergency departments to provide reliable follow-up care in the patient's home within 24 hours of discharge from the ED.
  - Goals are to decrease the number of patients admitted to the hospital under observation status and decrease return ED visits for chronic conditions.

Hospitals and skilled nursing facilities can reduce their risk of readmissions and avoid payment penalties by simply referring home health services.

Home Health Referral Indicators

- ❑ Frequent or recent hospitalizations
- ❑ Difficulty with walking, balance, transfers
- ❑ Recent fall
- ❑ Difficulty performing self-care activities
- ❑ New medications or adjustments
- ❑ Wound or skin breakdown
- ❑ UTI (new or recurrent infections)
- ❑ Cardiopulmonary concerns: shortness of breath, coughing, swelling, abnormal blood pressure
- ❑ Unusual bleeding or bruising
- ❑ Change in mental status (depression, anxiety, behavioral changes)
- ❑ Post-operative care (joint replacements, cardiothoracic surgery)
- ❑ Patient is 65+ and has **targeted diagnosis of**:
  - ❑ Congestive Heart Failure (**CHF**)
  - ❑ Chronic Obstructive Pulmonary Disease (**COPD**)
  - ❑ Myocardial Infarction (**MI**)
  - ❑ Pneumonia



Home Health Referral

Early identification is critical to prevent avoidable readmissions

Timely Response to Urgent Patient Needs

Patient Calls
With a Concern….

Customer Contact Center
Triage and Referral Nurse

Nursing Visit

Nursing staff are on-call 24/7 to respond to urgent needs

Clinical Eligibility

We have compiled a **Home Health Clinical Eligibility Quick Reference Guide** to help you determine whether your patients may be eligible to benefit from home health services:

- **"Homebound" Status Requirements**
  - Does the patient require the use of an assistive device, assistance from another person, or require special transportation?
  - If the patient leaves the home, does it take considerable and taxing effort?
  - Are absences from the home infrequent and of short duration?

- **Orders and Face to Face Encounter Requirements**
  - Does the patient's diagnosis require skilled medical care?
  - Is the need for home health clinically appropriate?

Documentation requirements and specific patient examples are included in the quick reference guide.

Physician Billing for Care Plan Oversight

We have compiled a **Care Plan Oversight Quick Reference Guide** to help you understand how you can be reimbursed for overseeing plans of care for Medicare patients:

- Care Plan Oversight: G0181
- Initial Certification: G0180
- Recertification: G0179

Not billing for care plan oversight will result in uncaptured revenue for the work you are already doing

Our Referral Process is Streamlined

- Contact our Customer Contact Center or your local representative and we'll handle the rest.

- Our multidisciplinary team evaluates the needs of the patient and develops a plan of care that will produce optimal outcomes.

For More Information or to Make a Referral

Information:

hna-businessdevelopment@upmc.edu

www.homenursingagency.com

Referrals:

Customer Contact Center: 1-800-445-6262

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