Care Transitions: Provider Communication

Expanded Home Health Value-Based Purchasing (HHVBP) Model

March 2023

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Featured Speaker

Lori Marmon, PT, MBA, COS-C

HHVBP Model TA Team

OASIS Answers, Inc

Objectives

- ✓ Define **care transitions**
- ✓ Examine **provider communication strategies with the potential to enhance** care transitions: SBAR & Interdisciplinary Team

Communication, and teamwork, in particular, are pillars of patient safety culture.

Agency for Healthcare Research and Quality. (2021). *Approach to Improving Patient Safety – Communication.* https://psnet.ahrq.gov/perspective/approach-improving-patient-safety-communication.

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What does “care transitions” mean?

Definitions

The movement of a patient from one health care provider or setting to another.

CMS, https://innovation.cms.gov/innovation-models/cctp

A set of actions to ensure coordination and continuity, including:

- Well-trained clinicians with information about patient's goals, preferences, & health status
- Education of patient and family
- Coordination among health professionals

The National Transitions of Care Coalition, www.ntocc.org

Goals of Effective Care Transitions

- ✓ Improve patient experience
- ✓ Mitigate risk of adverse events, potentially preventing
  - Falls
  - Pressure ulcers
  - Medication errors
  - Emergency room use
  - Hospitalization
- ✓ Reduce costs
- ✓ Improve performance on quality measures

Agency for Healthcare Research and Quality. (2018). *Transitions of Care.* https://www.ahrq.gov/research/findings/nhqrdr/chartbooks/carecoordination/measure1.html

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How might care transitions affect expanded HHVBP Model measures?

Risks During Care Transitions

- Increased risk for adverse events
- Interruptions to continuity of care
- Potential delay in delivery of information held in medical records
- Increased risk of hospital admissions or emergency department use
- Practical concerns such as misplacement of such individualized patient supports as hearing aids, glasses, teeth and walking aids – all of which play a large role in promoting a person's independence and participation in their own care
- Less patient engagement and satisfaction in their health care

Victoria Department of Health. (2022). *Minimising the risks of transitions.* https://www.health.vic.gov.au/patient-care/minimising-the-risks-of-transitions

Relevance to the Expanded HHVBP Model Measures

Safe and Effective Care Transitions
• Improve patient experience
• Improve patient outcomes
• Decrease risk of adverse events
• Increase cost savings

OASIS-based measures

Claims-based measures

HHCAHPS Survey-based measures

How might home health agencies support care transitions?

Applicable Measures in the Expanded HHVBP Model

Category	Count	Quality Measure
OASIS-based	5	Improvement in Dyspnea
		Discharged to Community
		Improvement in Management of Oral Medications
		Total Normalized Composite Change in Self-Care
		Total Normalized Composite Change in Mobility
Claims-based	2	Acute Care Hospitalization During the First 60 Days of Home Health Use
		Emergency Department Use without Hospitalization During the First 60 Days of Home Health
HHCAHPS Survey-based	5	Care of Patients/Professional Care
		Communication
		Specific Care Issues/Team Discussion
		Overall Rating
		Willingness to Recommend

What provider communication strategies might improve patient care transitions?

Critical Elements of Communication

- Structured and well organized
- Consistent and commonly understood
- Brief and focused
- Clear and concise
- Timely

Agency for Healthcare Research and Quality. (2021). *Approach to Improving Patient Safety – Communication.* https://psnet.ahrq.gov/perspective/approach-improving-patient-safety-communication

SBAR Communication Strategy

Situation	• Primary issue
Background	• Concise summary of information related to the situation
Assessment	• Clinician assessment/analysis of the patient
Recommendation	• Opportunity to ask questions or make recommendations

SBAR Can Potentially…

- Enhance efficient communication
- Promote effective collaboration
- Improve patient outcomes
- Increase patient satisfaction with care

- ➢ Prevent adverse events
- ➢ Reduce hospitalizations and ED use
- ➢ Improve patient outcomes

Home Healthcare Nurse. (2013). *Using SBAR Communications in Efforts to Prevent Patient Rehospitalizations.* https://journals.lww.com/homehealthcarenurseonline/Fulltext/2013/10000/Using_SBAR_Communications_in_Efforts_to_Prevent.8.aspx

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SBAR Requires Preparation

- Assess the patient
- Determine level of urgency
- Review the patient record
- Organize information and data using the SBAR structure

Goal is to be clear and concise!

Home Healthcare Nurse. (2013). *Using SBAR Communications in Efforts to Prevent Patient Rehospitalizations.* https://journals.lww.com/homehealthcarenurseonline/Fulltext/2013/10000/Using_SBAR_Communications_in_Efforts_to_Prevent.8.aspx

SBAR Content

Situation	• Your name and role • Patient's name and date of birth • Primary reason for communication and date of onset (e.g., change in condition, medication orders, transfer to emergency room)
Background	• Recent and concise summary of diagnoses, related events, what occurred prior to the situation, and what is happening now (e.g., symptoms) • Current medications, allergies, recent lab results, medical orders
Assessment	• Brief summary of the patient's condition and what you think the problem is
Recommendation	• Brief recommendation and/or additional questions needed to determine next steps • Clear identification of direct contact at HHA, if questions

SBAR in Action

Situation	Hello Dr. _____. This is ____, RN with XYZ Home Health Care. I am calling about one of your patients, Sam, DOB: 11/25/1940, with a primary diagnosis of Congestive Heart Failure, who today is experiencing signs of CHF exacerbation.
Background	Weight has increased three (3) pounds since last SN visit two (2) days ago. Blood pressure today is 164/100; BP has generally ranged 130-140/74-80. Heart rate increased to 110/minute. Patient now has edema in feet and ankles bilaterally. Patient becomes short of breath when walking to the bathroom. Patient states only change is that the five (5) day course of Furosemide was completed two (2) days ago, and there was no prescription refill.
Assessment	Patient experiencing onset of signs and symptoms of CHF exacerbation, including fluid retention, shortness of breath, and impaired mobility since completing post-hospitalization course of Furosemide 2 (two) days ago.
Recommendation	Would you like the patient to restart a diuretic now? If so, would you like them to have a higher dose today? The patient uses T Pharmacy at 100 Main St. The daughter is here with the patient and will pick up new prescriptions as needed. The daughter plans to stay and assist patient for at least three (3) days and will call with changes in condition. Would you like any new orders to include daily RN visits for the next two (2) days?

Interdisciplinary Team (IDT)

42 CFR 484.60 (d) Coordination of care.

The HHA must:

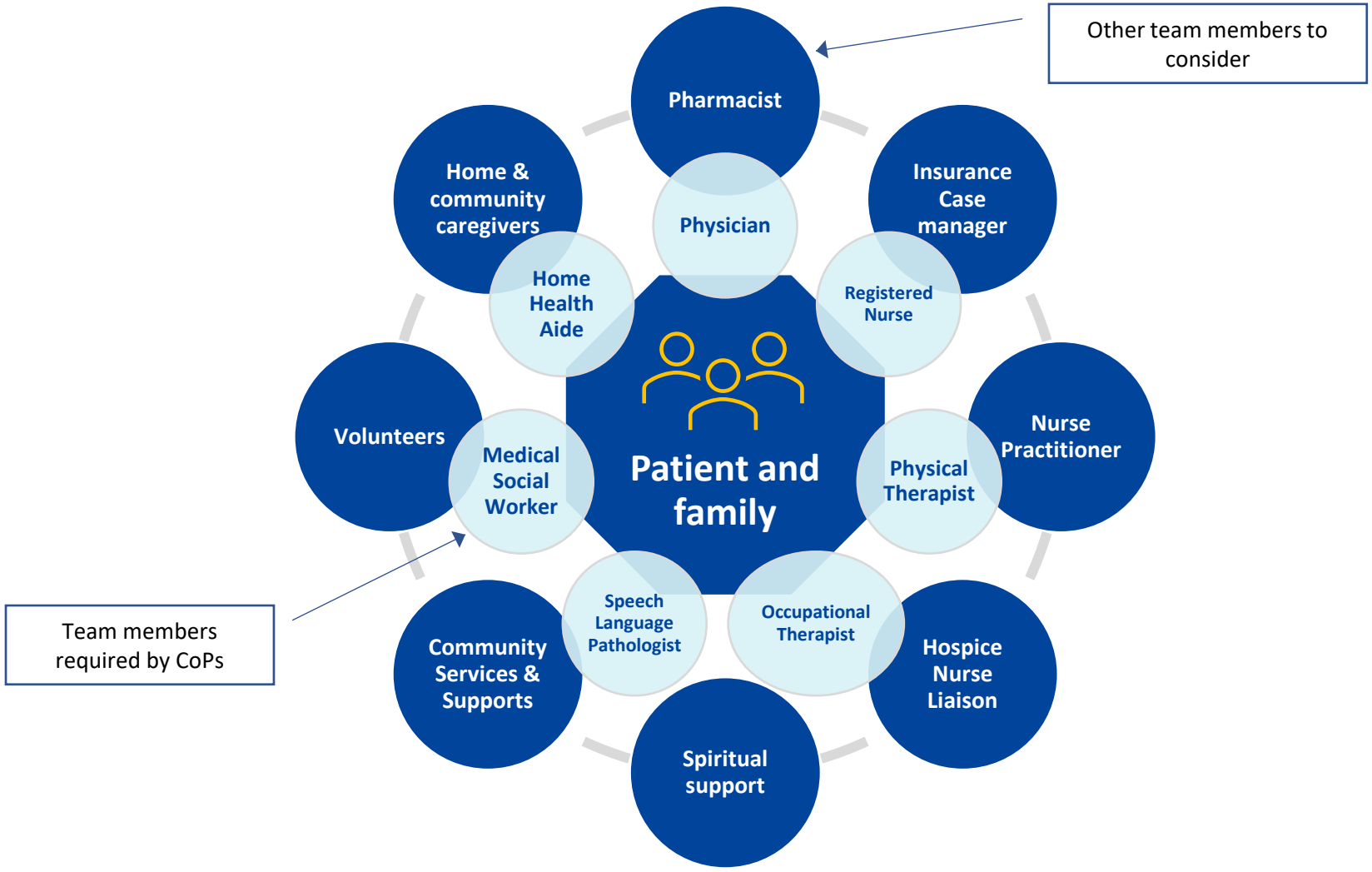
(1) ***Assure communication with all physicians*** involved in the plan of care.

(2) Integrate orders from all physicians involved in the plan of care to ***assure the coordination of all services and interventions*** provided to the patient.

(3) ***Integrate services***, whether services are provided directly or under arrangement, to assure the identification of patient needs and factors that could affect patient safety and treatment effectiveness ***and the coordination of care provided by all disciplines***.

Centers for Medicare & Medicaid Services. (2017). Medicare and Medicaid Program: Conditions of Participation for Home Health Agencies, p. 4582. https://www.govinfo.gov/content/pkg/FR-2017-01-13/pdf/2017-00283.pdf

Who is Part of the IDT?



Elements of the IDT Meeting

✓ Patients ✓ Process ✓ Structure ✓ Quality Outcomes	• Clear vision: Know the purpose and intended outcomes
	• Targeted staff training: Prepare staff on the goal, procedures, and schedule
	• Effective facilitation: Develop ground rules, including rules specific to remote participation; Provide everyone an opportunity to engage; Begin and end on time
	• Concise documentation: Update care plans; Identify action items, assignments, and timeline

Relevance to the Expanded HHVBP Model Measures

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- OASIS-based measures
- Claims-based measures
- HHCAHPS Survey-based measures

Effective Provider Communication during Care Transitions

References and Resources

References

- Agency for Healthcare Research and Quality. (2021). *Approach to Improving Patient Safety – Communication.* https://psnet.ahrq.gov/perspective/approach-improving-patient-safety-communication
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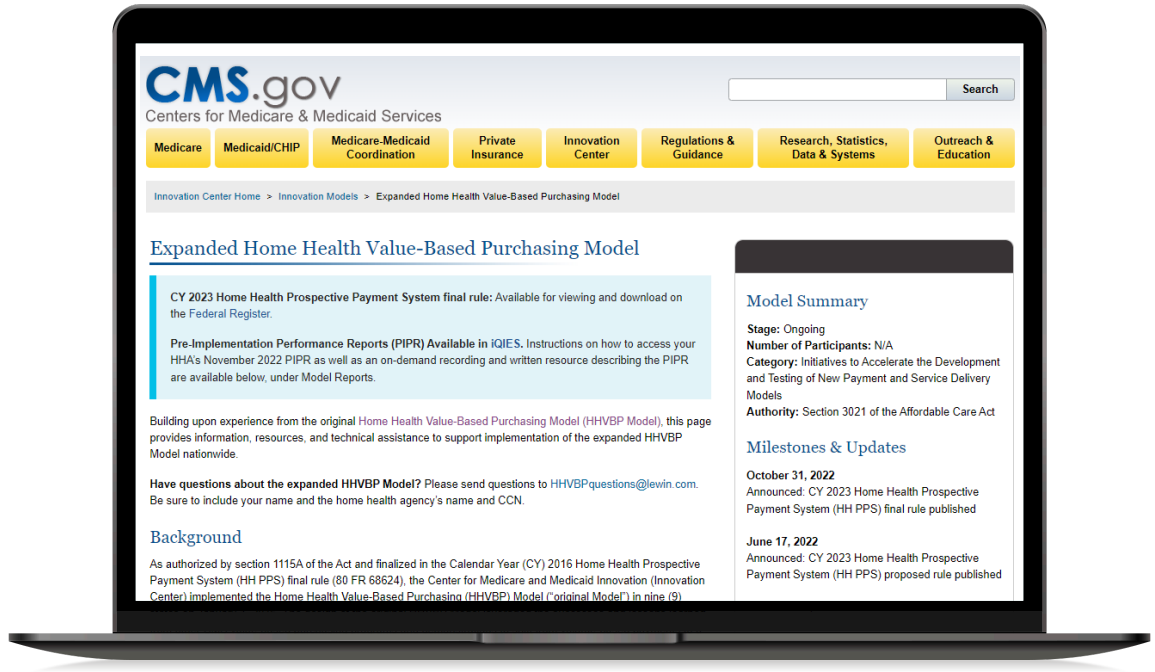
- Victoria Department of Health. (2022). *Minimising the risks of transitions.* https://www.health.vic.gov.au/patient-care/minimising-the-risks-of-transitions

Staying Connected Checklist

- Visit and bookmark the Expanded HHVBP Model webpage.
- Review the Expanded HHVBP Model YouTube playlist for all recorded content
- Subscribe to the HHVBP Expanded Model listserv by entering your email address on the contact form, then select "Home Health Value-Based Purchasing (HHVBP) Expanded Model" from the Innovations list. To ensure you receive expanded Model communications via email, please add "cmslists@subscriptions.cms.hhs.gov" to your email safe sender list.
- Access and review the reports available in iQIES in the "HHA Provider Preview Reports" folder.
- Contact the HHVBP Help Desk with questions: HHVBPquestions@lewin.com.



Thank You

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