About the Alliance

• 501(c)(3) non-profit research and education foundation

• Mission: To support research and education on the value home health care can offer to patients and the U.S. health care system. Working with researchers, key experts and thought leaders, and providers across the spectrum of care, we strive to foster solutions that will improve health care in America.

• [www.ahhqi.org](http://www.ahhqi.org)
Today’s Speaker: Tracey Moorhead

Tracey Moorhead
President and CEO, Visiting Nurse Associations of America

Tracey Moorhead is President and Chief Executive Officer of the Visiting Nurse Associations of America (VNAA). In this role, she spearheads VNAA's strategic vision and growth in collaboration with the VNAA Board of Directors. She effectively directs quality improvement programs, policy formulation and strategic advocacy activities and represents the non-profit home health, hospice and health promotion community before the media, allied organizations and constituents, and Federal policy makers. Ms. Moorhead is recognized as a leading health care advocate with considerable experience in public policy and coalition development and outreach. She previously served as President and CEO of the Care Continuum Alliance, an industry organization advancing population health management interventions through health and wellness promotion, disease management and care coordination. Prior roles also include Executive Director of the Alliance to Improve Medicare (AIM), a bipartisan coalition advocating comprehensive Medicare improvements through the Medicare Modernization Act of 2003 and Vice President, Government Relations for the Healthcare Leadership Council (HLC).
Margaret "Peg" Terry, Ph.D., RN, serves as the VNAA's Vice President of Quality and Innovation. In this role, Peg provides resources and guidance to member agencies in their efforts to improve quality of care, adopt innovative program models, and succeed in a competitive and rapidly evolving delivery system. She oversees educational programming and the Quality Initiative, where working closely with VNAA members, Peg led the development of the VNAA Blueprint for Excellence. She also plays a national role working with policy makers as they shape quality measures that will have an impact on VNAA member agencies and the patients they serve.

Previously Terry worked as the VP of Clinical Affairs for MedStar Health Visiting Nurse Association, headquartered in Maryland and serving the Maryland, DC, and Virginia region as part of a regional multi-hospital integrated delivery system. She served in that role since 2005, before which she was MedStar VNA's Vice President of Operations, Quality Improvement and Regulatory Affairs for seven years. Before joining the VNA, she served for six years as President and CEO of another nonprofit agency.

Beyond her significant hands-on agency operations experience, Terry is an accomplished educator and researcher. She served for six years as an Assistant Professor of Nursing in the Home Health and Continuity of Care Program in the School of Nursing at The Catholic University of America. She is a published researcher with distinguished work specializing in home care clinical practice, including heart failure and wound care. She has also been active in several quality measurement and standard-setting bodies, including The Joint Commission and the National Quality Forum of the American Health Lawyers Association and the American Bar Association.
Today’s Webinar

• During the presentation submit questions to “Teresa Lee” at the Fuze Chat Box.

• Slides will be posted on the “Webinars” portion of the Alliance website. We are also recording the webinar for playback on the website.
Best Practices in Home Health, Hospice and Palliative Care:

Supporting workforce development and consistency of care

Margaret (Peg) Terry, PhD, RN
VP of Quality and Innovation
Visiting Nurse Associations of America
Overview

VNAA

Industry Trends

Blueprint for Excellence

Modules

Q & A
Visiting Nurse Associations of America

- National trade association for nonprofit providers of home health, hospice and palliative care and health promotion services
- Over 3,200 nonprofit providers in U.S.
- VNAA members:
  - 51% provide home health and hospice services
  - 11% are stand-alone hospice agencies
  - 32% are hospital affiliated system agencies
Home Health

On the care continuum, home health care is the setting in which skilled practitioners provide services to individuals and their families where they live.

This care is provided to promote, maintain or restore health.

Home health professionals cultivate patient engagement/self-management and provide nursing care; physical, occupational or speech-language therapy; home health aide support; and social services.

Home health aims to ensure patients maximize independence, minimize the effects of the disability or illness, move smoothly through care transitions and remain in the home.
What is Hospice and Palliative Care?

Hospice care is a service delivery system that provides palliative care for patients who have a limited life expectancy and require comprehensive biomedical, psychosocial, and spiritual support as they enter the terminal stage of an illness or condition.

Hospice care also supports family members coping with the complex consequences of illness, disability, and aging as death nears.

Hospice care further addresses the bereavement needs of the family following the death of the patient.
Goals of Best Practices Project

• Position VNAA as a learning hub and network for exchange of information about the current and future practice of quality, cost effective home health care and hospice services.

• Assist in the ongoing education and training of those experienced in and new to the field, demonstrating the value of home and community-based programs and the role of the nonprofit home health care and hospices.

• Actively engage VNAA leadership as SMEs in the field and become the voice of hospice and palliative care services.

• Brand VNAA member companies in alignment with best practices in hospice care.
What is the Blueprint for Excellence?

VNAA Blueprint for Excellence is a pathway to expert practices for home health and hospice care providers, a touchstone for the expanded value and role of home health and hospice in new delivery models.

The VNAA Blueprint supports workforce development and consistency of care delivery, to achieve better health, better care and lower costs. The VNAA Blueprint strengthens care transitions and end of life care and underscores the value of accountable, measurable, coordinated care in the home health and hospice settings.”
VNAA Blueprint Features

- Free & publicly available to all
- Staff training resource
- Quality improvement tool
- Links to validated tools (with permission) and free or university-based training
About the Modules

- Each clinical section designed to be reviewed by members “over lunch” or to be used as training for clinical staff online
- Each clinical area identifies recommended Tools & Interventions, Training, Measures, and References & Resources
- Clinical pages linked to VNAA Training Webinars
- Additional trainings and briefs to be added
VNAA Presents a Blueprint for Best Practices in Home Health, Hospice and Palliative Care.

The VNAA Blueprint is a quality improvement and workforce training resource. It advances the use of best practices by gathering into one virtual location curriculum and training tools, as well as the relevant research supporting those tools. The VNAA Blueprint and its best practices demonstrate the value of home health, hospice and palliative care—both in lowering the overall cost of care and in improving health outcomes.
Care Transitions Learning Modules

- **Depression Screening**
- **Alzheimer's Disease**
- **Heart Failure**
- **COPD**
- **Hypertension**
- **CAD**
- **Diabetes**

**Care Initiation**
- Critical interventions 1st & second visit
- Front loading
- Scheduling MD appt within 7 days
- Pneumonia vaccine

**Clinical Conditions and Symptom Management**
- **Patient and Caregiver Engagement**

- Patient self-management and self activation

**Patient Safety**
- Risk Assessment
- Medication reconciliation
- Falls risk assessment and intervention
- Exacerbation of condition or red flags

Under Construction
Pain Assessment and Management

Overview

The American Society for Pain Management reported 51% of patients overall have pain at the end of life. In the last month of life, 60% of patients with arthritis have pain, and 64% of people with cancer have pain (Reynolds, 2013). The rate of patients experiencing pain varies according to the patient's underlying illness.

Experts stress that “Pain is what the patient says it is,” and should be treated accordingly (Herr, 2006; Pasero, 2011). Since no physiologic test is available to detect pain, patient report and professional assessment are needed to ensure appropriate treatment. A patient’s experience of pain is impacted by many factors, including the underlying cause, anxiety, cultural, psychosocial, and spiritual characteristics. Some patients may be able to verbalize their pain, while others may not. Hospice staff should be equipped to evaluate and address pain in diverse patient populations.
**Assessment:**
- Identify high-risk pts
- Determine hospitalization risk
- Perform medication reconciliation
- Assess understanding of Sx of exacerbation & if pt safe ‘til next visit
- Assess for telemonitoring

**Interventions:**
- Visit patients w/in 24 hours
- Frontloading for high-risk pts & those on high-risk medications
- Use teach back method
- Utilize emergency care plan
- Personal health record/log
- Follow-up MD appt. in 7-10 days

**Tools:**
- IHI Risk Assessment tool
- Stoplight/zone tools
- Confidence ruler
- PAM
Assessment:
- Screen for high risk Pts
- Determine need for 2nd visit
- Assessment for frontloading of visits in 1st 2–3 wks
- Review staffing capability & barriers to frontloading

Interventions:
- Admit w/in 24 hrs
- Visit frequency- 60% of nursing visits 1st 2 wks for high-risk Pts
- Arrange telemonitoring or electronic support telephonic, IVR for 30 days

Tools:
- HHQI Personal Health Record
- High Alert Medication List
- IHI Risk Assessment
- Personal Health Record - SCIC
- Philips National Chronic Disease
- SMART Goals
**Assessment:**

- Assess all Pts for PNA vaccination status

**Tools:**

- CDC.gov/pubs hand out
- HHQI BPIP Immunization
- ASSESS, ACCESS, and ADMINISTER assessment form

**Treatment:**

- Vaccination status via OASIS (M1050)—for those received vaccination during the episode &/or received in past (M1055)
- Ensure access by providing PNA immunizations/referrals to MD
- Utilize ASSESS, ACCESS and ADMINISTERED assessment form to assure organization protocols in place
- Design process to ensure immunization is administered
- Train staff to educate importance receiving PNA vaccination
Assessment:
- Assess if pt has a schedule follow-up appt. with MD

Tools:
- Personal Health Record

Intervention:
- Implement process to identify responsibility for making an appt.
- Address need to make follow-up appt.
- Discuss use of personal health record to engage Pts in own health care
- Use coaching as approach with Pt/caregiver
- Implement process for Pts referred from MD
- Incorporate changes in medical record
Depression

Assessment:
- Screen using PHQ-2 scale (OASIS M1730)
- Score at 3 or more-screen with PHQ9 for pts 64 & under; Geriatric Depression Scale (GDS) for those 65 & older
- Evaluate at discharge using depression screening tools to determine change

Treatment:
- Notify the PCP of all screening scores
- Request MSW referral, mental health follow-up & medication monitoring
- Obtain prescription order from PCP or specialist if appropriate

Tools:
- PHQ-9
- OASIS PHQ-2
- Geriatric Depression Scale (Short Form)
**Risk Assessment**

**Assessment:**
- Determine if pt moderate or high risk-IHI
- Prior hospitalizations w/in past yr.
- Pt’s knowledge clinical conditions- utilize stoplight & zone tools, teach back method
- Pt's confidence knowledge & ability to act if change occurs

**Treatment:**
- Develop process for early identification & intervention with high-risk patients w/in 24 hrs. of discharge to prevent hospitalization

**Tools:**
- IHI Risk Assessment
- LACE Index Component
- Importance and Confidence Ruler
- Zone and Spotlight tools (multiple clinical conditions)
Exacerbation and Red Flags

Assessment:
• Assess Pt knowledge of red flags for conditions

Tools:
• HHQI Personal Health Record
• My Emergency Care Plan
• Personal Health Record SBAR Physician Communication
• Personalized Red Flags

Treatment:
• Sx exacerbation/red flag lists in POC
• Embed red flag identification in processes
• Staff training on importance of communication & Pt engagement
• Use the Pt's PHR & skills in motivating interviewing/coaching
• Complete individualized red flag document at admission
• Develop emergency plan w/in 48 hrs of admission
Patient Engagement

**Assessment:**
- Pt understanding of care– zone tools
- Use Importance & Confidence Ruler to assess pt readiness

**Tools:**
- Stanford Self-Efficacy Tool
- Health Literacy Precautions
- SBAR Physician Communication
- HHQI Personal Health Record
- Importance & Confidence Ruler
- Zone tools

**Treatment:**
- Use pt ed. material at 4th grade level
- Communicate with Pt & family
- Teach-back technique
- Use consistent teaching materials
- Coaching to develop pt-centered goals
- Principles of motivational interviewing
VNAA Blueprint: Hospice and Palliative Care

- Aligned with hospice item set: modules on pain, dyspnea, treatment preferences and beliefs, bowel regimen
- Goes beyond HIS: crisis management; other symptoms; critical interventions, medication reconciliation and management, and others, “best practices”
- Also references CMS Hospice Conditions of Participation
- Expert Workgroup guided the process, identified best practices
- Site to undergo additional testing and review before public launch
Hospice and Palliative Care Learning Modules

- **Clinical Conditions and Symptom Management**
  - Pain
  - Dyspnea
  - Common Distressful Symptoms

- **Patient and Caregiver Engagement**
  - Artful Conversation
  - Beliefs and Spirituality
  - Treatment Preferences

- **Care Initiation**
  - Crisis Management
  - Critical Interventions

- **Patient Safety**
  - Falls Prevention
  - Medication Management and Reconciliation
Pain Screening, Assessment and Management

Tools:
- VDS – Iowa Pain Thermometer, FACES-R, BPI, McGill SF;
- for non-verbal: PAINAD, FLACC

Interventions:
- non-opioid;
- opioid, adjuvant;
- non-pharmacologic

Consider dose, adjustment frequency, route, plan for breakthrough pain, e-kit, management of side effects – bowel regimen
Assessment:
• presence of dyspnea
• severity
• effectiveness of treatment

Tools (verbal and observational):
• Numeric rating scale
• Visual analogue scale
• Modified Borg Scale
• RDOS

Interventions:
• positioning, environment, fan, breathing, evidence based oxygen
• control anxiety, opioids, anxiolytic, anticholinergics, bronchodilators, corticosteroids

Newer practices:
• nebulized lasix
• nebulized morphine
Assessment:

• Discussion of treatment preferences. Includes CPR, life-sustaining treatments, hospitalization, discussion within 5 days of admission.

Tools and Resources:

• The Conversation Project
• POLST

Interventions:

• Coach caregivers on ways to prevent crisis hospitalization, and assure they know how to communicate with hospice staff 24/7, reaffirm the initial preferences with patient and caregiver.
Assessment:
• Discussion with patient/caregiver within 5 days of admission, NCP suggests structured instrument, Culturally appropriate discussions

Tools:
• Nest, CAPC (a spiritual guide assessment tool) and FICA

Intervention:
• Offer pastoral care, Use structural approach, incorporate into care plan
Assessment:

- Comprehensive Assessment required for hospice COP, Many common in final days or during decline

Symptoms:

- n/v, fatigue, delirium, anxiety, bleeding, wounds, death rattle, diarrhea, constipation, depression

Tools:

- ESAS
- CAM
- Distress Thermometer
- BSI
- Memorial Delirium Assessment
- Death Rattle intensity Scale
- RDOS
- Geriatric Depression Scale

Interventions:

- Safety and comfort
- Educate patient and family
- Modify environment
- Optimize medication
- Spiritual
- Emergency plan
Steps to assure a smooth transition into hospice care:

Assessment:

• Assessment starts at referral to determine hospice readiness
• Assess pt/caregiver understanding of medical condition/prognosis
• Complete physical assessment, symptom management, caregiver/med rec and psychosocial (MSW)

Treatment

• Discuss levels of care/services available, complete election, consent, rights and responsibilities forms
• Discuss advanced directives & treatment options. Confirm that the decisions are still appropriate.
Assessment

Identify red flags, assessment prior to admission, evaluate patient/caregiver ability to learn and administer meds, support systems, CPR and hospitalization

Intervention:

Start to establish therapeutic relationship, involve the IDT: consider joint SW/RN visit, identify patient/caregiver concerns, get symptoms under control, establish and educate an emergency plan, coordinate with all providers
Assessment

• Review current meds and determine payment source for meds at admission
• Determine if the patient is self-managing/needs help in managing meds
• Identify risk for non-adherence leading to adverse events or symptom exacerbations such as cardiac or anti-depressants meds.
• Identify any combinations of meds that may be contraindicated and possible drug-drug interactions or therapeutic duplication

Treatment

• Med. rec. completed & reviewed by the IDT-discrepancies & clarify with MD/pharmacist within 24 hrs
• Use steps of verify, clarify and reconcile
• Clinician must be comfortable with first dosing, titrating and tapering, changing from one form of an opioid to another, changing the route of administration, equi-analgesic dosing among different opioids, use of PCA pumps & IV's (Hospice)
Assessment:
• Use multifactor standardized assessment -MAHC-10

Interventions:
• IDT should include interventions for each risk factor, risk factors include —incontinence, visual impairment, functional ability, environmental, polypharmacy, pain, cognitive impairment

Tools:
• MAHC-10, GEM, Fall Prevention Medication Review
Next Steps: Blueprint for Excellence

- Launched home health and hospice and palliative care best practices
- Developing technology best practices - Patient Remote Monitoring
- Under development - Practices for clinical conditions to include HF, COPD, Diabetes and Hip and Knees
How to Share - or - P.S. (Please Steal!)

• Link the hot button to www.vnaablueprint.org

• For newsletters, websites, email pushes to member organizations, intranet, education event announcements, etc.
VNAA Blueprint Sponsors
Contact

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Discussion & Questions

• Submit questions to “Teresa Lee” at the Fuze Chat Box.

• Presentation slides will be available at: http://ahhqi.org/education/webinars
Speaker Contact Information

If you have additional questions regarding today’s webinar, please feel free to contact the speakers via email.

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