Ambulatory COVID Response Care Coordination and Home Health Toolkit

Contents

Introduction

This toolkit provides an overview of ambulatory Care Coordination and Home Health in general, as well a ways to activate these services and resources during the COVID-19 pandemic to manage your populations in the ambulatory setting.

Ambulatory Care Coordination Overview

Care Coordination is the intersection of activities that mobilize resources and provide support for patients and providers across healthcare settings.

For the duration of the COVID-19 Pandemic, it is recommended that market care coordination teams take a "public health" approach to care coordination. Within the contractual requirements of the care coordination relationship, teams should be deployed for all COVID-19 positive patients, not just those within a value-based contract.

Approach:

- Targeting and identifying the population
- Manage utilization in the post-acute space
- Optimize transitions by addressing barriers that cause avoidable readmissions and ED utilization
- Assist the patient to regain or maintain optimum health or improved functional capability that best serves the patient.
- Reducing the risk of all-cause mortality

How Can Patients Access Ambulatory Care Coordination Services?

- These services can be provided in-person where the patient seeks care or lives, or at any location that is accessible to the patient.
- Services can also be provided by phone or other communication methods that work for the patient.

What Extra Services Does Ambulatory Care Coordination Provide?

Six Core Services:

- Care management
- Care coordination
- Health promotion
- Transitional care
- Member and family supports
- Referral to community and social supports CC services must be culturally appropriate and meet trauma-informed care standards. All communications must meet health literacy standards.

1) Care Management
    - The patient, their care coordinator, and their CC care team work together to develop a comprehensive, individualized Health Action Plan. This plan is based on the patient's health status, needs, preferences, and goals regarding:
    - Physical health
    - Mental health
    - Substance use disorders
    - Community-based long-term services and supports
    - Palliative care
    - Trauma-informed care needs
    - Community and social supports
    - Housing

2) Care Coordination

    Services are provided to help patients implement their health action plan and navigate and connect to needed health and community services. The care coordinator is a key point of contact for patients and their providers. Care coordination services may include:

- Helping the patient navigate, connect to, and communicate with health, behavioral health, and social service systems, including housing
- Sharing options for accessing care and providing information regarding care planning
- Monitoring and supporting treatment adherence, including medication management and reconciliation
- Monitoring referrals to needed services and supports, as well as coordination and follow-up
- Facilitating transitions among treatment facilities, including admissions and discharges, and reducing avoidable hospital readmissions
- Sharing information with all involved parties to monitor the patient's conditions, health status, medications, and any side effects
- Accompanying patients to appointments
- Holding case conferences for the care team to discuss the patient's needs and services

3) Health Promotion

- Patients are coached on how to monitor and manage their health, and identify and access helpful resources. These services may include:
  - Supporting health education for patients and their family and/or support team
  - Coaching about chronic conditions and ways to manage them
  - Using evidence-based practices to help patients manage their care

4) Transitional Care

- Patients receive services to facilitate their transitions between treatment facilities, including admissions and discharges, and to reduce avoidable hospital admissions and readmissions. This includes transitions between the emergency department, hospital inpatient facility, residential/treatment facility, mental health facility, skilled nursing facility, incarceration facility, or other treatment center, and their own home. These services may include:
- Collaborating, communicating, and coordinating with all involved parties
- Planning timely follow-up appointments with outpatient and/or community providers and arranging transportation as needed
- Educating patients on self-management, rehabilitation, and medication management
- Planning appropriate care and social services post-discharge, including a place to stay
- Developing and facilitating the transition plan, evaluating the need to revise the Health Action Plan, and preventing and tracking avoidable admissions or readmission
- Providing transition support to permanent housing

5) Member and Family Supports

- Patients and their family and/or support team are educated about their conditions to improve treatment adherence and medication management. These services may include:
- Assessing strengths and needs of patients and the family and/or support team and promoting engagement in self-management and decision-making.

- Linking patients to self-care programs and peer supports to help them understand their condition and care plan.
- Determining when patients are ready to receive and/or act upon information provided and assist them with making informed choices.
- Helping patients identify and obtain needed resources to support their health goals.
- Accompanying patients to appointments when necessary.
- Evaluating the family and/or support team's need for services.

6) Referral to Community and Social Supports

- Patients receive referrals to community and social support services and follow-up to help ensure they get connected to the services they need. This may include:
- Identifying community and social support needs and community resources
- Identifying resources and eligibility criteria for programs, including housing, food security and nutrition programs, employment counseling, child care, and disability services
- Actively engaging with appropriate referral agencies and other community and social supports
- Providing housing transition services and tenancy sustaining services
- Routinely following up to ensure needed services 5 are obtained

Health Action Plan
This is a comprehensive plan developed with the patient that addresses their physical and mental health and community support needs and goals. The plan is used to guide and track their care. It is reviewed and revised over time based on their changing needs.

Home Health Overview

Home Health is skilled care provided in the comfort of the patients home. Care is focused on helping your patient mange a chronic condition and/or recover from acute illness, surgery accident or change in medical condition.

Our mission is to help patients remain at home and in their own communities, surrounded by friends and family, while receiving the highest quality, most compassionate home based care possible.

Services are delivered according to a plan of treatment developed through a collaborative effort with the provider, the patient and the home health team to maximize independent functioning. In-home care allows your patient to remain safe in familiar surroundings and is provided with the involvement of family members and caregivers.

In order for patients to qualify for home health services, there are several factors that must be met. There are specific COVID-related criteria during the Public Health Emergency (PHE).

Patients must be homebound: meaning they have a normal inability to leave the home. Leaving the home is a taxing effort for the patient and requires assistance of another, or is medically contraindicated due to a condition or DX.

**Regulatory waivers in place as part of the State of Emergency expands homebound status to include: Any individuals determined by the physician to be at high risk of contracting COVID-19 virus due to a compromised health condition, meets the homebound requirement because it is "medically contraindicated" to leave the home. **

- The skilled care to be provided must be intermittent by nature.
- The care to be provided must be medically necessary and reasonable
- The care to be provided must be ordered by a physician/ nurse practitioner who is willing to follow the episode of care.
- A face to face with a physician or APP to qualify (90 days before or up to 30 days after start of care)

Comprehensive Care

Home health provides comprehensive care through a multidisciplinary team. This team works in collaboration with the PCP, additional physicians, and outside care entities to ensure patient care needs are met safely in the home.

Services covered by Medicare's Home Health benefit include:

- Intermittent Skilled Nursing Care
- Therapy (PT, OT, ST)
- Social Work
- Home Health Aide
- Covered by Medicare Part A, as well as commercial insurance plans
- Most agencies provide 24/7 on-call services
- All Medicare Advantage Plans must provide at least the same level of home health care coverage as traditional Medicare, but may impose different rules, restrictions (service limitations), and costs

Non-Reimbursed Services:

Services that are not covered by the medical benefit and fall outside the normal scope of services for home health agencies include:

- 24-hour/day care at home
- Prescription drugs
- Meals delivered to your home
- Custodial care (homemaker services), including light housekeeping, laundry, and meal preparation
- Home health aides may perform some custodial care when visiting to provide other health-related services. However, aides cannot visit with the sole purpose of performing custodial duties

Value of Home Health Care

Home Health works collaboratively with providers to provide their patients with the highest quality care, acting as an extension to what the ambulatory providers aim to give their patients. As a result, this collaborative focus provides patients with multiple benefits:

- **Stronger Physician/provider connection:** Ongoing communication and status updates prn
- **Decreased Readmissions:** Additional assurance at discharge that the patient will be evaluated and receive services needed to adapt to their home care environment, thus <u>decreasing</u> the need for <u>re-admission</u> to the hospital within 60 days, pt. not discharged until pt. centered goals are met, and can be re-certified if needed
- **Increased Patient Satisfaction:** A partnership among healthcare settings focusing on a holistic approach to care that can be demonstrated through outcomes and shared with patients, families and referral sources, thereby increasing <u>patient satisfaction</u>
- **Continuity of Care:** A consistent approach and focus to continue the care plan the patient is currently receiving in the hospital – a true <u>continuity of care</u>

Advantages of Home Health Care

The COVID 19 pandemic has brought to light more so than ever patients desire to remain in the home. This is the space that home health is the subject matter expert. The advantage of this extensive experience comes with a multitude of advantages for patients, the providers and the health care system overall:

- Home care helps patients avoid being admitted/re-admitted to the hospital
- Patients can reduce the amount of time they spend in the hospital
- Patients can avoid being sent to long-term care facility or nursing home
- Home health care costs significantly less than many other settings of care
- Patients are more comfortable at home
- Patients can enjoy the support of family, caregivers, and friends
- Patients and family members can be more involved with treatment lending to sustainable health maintenance and chronic disease management education
- Patients can enjoy a higher level of personal independence
- Patients experience higher morale and more favorable outcomes when they heal at home

- Research results suggest patients recover more quickly when at home
- Triple Aim: Lower cost, better outcomes, better experience

Getting Started

Once orders are received and qualifications are established, home health will contact the patient and coordinate an in-home comprehensive assessment. They will then work in conjunction with the providers, patient and the multidisciplinary team to develop a plan of care. The team remains in close contact with the physician regarding patients' progress. The home health team facilitates achievement of patient centered goals through a combination of specialized services, continuous patient education, and highly skilled teams of professionals all focused on optimizing both quality and patient experience.

Ambulatory Care Coordination and Home Health COVID-19 Clinical Guidelines Process Flow

The diagram below (link as well) is a complement to the Ambulatory COVID-19 Clinical Guidelines process flow (Link: COVID-19 Clinical Guidelines) to illustrate the connection points between ambulatory/primary care, care coordination and home health.

Ambulatory Care Coordination and Home Health COVID-19 Clinical Guidelines
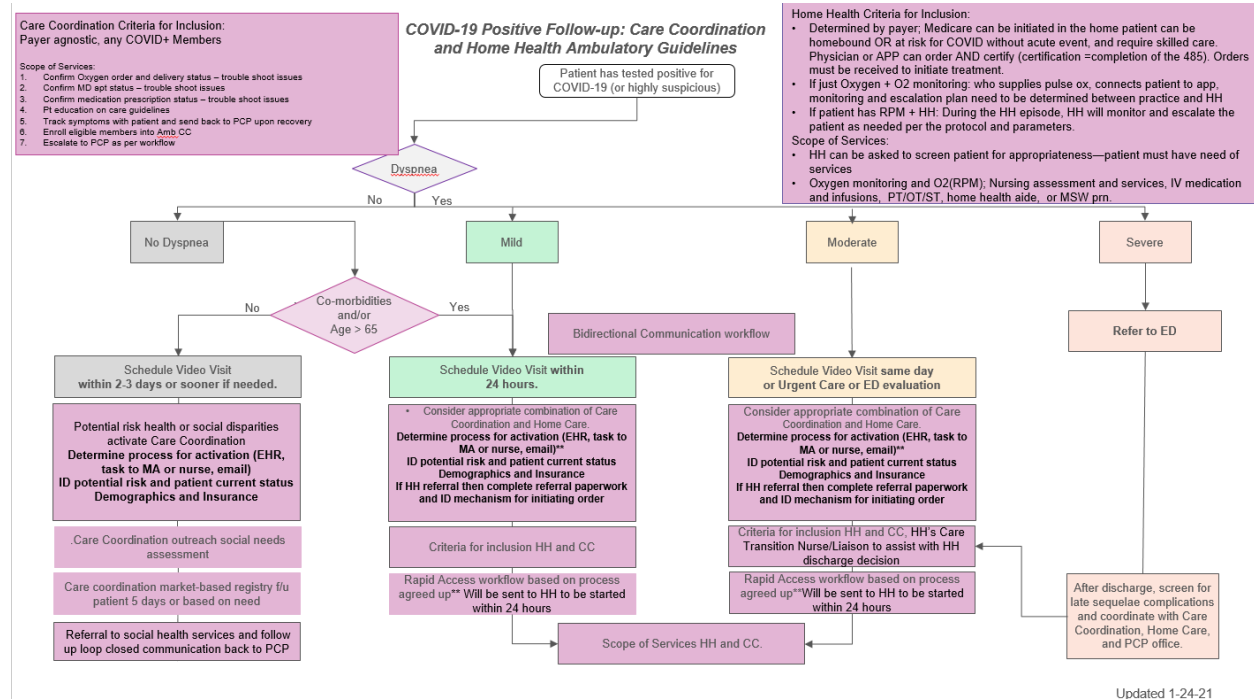
Ambulatory Care Coordination and Home Health Workflows for COVID positive patient

The workflows below (link and samples) provide an overview of the general workflows that ambulatory care coordination and/or home health can consider enacting once a COVID+ patient is referred.

[Ambulatory Care Coordination and Home Health Workflows for COVID positive patient](#)

Care Coordination COVID Response Patient with No or Mild Dyspnea (May have SDOH Need)

2/8/21

RN

- CC receives Ambulatory Referral
- Patient contact confirm clinical status (No/Mild Dyspnea)
- Target within 72 hours from discharge
  1. Review COVID Care Guidelines with patient
  2. Schedule follow up video or telephone visit in 5 days and then 10 days with RN
  3. Upload Care Guideline Tracking into Athena or other system (Tickler to LVN/navigator)
- Assess Social Needs and refer as necessary (see below)
- Done via telephone call & established process: Initial, 1, 5, 10 Day RN visit change/ worsening symptoms escalate to PCP
- Communication Loop PCP

LVN/LPN/Navigator

- Verifies patient in Care Guideline tracking system
- May be assigned differently based on market: Calls patients 2 days after RN intake and every 2 days after to review tracking sheet
- Change in care tracking/symptoms escalate per protocol
- After 10 days tracking patient stable no change or deterioration. Complete care tracker form

Abbreviations
APP – Advanced Practice Provider
CC – Care Coordination
HH – Home Health
F2F – Face to Face
PCP – Primary Care Provider
PUI – Person Under Investigation
RPM – Remote Patient Monitoring
SBAR – Situation/Background/ Assessment/Recommendation
SDOH – Social Determinants of Health
SOC – Start of Care

* Check with state licensing guidelines

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Care Coordination COVID Response Patient with Moderate Dyspnea

2/8/21

RN

CC receives Ambulatory Referral

Patient contact confirm clinical status (No Change in Dyspnea), Confirm if HH if ordered

Target within 24-48 hours from discharge
1. Review COVID Care Guidelines with patients
2. Call patient every 2 days for next 2 weeks
3. Value Based patient – Use tool A
4. If not Value Based or declines CC continue to follow until breathing status returns to mild, then transition to LPN/ LVN/Navigator
5. Social Determinants of Health Assessment

Done via telephone call & established process

Remote Patient Monitoring or HH Involvement? Coordinate patient contacts and interventions

RN Encounters (Initial and every 2 days). If symptoms worsen, escalate to PCP

Communication Loop PCP

LVN/LPN/Navigator

May be assigned differently based on market

Verifies patient in Care Guideline tracking system

Calls patients 2 days after RN intake and every 2 days after to review tracking sheet

Change in care tracking/symptoms escalate per protocol

Wait 10 Days

Dyspnea Assessment

None

Mild Or Worse

Escalate to PCP & ask if HH needed

Not Needed

Continue following and reassess in a week.

Needed

Home Health

HH process, refer to HH Workflows

Social Services

Follow up based on RN Social Determinants of Health assessment

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ED/Inpatient Discharge

2/8/21

RN COVID Discharge

Target within 24-48 hours

CC receives system generated outreach list

Is HH ordered? — YES / NO

1. Confirm breathing status as per Dyspnea evaluation.
2. Confirm if oxygen ordered and received
3. Confirm if Pulse Ox received at discharge
3. Educate per COVID guide
3. Confirm date and time of apt with PCP is scheduled
4. Identify and address SDOH
5. Confirm HH in place *IF* ordered

Hand off to market including results of listed confirmations, send RN contact information.

Communication Loop PCP
- Alert if Worsening symptoms
-Alert if Med Concerns/changes

Use relevant swim lane based on license of team member

LVN/LPN COVID Discharge

CC receives system generated outreach list

Is HH ordered? — YES / NO

1) Asking urgent medical questions on COVID Care Guide...
- Trouble Breathing
-Persistent pain or pressure in chest
-New confusion or low energy upon walking
-Bluish lips or face
-Difficulty getting fever down
-Oxygen saturation that is below 90%
2) Symptoms better or worse per COVID Care Guide
3) Transitional Care Management elements
4) Ask if Pulse Oximetry received at discharge

Positive response to any urgent medical question? — YES / NO

Send to Emergency Room

Picked Up by Amb CC

RN Local Markets

Done via telephone call & established process

Patient contact confirm clinical status (No Change in Dyspnea)

1. Review COVID Care Guidelines with patients.
2. Call pt every 2 days for next 2 weeks
3. Value Based patient – Use tool A
4. If not Value Based or declines CC continue to follow until breathing status returns to mild, then transition to LPN/ LVN/Navigator
5. Social Determinants of Health Assessment

RPM or HH Involvement? Coordinate patient contacts and interventions

RN Encounters (Initial and every 2 days). If symptoms worsen, escalate to PCP

Communication Loop PCP

Home Health

HH process, refer to HH workflows

Social Services

Follow up based on RN SDOH assessment

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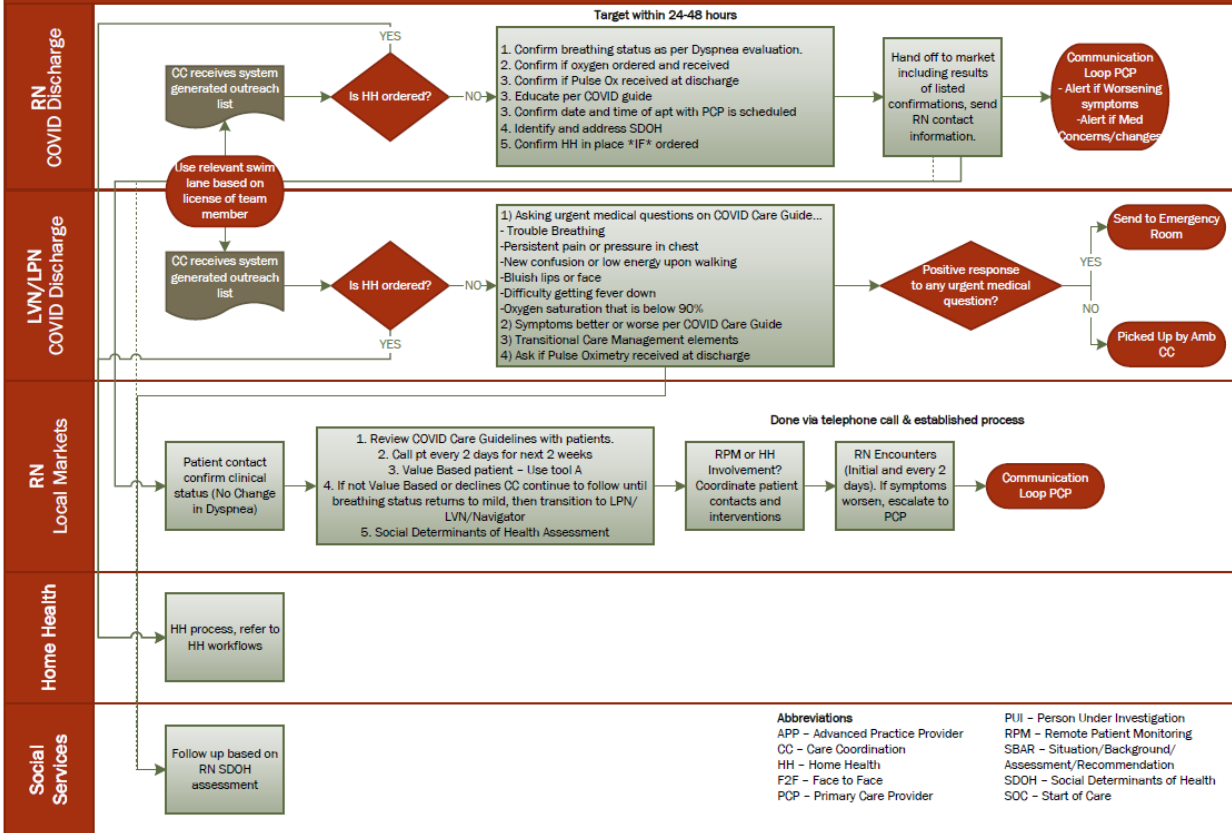SDOH – Social Determinants of Health
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Initiating Home Health from Ambulatory Care COVID+ Patient with Mild/Moderate Dyspnea

2/8/21

Ambulatory Clinic

Provider determines pt may benefit HH by ID of COVID+ or PUI

Order workflow initiated provider orders/referral. If care coordination also involved indicate this on order set

Target within 24-48 hours from discharge
1. Confirm orders include RPM and that HH has RPM available
2. Verify parameters set which triggers escalation process via SBAR with change in condition.
3. Indicate patients Care Type COVID+/PUI
4. Per Federal Regulations patient needs "face-to-face" within 90 days before SOC or within 30 days of SOC

Issue peripherals for RPM

Communication Loop PCP

Home Health (HH) Agency

-Order received
-Contact w/in 1 day
-Admin intake complete
-Care Type designation COVID+/PUI.
-Verify F2F or plan to obtain.

-RN/Therapy visit within 24 hours for initial assessment
- Notify CC that HH has admitted and will be primary during episode.

Enroll patient in RPM either Mobile or Tablet based
-Ensure remote visits if patient declines RPM

Green: no action needed
Yellow: Contact patient & Case Mgr, triage/educate/determine needs
Red: contact Patient & Case Mgr, initiate visit
Criteria for COVID Escalation

-PCP and/or APP contacted for escalation decision, further orders.

1) Evaluation of continuing medical necessity.
- If need remains obtain orders as indicated.
- If no further skilled need discharge/graduate from HH with PCP orders
2) Determine if CC will reestablish monitoring

No further skilled need

Results of evaluation

Need remains

Remote Patient Monitoring (RPM)

-Issue of peripherals (if not provided by PCP/CC)
-Enrollment on RPM
-Parameters set for individual norms to monitor

Daily RPM Monitoring

Patient Monitoring Daily 8am – 5pm

Video Visits as needed

Continuing Care Decisions

Telehealth Nurse communicates with Case Manager as escalation process indicates

Long Term Sequelae needs for continued care

At discharge, HH will fax discharge summary to PCP

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Initiating Home Health from Ambulatory Care non-COVID Patient w/ Chronic Disease Potential for Exacerbation

2/8/21

Ambulatory Clinic

Prov. determines patient may benefit HH for Chronic Disease Management or COVID Risk Factors

Order workflow initiated Provider orders/Referral. If care coordination also involved indicate this on order set

Target within 24-48 hours from discharge
1. Confirm orders include RPM and that HH has RPM available
2. Verify parameters set which triggers escalation process via SBAR with change in condition.
3. Indicate patients is a risk for COVID from CDC list
4. Per Federal Regulations patient needs "face-to-face" within 90 days before SOC or within 30 days of SOC

-Issue peripherals for RPM, or order HH to do so since it may include more than pulse oximeter

Communication Loop PCP

Home Health (HH) Agency

-Order received
-Contact w/in 1 day
-Admin intake complete
-Care Type designation COVID+/PUI.
-Verify F2F or plan to obtain.

-RN/Therapy visit within 24 hours for initial assessment
- Notify CC that HH has admitted and will be primary during episode.

Enroll patient in RPM either Mobile or Tablet based
-Ensure remote visits if patient declines RPM

Green: no action needed
Yellow: Contact patient & Case Mgr, triage/educate/ determine needs
Red: contact Patient & Case Mgr, initiate visit

-PCP and/or APP contacted for escalation decision, further orders.

1) Evaluation of continuing medical necessity.
- If need remains obtain orders as indicated.
- If no further skilled need discharge/ graduate from HH with PCP orders
2) Determine if CC will reestablish monitoring

No further skilled need

Results of evaluation

Need remains

Criteria for COVID and/or Chronic Disease Mgt Escalation

Remote Patient Monitoring (RPM)

-Issue of peripherals (if not provided by PCP/CC)
-Enrollment on RPM
-Parameters set for individual norms to monitor

Daily RPM Monitoring

Patient Monitoring Daily 8am – 5pm

Video visits as needed

Continuing Care Decisions

Telehealth Nurse communicates with Case Manager as escalation process indicates

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COVID-19 Ambulatory Care coordination outreach script

Below is a link to an example template that can be used during the initial patient outreach regardless of where the patient is coming from.

COVID-19 positive patient ambulatory care coordination script:

COVID-19 Positive Patient Care Coordination Script

COVID-19 Care Guides

Below is a checklist that was published in the CommonSpirit Health COVID-19 Care Guide that can be used by care coordination and home health teams to track symptoms.

COVID-19 Care Guide - Dignity Health

COVID-19 Care Guide - CHI

Symptom	Severity	(Example) 4/28/21	Date	Date	Date	Date	Date
Breathing difficulty	Same	x					
	Worse						
	Better						
	Resolved						
Cough	Same						
	Worse						
	Better	x					
	Resolved						
Diarrhea	Same						
	Worse						
	Better						
	Resolved						
Fever	Same						
	Worse						
	Better						
	Resolved						
Nausea	Same						
	Worse						
	Better						
	Resolved						

Escalation Guidance

Symptoms that require immediate medical attention:

– Trouble breathing
– Persistent pain or pressure in your chest
– New confusion or low energy upon waking
– Bluish lips or face
– Difficulty getting fever down
– Oxygen saturation that is below 90%

Develop an action plan on the process to escalate to the PCP if a new or worsening symptoms or questions on managing your symptoms.

Communication Pearls

During these unprecedented times, extra precaution must be taken to ensure consistent hand-offs occur between the ambulatory practice, care coordination and home health. Often the care coordination team and home health will facilitate handoffs between the organization based on who is lead—this may mean if a patient is eligible for a home health episode they will take over care and care coordination will be on hold until the end of the home health episode.

Because there is much we still do not know about COVID, and symptoms can change rapidly, we recommend warm hand-offs with active communication to the PCP not only when a change in symptoms or status occurs, but when a patient is moving from the care of one entity or another, or is deemed eligible. This may mean different tiers of communication protocols. The importance is to make sure the lines are open and you have a clear accountability partner in each of the entities so no patient falls through the gaps!

CommonSpirit Health Values
Compassion
•Care with listening, empathy and love.
•Accompany and comfort those in need of healing.
Inclusion
•Celebrate each person's gifts and voice.
•Respect the dignity of all.
Integrity
•Inspire trust through honesty.
•Demonstrate courage in the face of inequity.
Excellence
•Serve with fullest passion, creativity and stewardship.
•Exceed expectations of others and ourselves.
Collaboration
•Commit to the power of working together.
•Build and nurture meaningful relationships.

Home Health Referral and Ordering Guidance

Whether your medical group partners with CommonSpirit Health at Home or a partner agency, there are core components to the referral and ordering process that are necessary to ensure a smooth workflow. A general outline is provided below. Remember, if you are not sure if the patient is eligible for home health the team can do an assessment for you!

Referral for Home Health

If you are not sure if patient qualifies for Home Health you can ask for a screening for appropriateness for Home Health!

(Could be entered as order set in EMR/printed and faxed to HH)

Basic Referral Information:

- Date of Referral
- Patient Name
- DOB
- Referral for: Start of Care/Resumption of Care(previously under HH and returning post Hospitalization)
- Hospitalization (if applicable):
    - Anticipated Hospital DC date:
    - Admission Status for Hospitalization: Observations/Full admission/Room #
    - Admission dx:
- Planned SOC Date:

Referral Source

- Facility/Physician/APP:
- Contact phone number:
- Fax number:

Physician Information:

- PCP/APP/Provider following HH episode:
- Pts last/next appointment:
- Contact Phone/fax:
- Other Providers involved in pts care: (specialists)

Patient Documentation Needed:

- Face Sheet (demographics/payor source)
- H & P
- F2F/Supporting Documentation (encounter timing - 90 days before SOC or within 30 days of SOC)
- POA/ Guardianship
- Medication Profile
- D/C Summary (if hospitalized)

Patient Homebound Reason:

- Because of _____ (illness or injury) patient requires the following to leave their place of residence: (mark all that apply)

- Supportive devices (crutches, cane, walker, wheelchair)
- Supporting assistance of another person
- Special transportation
- Patient has _____ (condition) and because of this leaving their home is medically contraindicated due to _____.
- Additionally: (must meet both to meet criteria)

  - Patient has a normal inability to leave home due to (describe physical limitations impacting function) _____.
    (**Example**: Patient must use a quad cane while ambulating even short distances in the home, and even then has a very slow, unsteady gait. At times, requires the assistance of another to get up and moving safely. (Simply documenting the use of a cane or walker may not support homebound as many patients who use a cane or a walker are not homebound).
  - Leaving home requires a considerable and taxing effort as demonstrated by (provide physiological impact when pt. exerts the energy to leave the home and duration of impact) _____.
    (**Example**: Patient can only walk 10 feet before becoming extremely short of breath and diaphoretic at which time the patient needs to rest. In addition, the patient needs to hang onto furniture while walking.)

Orders:

- Home Health admissions for DX of:
- Home Health/Provider Care Collaboration:
  - Upon admission and with significant changes in condition (**per regulations**)
  - Additionally on day's #:_____ (free text- example: days 5 and 8 from SOC date.)

- Technology Support
  - Remote Patient Monitoring/Telehealth (yes/no)
  - Supplement POC with virtual visits (yes/no) Recommended frequency: (1 x wk., every other week, etc.)
- Vital Sign Parameters: Licensed Professional to report V/S falling outside the following parameters. (Hard wire with standard practice- with an option for the provider to edit. Those in yellow are required)
  - Temp: < 95 > 101.1
  - Pulse: < 50 > 100
  - Resp: < 12 > 25
  - Systolic BP: < 90 > 160
  - Diastolic BP: < 50 > 100
  - O2 Sat: < 88
  - Blood Glucose: < 60 > 140
  - PT/INR Goal Range: _____
- Disciplines ordered:
  - SN for:
    - Skilled Observation related to dx:____

- Education related to disease process and management of as related to DX:_____
- IV medication administration/education as follows (enter medication specifics):____
- Wound Care and education to promote pt./caregiver self-mgmt. as follows (enter specific wound care orders): _____
- Medication Management/adherence education and evaluation of medication effectiveness
- Labs as follows: (free text type and frequency)(not considered a free standing skill per regulations but can do in conjunction with other skilled orders)_____
- Other Hands on Skills: (F/C changes, Chest Tube drainage, IV dressing changes etc.)_____
- COVID 19: (Positive or PUI?)
    - Patient/Caregiver/Household member education regarding COVID 19 disease process, response, and management. Including infection control, S/S of exacerbations and vaccine education.
    - Assessment/skilled observation of disease process, respiratory and cardiac functions.
    - Additional orders: (free text)
    - Anticoagulant therapy mgmt.:
        - Anticoagulant: (name, dose, frequency)
        - PT/INR: (frequency)
    - COVID 19 Comorbidities concerns: (Select all applicable)
        - HTN
        - CAD
        - DM
        - Lung Disease: COPD, Asthma, Obstructive Sleep Apnea
        - Kidney/Liver Disease:
        - Malignancy
        - Pregnancy
        - Tobacco Use
        - Obesity
        - Immunocompromised: oncology, transplant, immunosuppressive medications
        - HIV
        - Asplenia
        - Hemoglobinopathies
        - Other:
        - Social Determinants of Health

- PT
    - Eval and treat related to:
    - Special Precautions:
- OT
    - Eval and treat related to:

- Special Precautions:
  - ST
    - Eval and treat related to:
    - Special Precautions:
  - MSW
    - Evaluation/support related to:
  - HHA
    - Personal Care
- Discharge Planning
  - Discharge when goals are met or pt. no longer meets criteria for Home Health after collaboration with provider
  - Discharge plan includes post discharge support from Care Coordination: (provide area contact)

Remote Patient Monitoring in Home Health

- Remote patient monitoring (RPM) done in a home health (HH) episode is part of the HH care and therefore included in the HH episode of care
- Different HH's may use a variety of RPM solutions, but the basic use is the technology allows the patient to download their biometric measurements to be monitored into the technology via an app. on their smart device or on a provided tablet.
- Appropriate peripherals to measure the biometrics are generally provided or current ones the patient has are used to gain the biometric measurements. Some may be Bluetooth enabled depending on the RPM solution used.
- Generally, a telehealth nurse monitors a dashboard to discern if a patient is stable or declining and if declining, is it outside of set parameters. If it is outside of parameters, an escalation process ensues to triage the patient and move them to the next most appropriate level of care.
- The escalation process is defined for COVID + patients and O2 saturation parameters are pre-set by the PCP.
- While in HH, the HH should monitor the patient and escalate them as needed, and keep the PCP apprised of the patient's status at appropriate intervals.
- Once stable, goals met and ready for discharge, there should be a warm handoff back to CC or the PCP.
- The patients in a HH episode being monitored in this program would fit into either Tier 2 (COVID +) patients, or Tier 3 (At risk patients for COVID-19)
  COVID-19 O2 solutions with RPM table below:

Tier 1	**Remote Patient Monitoring**	
	• COVID +, or PUI, mildly or asymptomatic, minor oxygen needs • From ED, physician practice or hospital • Remote patient monitoring only, utilizing technology to monitor symptoms daily, escalate declining patients • CSHAH offers our RPM technology	
Tier 2	**Home Health and Remote Patient Monitoring**	
	• RPM + a Home health episode is required • COVID (+) but stable that could be discharged if they had a destination with homebound status <4l of Oxygen • From Hospital or ED or Physician practice • Home Health to monitor, treat, and follow for the episode of care and try to prevent readmission • Early dismissal with home health support to create hospital capacity	
Tier 3	**Home Health and Remote Patient Monitoring**	
	• Moderately acute Chronic Disease Management patients to prevent acquiring COVID in a facility • From Hospital, ED or physician practice • Home Health episode with Telehealth RPM to monitor, treat, and follow for the episode of care and try to prevent readmission • Early dismissal with home health/ Telehealth RPM support for patient safety and to create hospital capacity	
Tier 4	**SNF@Home or Hospital@Home Initially, then become Home Health**	
	• Acute needs require hospital or SNF level of care but could go home with Home Health telehealth/RPM and visiting physician/APP oversight • From Hospital or ED • Hospital at Home /SNF at Home that requires: MD or APP oversight and visits, QD Home health visits, tele-monitoring with Bluetooth peripherals, needs daily case conference, needs the whole ecosystem, takes a lot of capacity up from both sides Hospital and HH, but still creates bed capacity	

Abbreviation Terms

CC- Care Coordination

DC- Discharge from HH care

Episode- can last 60 days as long at patients meet criteria

F2F- Face to Face documentation from Physician visit 60 days prior or within 30 days after the SOC for HH

H & P- History and Physical

HB- Homebound

HH- Home Health

POC- Plan of Care for the HH episode

RC- Re-certification (continuation of care) for an additional episode of HH

RPM- Remote Patient Monitoring

SN- Skilled Nursing (could be RN or LPN)

SOC- Start of Care begins the HH episode

WK- week (used in scheduling frequencies)

Evaluation Metrics

In development

Appendix:
Resource Documents

1. PE Org Structure Medical Groups with Care Coordination Contacts *
   PE Ord Structure_MedGrps with CC contacts
2. PE Org Structure Medical Groups with Home Health Contacts *
   PE Org Structure_MedGrps with HH contacts

* The Care Coordination and Home Health contact lists are living documents mapping these resources to our enterprise medical groups. This will foster more intentional dialog and partnership to support patient care. Please use this list as a contact list to reach out to patients needing services. It may be of value to reach out before the need arises to develop the processes and workflows together if not already done so. Of note, it is out recommendation that care coordination teams consider a true population health approach and work across the clinic population regardless of payer status during the pandemic (within the legal and regulatory as well as contractual boundaries).