Home Health: Not Just A Visiting Nurse

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**Presentation Objectives:**

1. Participants will understand the importance of the role of home health in the post-operative orthopedic and spine care continuum.
2. Participants will be able to recognize the members of the home health team including nurses, physical therapists, occupational therapists, speech language pathologists, medical social workers and home health aides.
3. Participants will be able to identify the primary functions of a home health assessment including medication management, pain management, home safety, caregiver training, equipment needs and overall functional mobility.
DEFINITION OF HOME HEALTH:

• According to The Alliance for Home Health Quality and Innovation:

“At its basic level, ‘home health care’ means exactly what it sounds like – medical care provided in a patient's home. Home health care can include broad care given by skilled medical professionals, including skilled nursing care, physical therapy, occupational therapy and speech therapy. Home health care can also include skilled, non-medical care, such as medical social services or assistance with daily living from a highly qualified home health aide. As the Medicare program describes, home health care is unique as a care setting not only because the care is provided in the home, but the care itself is "usually less expensive, more convenient, and just as effective" as care given in a hospital or skilled nursing facility.

Home health care improves healing, serves as a critical link between patient and physician, can better identify when a patient shows signs of deterioration, and often intervenes before a patient needs hospitalization.”
Criteria:

- Physician orders
- Medically necessary
- Skilled Care
- Intermittent
- Homebound Criteria
- Covered by most insurance
Roles in Home Health (some general examples):

RN – Comprehensive assessment of systems also including psychological and emotional evaluation, CVP monitoring, medication management, pain management, lab draws, wound care, IV administration, home safety evaluations and patient/caregiver education.

PT – Comprehensive functional assessment, medication reconciliation, pain and edema management, functional mobility (including strengthening, flexibility, bed mobility, transfer training, balance, gait training, home access and safety), DME and patient/caregiver education.

OT – Comprehensive functional assessment, training of ADL’s (activities of daily living) and IADL’s (instrumental activities of daily living), home safety, energy conservation, DME and patient/caregiver education.

SLP – Comprehensive assessment and treatment in all areas of communication, cognition and swallowing skills.

MSW - Providing emotional counseling and helping find community resources.

HHA - Assisting patients with personal hygiene such as bathing, washing hair, toileting, dressing, positioning.

RN’s, PT’s, OT’s and SLP’s can work independently in the home. MSW’s and HHA’s require a “qualifying discipline” to be out on the case in order to serve the patient in the home.
Home Health following THA/TKA/TSA

- Usually PT admit to home health unless specific nursing needs such as anticoagulant administration or lab monitoring, IV’s, multiple complicated co-morbidities.
- Federal regulation to admit within 48 hours of referral. Ortho usually within 24 hours.
- Initial admit visit typically 1-1.5 hours long and includes introduction to agency, consent, medication reconciliation, comprehensive assessment of systems, pain, edema and functional mobility. Treatment interventions can include some or a combination of: skin/incision/dressing care, pain and edema management, instruction in home safety, HEP, DME evaluation, gait and balance training, patient and caregiver education.
- Visit frequency is established based on patient’s diagnoses, functional level, help at home, pain, safety and overall health. Typically 2-3 times a week for 2-4 weeks but can vary.
Home Health following Spine Surgery

- Can be an RN or PT to admit to home health depending on patient’s needs and co-morbidities.
- Federal regulation to admit within 48 hours of referral. These patients have typically spent more days in the hospital, so 24-48 hours to admit.
- Initial admit visit typically 1-1.5 hours long and includes introduction to agency, consent, medication reconciliation, comprehensive assessment of systems, pain and functional mobility. Treatment interventions can include some or a combination of: skin and incision/dressing care, pain and management, instruction in home safety, HEP, DME evaluation, brace management, gait and balance training, patient and caregiver education. Focus is on precautions and general mobility.
- Visit frequency is established based on patient’s diagnoses, functional level, pain, safety and overall health. Typically 2-3 times a week for 2-3 weeks but can vary.
Important aspects of care:

- EDUCATION and MD expectations for 2 week follow-up
- Medication reconciliation
- Pain and edema management
- Constipation
- Wound/incision care
- Home safety/barriers
- Monitoring complications
- Physical and Functional Progression
Why Home Health?

• Short hospital length of stay
• Bridge/continuum from hospital to outpatient
• Decreased cost (we can be more “aggressive” due to patients screened well and less comorbidities)
• Financial/Transportation/Comorbidities
• Every day activities in the patient’s own home environment
• Demographic not always conducive to outpatient
How Can You Help?

- Understanding what we do. Extension of the hospital.
- Setting up patient expectations at discharge (pain management, intermittent care, short term)
- Case management: insurance authorization, patient demographics, DME
- ACCURATE AND CURRENT FINAL MEDICATION LIST
- Warm hand-off/Communication for complicated cases and coordination of care (emails and pathway)
- Patient’s perspective of a smooth transition/continuum (same info from hospital, to home health, to MD and outpatient). Give the same message.
In Conclusion:

• Not just exercises and walking
• Extension of the hospital and bridge to outpatient/community
• Patient’s perception is key – same message across the continuum

*Credit and thanks to Fred McDowell for the awesome home health inspired cartoons!*
?QUESTIONS?