THE BRIDGE PROGRAM

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Objectives

- Describe model of care most appropriate for a Bridge program from HH to Hospice
- List components for success
- Identify processes for implementation and efficiency
- Review forms and resources for a toolkit
- Work through case study to reflect the care model

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Why a Bridge Program?

- Designed to reflect changing needs of patient
- Important to provide patient-centered care to meet goals and improve patient outcomes
- The Bridge Program focuses on giving patients care choices that help them achieve their goals in the comfort of their home.

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What is the Bridge Program?

- Collaboration leading to partnership synergy where patient/family benefit
- A team approach to care that provides transition between Home Health and Hospice based on patient needs
- The patient receives a full spectrum of care throughout the changes in their course of illness

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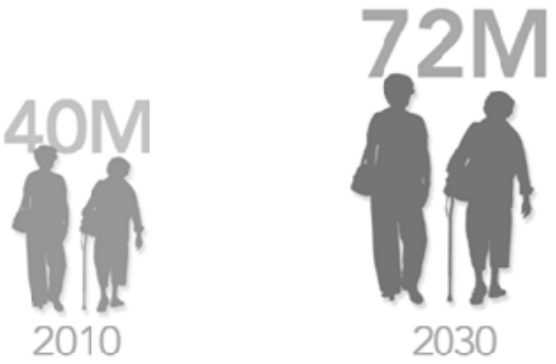
Why Bridge now?



10,000 U.S. citizens become eligible for Medicare each day. This trend is expected to continue until 2030

Reference: 2010 - U.S. Census Bureau. 2030 estimate - Administration on Aging, Dept. of Health & Human Services.

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Why a Bridge Program Now?

- ►Participating in solutions to healthcare dilemma
- ►Adding value:
  - Avoidable Hospitalizations
  - Care Coordination
  - Management of Transitions
  - Medication Reconciliation
  - Physician Engagement
  - Choosing the Optimum Site of Service

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Opportunity

Discharged from hospice due to extended prognosis

Deceased on Home Health

Hospice patients who revoked for aggressive treatment

Patients not taken under care by hospice due to aggressive treatment, refused care, not appropriate

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Benefits

- ►Provide patient-centered care
- ►Improved patient satisfaction
- ►Improved referral source satisfaction

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Program Goals

- Earlier patient identification
- Communication of patient needs
- Informed choice for both types of care
- Transitional planning
- Integrated system to provide support
- Achievement of optimal outcomes

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Core Program Components

- **Clinician and staff education**
  - Partner knowledge
  - Identification of patients
  - Tools for care transition
- **Care processes for implementation**
  - Drives efficiency
  - Performance outcome
- **Patient and family education**
  - Care Differentiation
  - Informed choice

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Basic Tenets

Getting Started

- Building the Foundation
  - Understand the basics of your partner agency
    - ✓Eligibility criteria
    - ✓Care teams
    - ✓Services provided

Getting Connected

- ►Getting to know you
- ►Branch / Program leadership
  - Sales
  - Clinical leadership
- ►Fostering trust between partners
- ►Overcome barriers and challenges
- ►Open communication channels

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Staying Connected

- ►Quarterly engagement
- ►Collaborative education and training
- ►Weekly calls
  - Tracking of patients
  - Communication with transitions

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Basics Review

Patient	Home Health	Hospice
Goal of care	✓ Rehabilitative care ✓ Treatment of disease ✓ Independent living	✓ Palliative, comfort care ✓ Treatment of symptoms, not disease ✓ Quality of life/peaceful death
Prognosis	✓ No criteria	✓ 6 month or less
Patient status	✓ Has a skilled need ✓ Homebound status required	✓ No skilled need required ✓ Usually homebound, but not required

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Transfer Types

- Home Health to Hospice
- Hospice to Home Health

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Home Health to Hospice Screening Tool

Descriptors	Indicators
Patient goal of care	Comfort care, undecided
Has the patient been hospitalized in the last 6 months?	Yes
Has the patient had any ER visits in the last 6 months?	Yes
Patient has had a recent functional decline? Falls in the last 6 months?	Yes, how many _____
Unmanageable pain > 25% of the time on current regimen?	Yes
Patient has failed rehab?	Yes

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Hospice to Home Health Screening Tool

Descriptors	Indicators
Patient Status	NTUC, Hospice Eligibility, Revocation
Skilled Need	Yes
Homebound Status	Yes
Level of Function	Improved, Increased Independence
Symptom Management	Improved
Pain Management	Consistently Managed
Patient Goal of Care	Acute/Aggressive Treatment; Curative/Rehabilitative

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The Processes

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Referral to Intake: Home Health

- Referral to HH is received
- Patient interview determines patient is more appropriate for Hospice
- Discussed with Discharge Planner and physician with order obtained
- Patient goals and choice identified and considered
- If choice is ”no” continues with HH; physician notified and communication potential bridge to Clinical Manager; patient placed on tracking log and monitored for potential need to transfer
- If choice is “yes”, coordinates with Hospice partner; admission performed if clinically eligible; care provided

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Home Health to Hospice

- RN Case Manager identifies and discusses patient status with care team and Clinical Manager
- Patient is placed on tracking log
- HH Clinical Manager to contact Hospice Clinical Manager to review case if appropriate
- HH Clinical Manager contact’s physician to obtain order
- RN CM educates patient/family on Hospice
- Patient Goals and choice identified and considered
- Patient referred to Hospice Admission Coordinator if meets criteria and patient-centered goals
- Joint team review with potential joint visit
- HH discharges patient to Hospice admission if clinically eligible

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Referral to Intake: Hospice NTUC

- Clinical consults Hospice MD and it is determined patient does not meet criteria
- Clinician notifies referral source and offers Home Health
- Clinician contacts referring MD to request verbal order for home health
- Clinician contacts home health partner to notify them of referral and provide pertinent patient data
- Patient admitted to homecare if clinically eligible

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Hospice to Home Health: Revocation

- Patient notifies of desire to revoke hospice services
- Patient is educated on options for DC plan.
- Nursing managers review case and determine if patient meets home health qualifications. (No PHI exchanged)
- Pt/Family agree to transition
- Physician is contacted for verbal order
- Referral provided to Home Health
- Need for joint patient visit determined
- Hospice completes DC
- Home Health Admits if clinically eligible

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Hospice to Home Health: Extended Prognosis

- RN determines patient is no longer demonstrating a clinical decline
- Patient is reviewed at IDG to determine continued hospice eligibility.
- Patient is educated on options for DC plan.
- Nursing managers review case and determine if patient meets home health qualifications. (No PHI exchanged)
- Pt/Family agree to transition
- Physician is contacted for verbal order
- Referral provided to Home Health
- Need for joint patient visit determined
- Hospice completes DC
- Home Health Admits if clinically eligible

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Tracking Log

- Tracking log
  - Way to identify potential patients
  - Validate eligibility
  - Early identification of payer
    - —Payer Contract/exception


GENTIVA Program / Branch _____ Month / Year: _____

BRIDGE PROGRAM TRACKING - REFERRAL LOG

Patient / MR Number	Partner Program Eligibility Date	Referral Date	Patient Name (Shared Date at Time of Referral)	Payor Source	Partner Program Patient Referred To	Info Visit Date	Joint Visit Date	Admit (Date or N/A)	Follow Up

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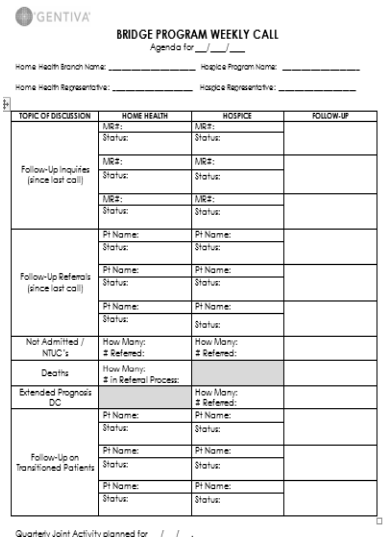
Weekly Calls

- Weekly agenda
  - New patients
  - Update on pending transfers
  - Not taken under care/non admits/deaths
  - Update on transfers completed



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BRIDGE PROGRAM WEEKLY CALL

Agenda for __/__/__

Home Health Branch Name: _____ Hospice Program Name: _____

Home Health Representative: _____ Hospice Representative: _____

TOPIC OF DISCUSSION	HOME HEALTH	HOSPICE	FOLLOW-UP
Follow-Up Inquiries (since last call)	MR#: Status:	MR#: Status:	
	MR#: Status:	MR#: Status:	
	MR#: Status:	MR#: Status:	
Follow-Up Referrals (since last call)	Pt Name: Status:	Pt Name: Status:	
	Pt Name: Status:	Pt Name: Status:	
	Pt Name: Status:	Pt Name: Status:	
Not Admitted / NTUC's	How Many: # Referred:	How Many: # Referred:	
Deaths	How Many: # in Referral Process:		
Extended Prognosis DC		How Many: # Referred:	
Follow-Up on Transitioned Patients	Pt Name: Status:	Pt Name: Status:	
	Pt Name: Status:	Pt Name: Status:	
	Pt Name: Status:	Pt Name: Status:	

Quarterly Joint Activity planned for / / .

System tracking

- Tracking Referrals
  - Received from partners
  - Sent to partners
- Reporting

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NOVA                MAINTAIN PATIENT MASTER - PAGE 1                1/17/12
JOBETT11    Office: 2091   Patient: 17955  Date entered: 11 08 11   17:54:37
Pa
La
Fi   Select   Referral Source Code
At      _     85 Received from Branch-Phone
Ad      _     86 Received from Branch-Fax
Ad      _     87 Hospice - Gentiva
Ci      _     88 ECIN Referrals
Ph      _     90 CCX/ATS Upload
Un                                                        Bottom
Se   F3=Exit                                                      6
Re
Patient Status.............. 30        Anticipated SOC: 0/00/00   Source: 87
Primary Referral #1........ 0000019537 DETURRIS STANLEY
Referral Source #2......... 0000000000
Referral Source #3......... 0000000000
Referred Date/Time......... 11/08/11  3:45 P Office Called.: 0/00/00  0:00 _
Accept/Reject Date/Time.... 0/00/00  0:00 _ Planner Called: 0/00/00  0:00 _
Memos:  F2F 10282011
F1=Help   F2=Search   F3=Exit   F4=ICD9's   F5=Hos/Doc   F6=Print   F7=Pat/Pyr
Press enter to process.
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The Home Health Conversation…

- "I've noticed that your symptoms are better recently"
- " You have mentioned wanting to seek X (advanced treatment)"
- "Do you think you would be able to walk better if you received services from a Physical Therapist?"
- "Do you think you can be more independent with bathing if you received services from an Occupational Therapist?"

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The Hospice Conversation…

- "What changes have you seen with your illness over the last few weeks/months?"
- "Do you feel you are making as much progress as we did when you first started Home Health?"
- "Besides helping you be more comfortable physically, we also offer emotional and spiritual support. And we support your loved one. Do you feel that you or your loved one could benefit from this type of support?"

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Success Factors

- ►There is a champion
- ►Talk with partner constructively about any issues
- ►Consistently questioned at team conferences
  - When patient is not making progress
  - Uncontrolled symptoms
- ►We have a relationship
- ►Ongoing efforts

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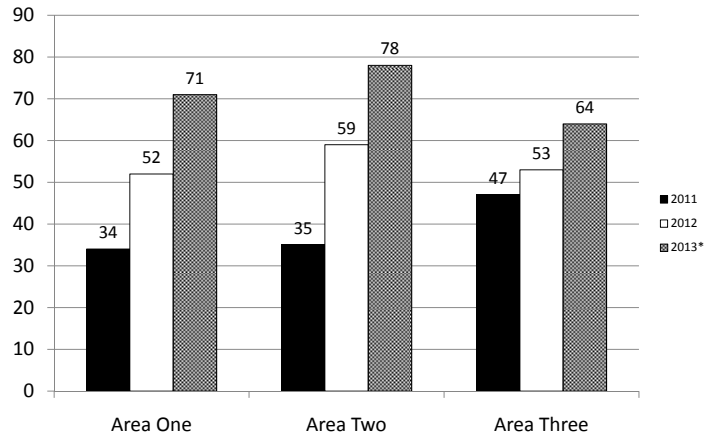
Results: Home Health to Hospice



*2013 annualized

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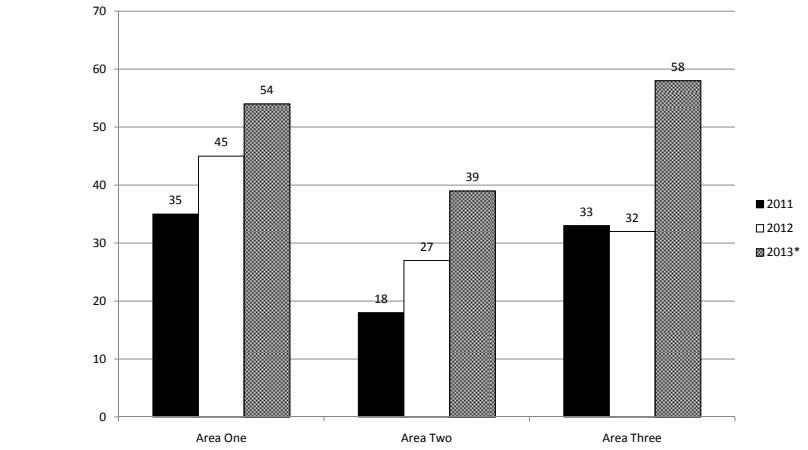
Results: Hospice to Home Health



*2013 annualized

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Case Study 1

- 72 y/o female with history of diabetes, hypertension, and stroke 6 months ago
- Dysphagia with frequent choking and BMI of 23
- Hospitalized for aspiration pneumonia 3 months ago
- Patient displays right sided weakness
- Patient is able to ambulate with a walker, yet has difficulty transferring and performing ADL's by herself
- Lives alone, limited family support
- Patient has goal of being independent with ADL's and ambulation

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Case Study 2

- 76 y/o male with COPD that has shown a decline in the last several weeks
- He has a history of multiple hospitalizations in the last 6 months, CHF, dependent edema, hypertension
- On O2 per nasal cannula continuously
- Dyspnea at rest
- Mainly sits due to poor functional activity tolerance
- Optimally treated with diuretics
- Current treatment plan has been changed but no improvement
- Patient and family stress has increased as the effectiveness of disease management has decreased
- Patient's goal is to be cared for at home

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Outcomes

- Improved patient and caregiver well-being
- Improved patient and family satisfaction
- Earlier identification of patients changing needs
- More effective hospital partnerships
- Decreased hospital re-admissions

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Considerations

- Care processes…
  - Provide structural integrity
- Care conferences…
  - Promote the right care at the right time
- Care coordination…
  - Helps meet the patient and families needs
- Care consistency…
  - Provides comfort
- Optimal clinical outcomes

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Summary

- Model of care most appropriate for a Bridge program from HH to Hospice
- Program components for success
- Efficient processes for implementation and optimal outcome performance
- Toolkit of forms and resources

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Questions ?