Home Health

Aurora Health at Home

Advocate Health at Home

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Home Health: Promoting Independence

- Improve function
- Live with greater independence
- Assist the patient to remain at home
- Avoid hospitalization or admission to long-term care institutions

Home Health 101

What?	Skilled care for the purpose of treating or managing an illness, injury or medical condition
Who?	Skilled nursing, physical therapy, occupational therapy, & speech therapy Non-medical services such as social services or CNAs for assistance with daily living can be added but cannot stand alone
Where?	Patient's residence (e.g. private home, adult foster home, ALF) *Not able to provide care in SNFs (duplication of services)*

Home Health 2.0: *Virtual Monitoring*

Tier 1

- Patient outreach calls

Tier 2

- Patient uses their own devices (e.g. smart phone) to upload vitals into a centralized electronic health data entry program

Tier 3

- Blue tooth enabled biometric devices that are supplied & funded through the agency

Criteria for Insurance Coverage

(1) **Skilled Care**

- Home health care only provides *medically necessary skilled services*
- It does not provide unskilled services or daily necessities such as cooking, cleaning, bathing, & transportation.

(2) Patients must be **Homebound**

Homebound

1. Criteria-One

The patient must either:

- Because of illness or injury, need the aid of supportive devices such as crutches, canes, wheelchairs, & walkers; the use of special transportation; or the assistance of another person in order to leave their place of residence **OR**
- Have a condition such that leaving his or her home is medically contraindicated.

If the patient meets one of the Criteria-One conditions, then the patient must ALSO meet two additional requirements defined in Criteria-Two below.

2. Criteria-Two

- There must exist a normal inability to leave home; **AND**
- Leaving home must require a considerable & taxing effort

However

Absences from home for the **purpose of receiving medical treatment** (regardless of the frequency) are appropriate & do not affect home bound status.

Examples:

- Outpatient Dialysis
- Chemotherapy/Radiation therapy
- Outpatient wound clinic

** Attendance at licensed adult daycare is also allowed

Common Referral Diagnoses

- Chronic disease management (HF, COPD, DM)
- Medication education
- Recovery from illness or surgery
- Skilled procedures such as wound care, infusion, etc.
- Therapy needs & unable to attend outpatient

Home Health Management

- **SN:**
  - GOC discu
  - **CHF/COP** assessmer componen
  - **A fib:** coo
  - **DM:** Asses s & monitor

Case Study

82-year-old male who lives alone at home
Past Medical History: COPD on home oxygen 2 L, chronic systolic heart failure, lumbar spinal stenosis, diabetes type 2 without long-term use of insulin, CKD stage III, atrial fibrillation on long-term coumadin use, hypertension, fall while getting his mail on the driveway

Admitted to SNF for rehabilitation and ongoing medical management

pulmonary education lance

- **PT:** gait training, mobility/ROM HEP **s/p ORIF**; home safety evaluation to prevent future falls (e.g. equipment/environmental modifications)
- **OT:** ADLs **s/p ORIF**; energy conservation **COPD;** cognition (@ risk for hospital-induced delirium)
- **Home Health Aide**
- **Social Work:** community resources to maintain independence
- All team members address oxygen safety - **COPD**

COVID Specific Programs

Hospital site must have a COVID Index Score in the red zone
Program available Monday–Friday

Home Hospital

- *Patient Criteria:*
  - Have exertional Sp02 90-92% on room air AND
  - Are well-appearing AND
  - Have no COVID high-risk factors AND
  - Remains stable - SpO2 93% or greater on ≤2L O2 NC after 4 hours in ED
- *Program Description:*
  - APC virtual visit same day of discharge, then daily x 3-5 days
  - Home oxygen
  - Virtual monitoring equipment including pulse oximetry
  - Home health admit within 24 hours & daily visits x 3-5 days
    - RN home visits front-loaded for 2 weeks then tapered according to patient need with a transition back to PCP

COVID Specific Programs

Hospital site must have a COVID Index Score in the red zone
Program available Monday–Friday

Recovery at Home

- *Patient Criteria:*
  - Have exertional SpO2 93-94% on room air AND
  - Are well-appearing AND have respirations under 22 breaths/minute
  - Remains stable for 2-3 hours

  OR
  - Have exertional SpO2 ≥ 95% on room air but has limited support, mild cognitive impairment, or other chronic conditions
- *Program Description:*
  - Patient provided pulse ox at discharge - instructed to check 4 x day & to call care team if reading is < 93%
  - APC virtual visit next day & daily x 3 days
  - Home health admit within 48 hours, visits front-loaded for 1 week then tapered according to patient need with a transition back to PCP

Provider FAQ

Who can perform the required Face-to-Face encounter?

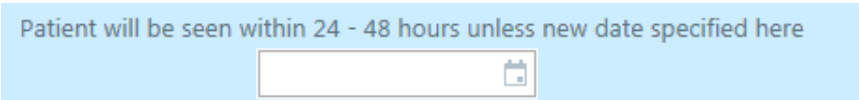
- To certify eligibility for the home health benefit Face-to-Face (F2F) encounters with patients are required.
  - The certifying physician
  - The physician who cared for the patient in an acute or post-acute care facility (from which the patient was directly admitted to home health)
  - A nurse practitioner, clinical nurse specialist, certified nurse-midwife or physician assistant who is working in collaboration with the certifying physician or the acute/post-acute care physician

Provider FAQ

My patient is high-risk for readmission. How can I ensure they get seen in a timely manner?

- Home health is a great strategy to try to prevent readmissions. We know that most readmissions occur within the first 7 days after discharge. Home health clinicians can bridge the gap between discharge & their first appointment with you & partner with providers to provide the education & support needed for the patient to meet their goals.

- When using the HOME CARE SERVICES Order Set, enter the next calendar date in this field



Provider FAQ

Who can sign home health orders?

- In addition to physicians, the CARES Act in 2020 permanently authorizes physician assistants (PAs) & nurse practitioners (NPs) to order home healthcare services for Medicare patients (in a manner consistent with state law)
  - WI & IL: Plans of care can be established by a physician, an advanced practice nurse prescriber, or a physician assistant
- The comprehensive Plan of Care provides orders for a certification period = 60 days.

Provider FAQ

- **What is a recertification & how long can home care last?**
  - Within 5 days of the end of the initial 60-day certification period, the home health clinician will assess progress towards goals & collaborate with the provider on whether to recertify the patient for a subsequent 60-day certification period.
  - If recertified, the clinician will conduct another comprehensive assessment, update the Plan of Care & send for signature.
  - Medicare does not limit the number of continuous 60-day recertification periods for patients who continue to be eligible:
    - Skilled care
    - Homebound

Provider FAQ

What is a ROC?

- In the event your patient is admitted to the hospital (for a minimum of 24 hours), the home health clinician will complete a Transfer & the patients home health services are on hold.

- When the patient is discharged & home health is re-ordered, the home health clinician will complete a new comprehensive assessment called a Resumption of Care or ROC.

COVID-19 UPDATE

AdvocateAuroraHealth

Home Hospital

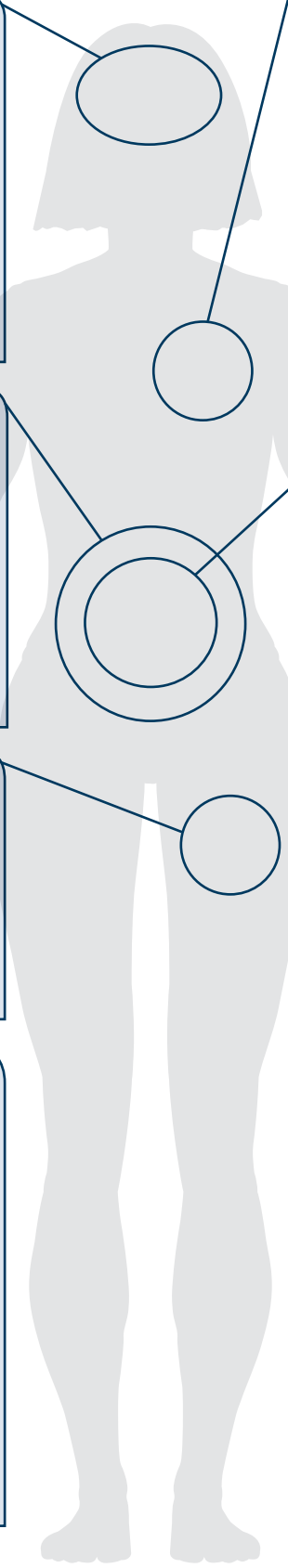
Hospital site must have a COVID Index Score in the red zone
Program available Monday – Friday
Illinois, South and Central Wisconsin Emergency Department and Observation Only
North Wisconsin Emergency Department, Observation and Inpatient
Patient must be in-network for Advocate Aurora at Home
Patient must have a physician to manage care after discharge from the program
Adult patients (not available for pediatrics and or maternity patients)

	Recovery at Home Pathway (Without oxygen)	Home Hospital Pathway (With oxygen)
Patient Criteria COVID 19	• Exertional RA SpO2 93-94% AND • Patient well-appearing AND RR<22 • Patient remain stable after 2-3 hours in ED OR • Exertional SpO2≥95%, but patient has limited support, mild cognitive impairment, or other chronic conditions	• Exertional RA SpO2 90-92% AND • Patient well-appearing AND • No uncontrolled COVID high-risk factors • Patient remains stable -SpO2 93% or greater on ≤2L O2 NC after 4 hours in ED • ***Requires 4-hour TAT for oxygen delivery. Patient to leave hospital between 6 a.m. – 3 p.m. for connection to virtual monitoring and APC same day virtual visit.***
Notes Regarding O2 levels and Oxygen	• **Exertional SpO2 - one-minute sit-to-stand test -** please have the amount of oxygen or RA documented along with the Sp02 results when the sit to stand is performed • Medicare and most commercial insurances waive need to qualify pts for home oxygen • **For pts whose SpO2 is fluctuating between 90-94% please order Home Hospital**	
Program Description	• Patient provided pulse ox at discharge and instructed to check SpO2 four times daily and to call care team if reading is less than 93% • APC virtual visit next day and daily x 3 days • Home health nursing visits based on patient need • Patients followed 5-7 days; visits tapered according to patient need; transition back to PCP	• Patients are discharged home with oxygen tanks from respiratory therapy • Oxygen concentrator and virtual monitoring equipment with pulse ox will be delivered to the home. • Same day APC virtual visit* then daily x 3-5 days • Next-day home health nursing visit then daily x 3-5 days • Patients followed 7-10 days; visits tapered according to patient need; transition back to PCP
Ordering Services	• **Program is available Monday – Friday** • See Epic *Tip Sheet for Ordering Home Hospital/Recovery at Home* • Clinical staff should work with home care liaisons assure timely coordination of services. • Waiver allows for any COVID patient to be consider homebound and qualify for home health services	

For more information, contact your AAH Home Health Liaisons
Home Hospital Patient Flyer, Patient Education: COVID-19 Symptoms, Action Plan and Tip Sheets for entering Orders can be found on the sharepoint site
Hospital Resources for Home Hospital

Anatomy of a home health referral

How to identify home health care needs head to toe



Neurological indicators

1. Newly diagnosed CVA/TIA
2. S/P Neurosurgery
3. Management of chronic neurological illness (i.e., MS, Parkinson's Disease, ALS)
4. Altered mental status and dementia
5. Comprehension lacking in how to manage illness
6. Therapy i.e., ST, OT, PT
7. Complications of oncology diagnosis

Gastroenterology indicators

1. S/P any abdominal surgeries with incisional, wound or drain care
2. New on enteral or total parenteral nutrition
3. Diabetic management
4. Ostomy care management
5. Complications of oncology diagnosis
6. Transplant management
7. Electrolyte and fluid management

Musculoskeletal indicators

1. S/P joint replacement, amputation of a limb
2. Muscle debility or gait abnormalities; new use of walker or other assistive device
3. Ulcers or open wounds
4. Therapy i.e., ST, OT, PT
5. Complications of oncology diagnosis

Infusion therapy indicators: Highly dependent on payer source

1. Central venous access device management (i.e., peripherally inserted central catheter (PICC), tunneled catheter, implanted port)
2. IV therapy management
   - Antibiotics
   - Hydration
   - Pain
   - TPN
   - Chemotherapy
   - Inotrope
   - Electrolyte management
   - Immuno globulin
   - Other specialty infusion

Cardiopulmonary indicators

1. Anti-coagulation management
2. Newly diagnosed or exacerbated heart failure or COPD
3. S/P pneumonia, bronchiolitis, asthma, new trach patient
4. New on oxygen, nebulizer or suction therapy
5. S/P thoracentesis, lobectomy, chest tubes
6. S/P CABG, AVR, MVR, transplant management
7. LVAD management
8. Pleural catheter management
9. Complications of oncology diagnosis

Gynecology/urology indicators

1. S/P TURP
2. Foley or suprapubic catheter in place
3. New urostomy patient
4. S/P mastectomy with JP drain care
5. S/P TAH
6. Complications of renal failure
7. Complications of oncology diagnosis
8. Transplant management

Medical management indicators

1. Frequent ER visits, re-hospitalizations, and/or falls
2. Comorbid disease exacerbation with need for clinical intervention and monitoring
3. Medication reconciliation
   - Six or more medications prescribed at discharge
   - New medications or changing doses of medications
4. Wound vac management
5. Pyschosocial assessment, management, and referrals
   - Recent loss
   - Age 65 or above, and living alone
   - Caregiver abilities and burden of care assessment (capable, willing, and available)

To make a referral or for more information, call **1-800-862-2201** or contact an Aurora Health at Home representative.

Aurora Health Care
Health at Home

We are AdvocateAuroraHealth

59-8170

12/19 MC 0910

Physician Guide to Ordering Post-Acute, Hospice, and Home Care Services in Epic

Approved by Inpatient, Post-Acute, Physician and HIT Leadership; OCTOBER 10, 2019

Written by: Post-Acute Clinical Informaticists

October 2019

Created by: Post-Acute Informatics Nurse Specialists

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October 2019

AdvocateAuroraHealth

Post-Acute Services

Ctrl/click on the Service desired below

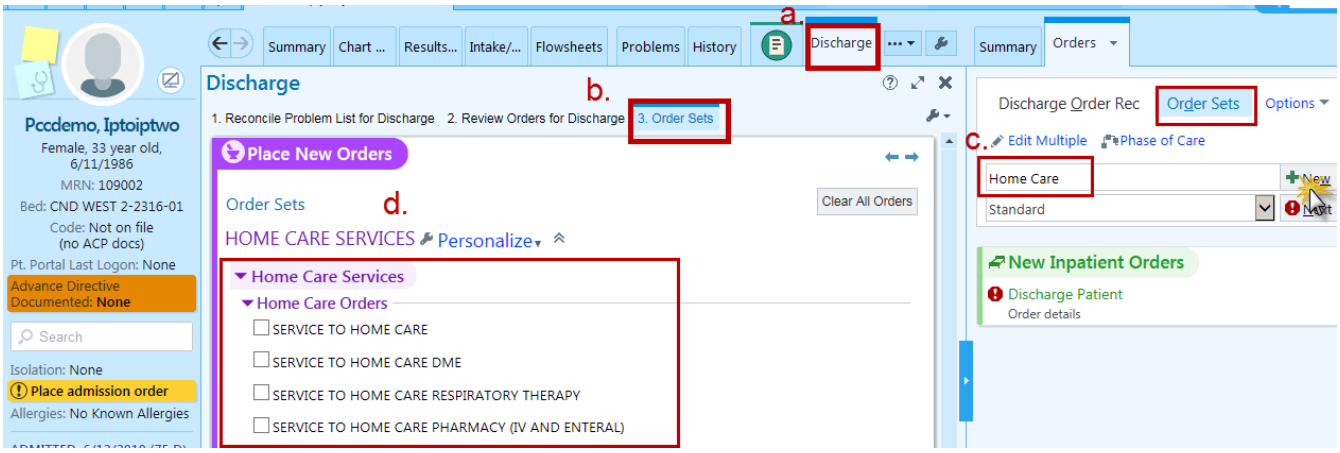
How to access Home Care Services Order Set

Hospital Providers

If you are ordering homecare, inpatient hospice, or other post-acute services while your patient is still hospitalized:

a. Go to DISCHARGE tab then, DISCHARGE ORDERS in left side navigator
b. Click ORDER SETS
c. Enter "Home" in Order Set search field to locate the Home Care Services Order Set. Open Order Set
d. Select the appropriate Home Care Service desired.

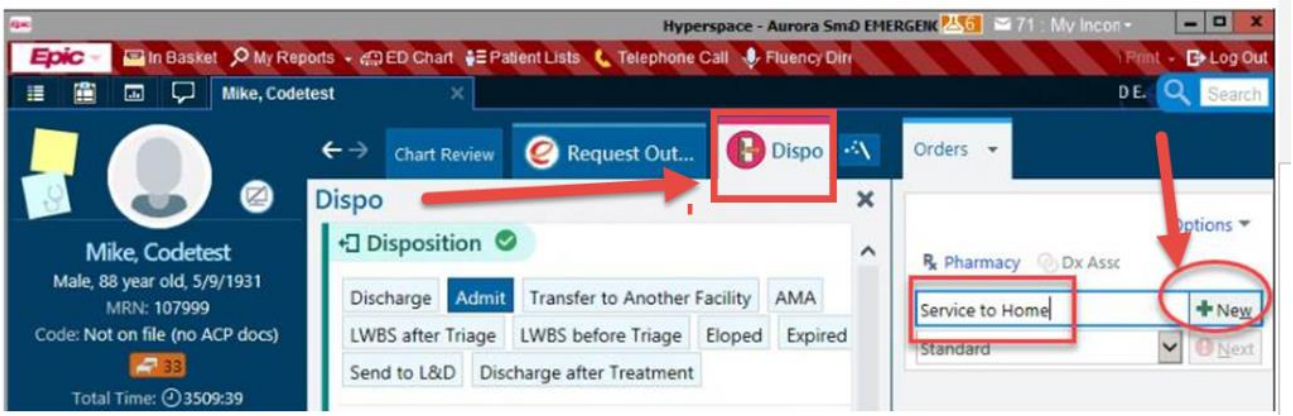
If you are not discharging the patient home on the same day you are entering this order, remove the "Discharge Patient" order (that auto displays) by clicking the x.



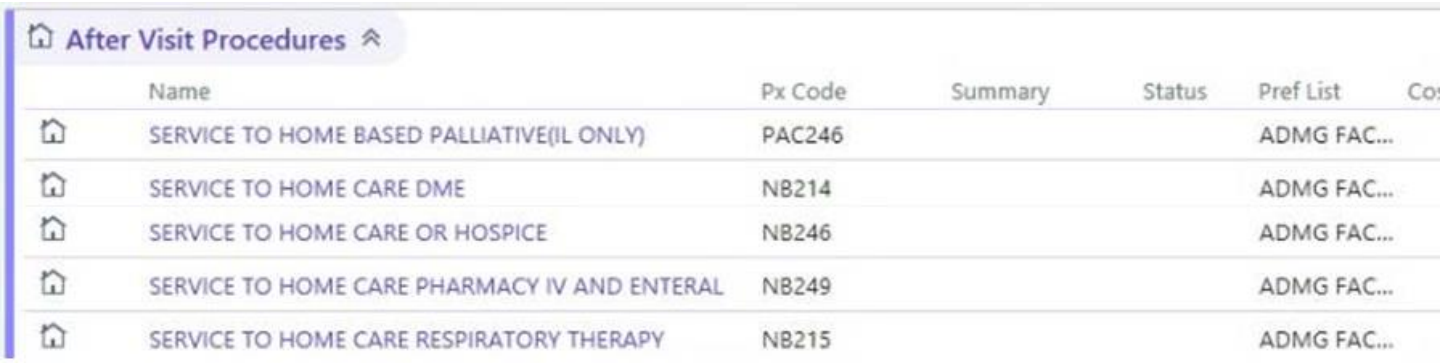
ED Providers

If you are ordering homecare, inpatient hospice or other post- acute services *(services to take place after your patient is discharged from the ED setting)* while your patient is still in the ED:

a. Go to DISPO navigator
b. Click on New Order in Prescriptions and Orders section. Enter Service to Home



c. Select the Service to order for the desired Post-Acute need



Ambulatory Providers

1. For a CLINIC patient - If you are ordering homecare or other post- acute services while your patient is at a clinic visit

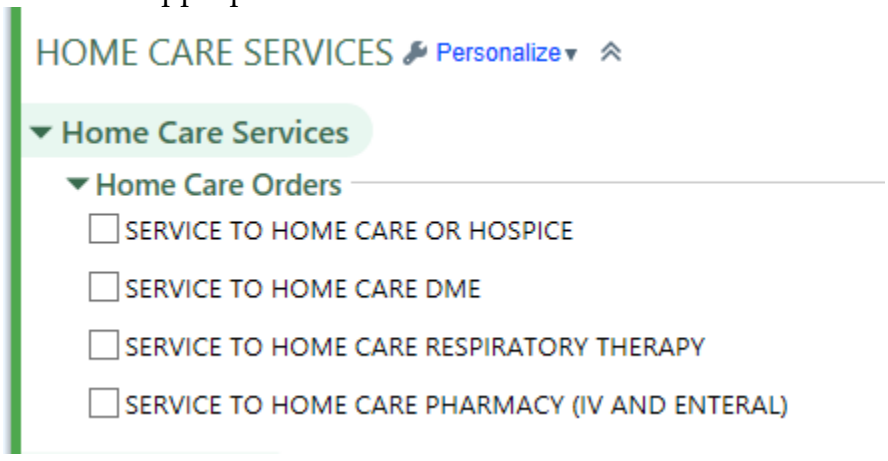
a. Once in your Visit encounter, click on the 

icon toward the top of your screen.

b. Enter "Home" in Order Set search field to locate the Home Care Services Order Set.

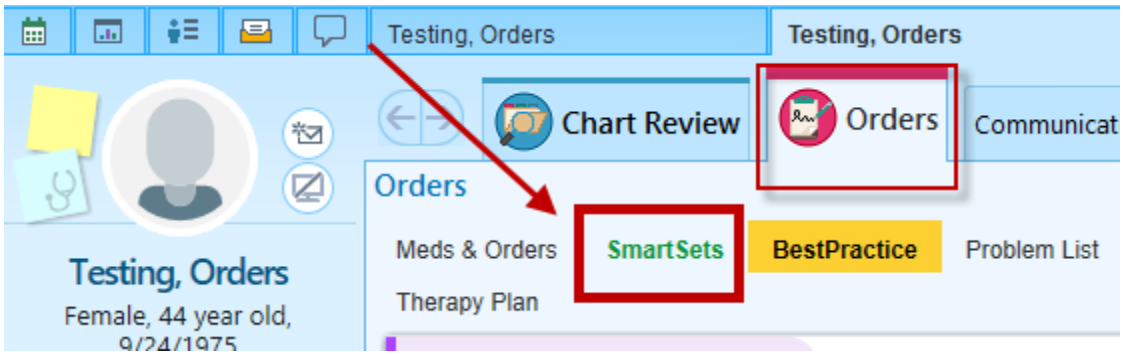
c. Right Click and make this a Favorite so it always displays when you click on SmartSets in the future for any patient!

d. Select the appropriate Home Care Service desired.



2. NON-CLINIC patient - If you are ordering homecare or other post- acute services and your patient is not currently in a visit

a. Open an Orders only encounter (do not use telephone encounter)



b. Enter "Home" in SmartSet search field to locate the Home Care Services Order Set.

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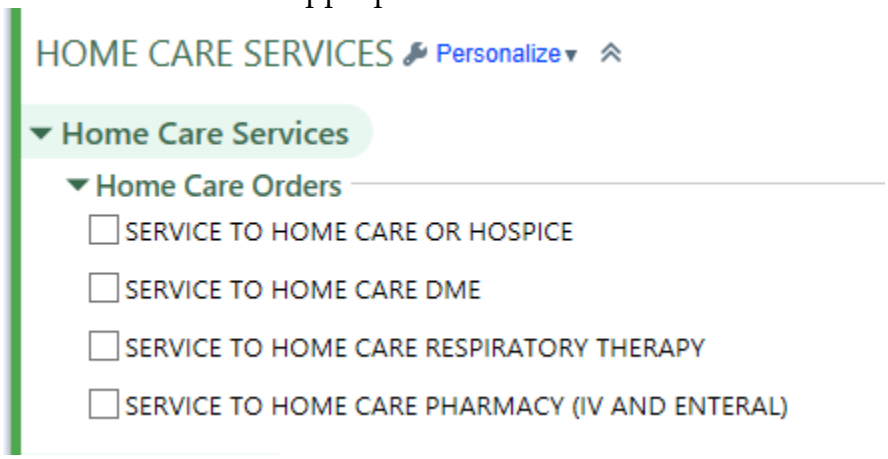
a. Select the appropriate Home Care Service desired.



Service to Home Health Nursing/Therapy

"Service to" Order Entry Steps

I. Locate the Home Care Services Order Set

II. Select Service to Homecare or Hospice box

- Click on the blue hyperlink to open the order composer to enter specific order details

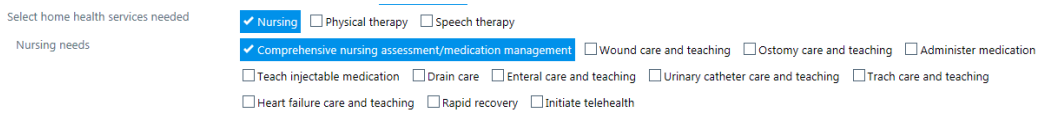
III. Enter Home Care details

a. *Select Home Health button*

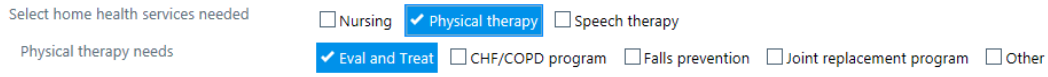
b. *Select the Discipine needed* (Nursing /Physical Therapy/ Nursing)

✓ For each discipline selected, you can further define orders by clicking on the specific category of services needed.

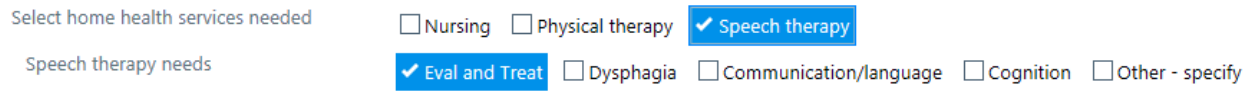
Nursing :



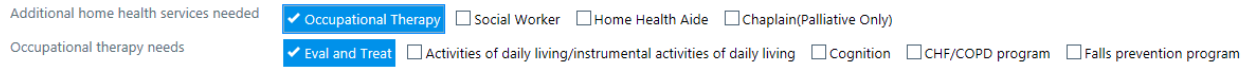
Physical Therapy:



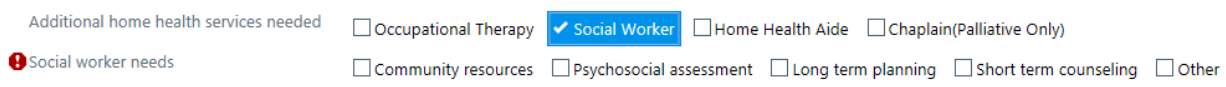
Speech Therapy:



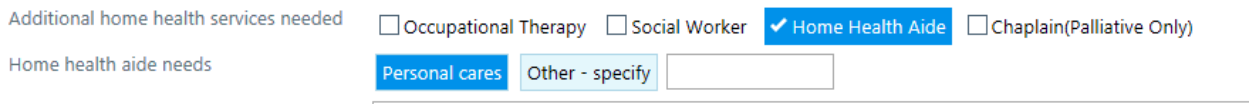
Occupational Therapy:



Social Worker:

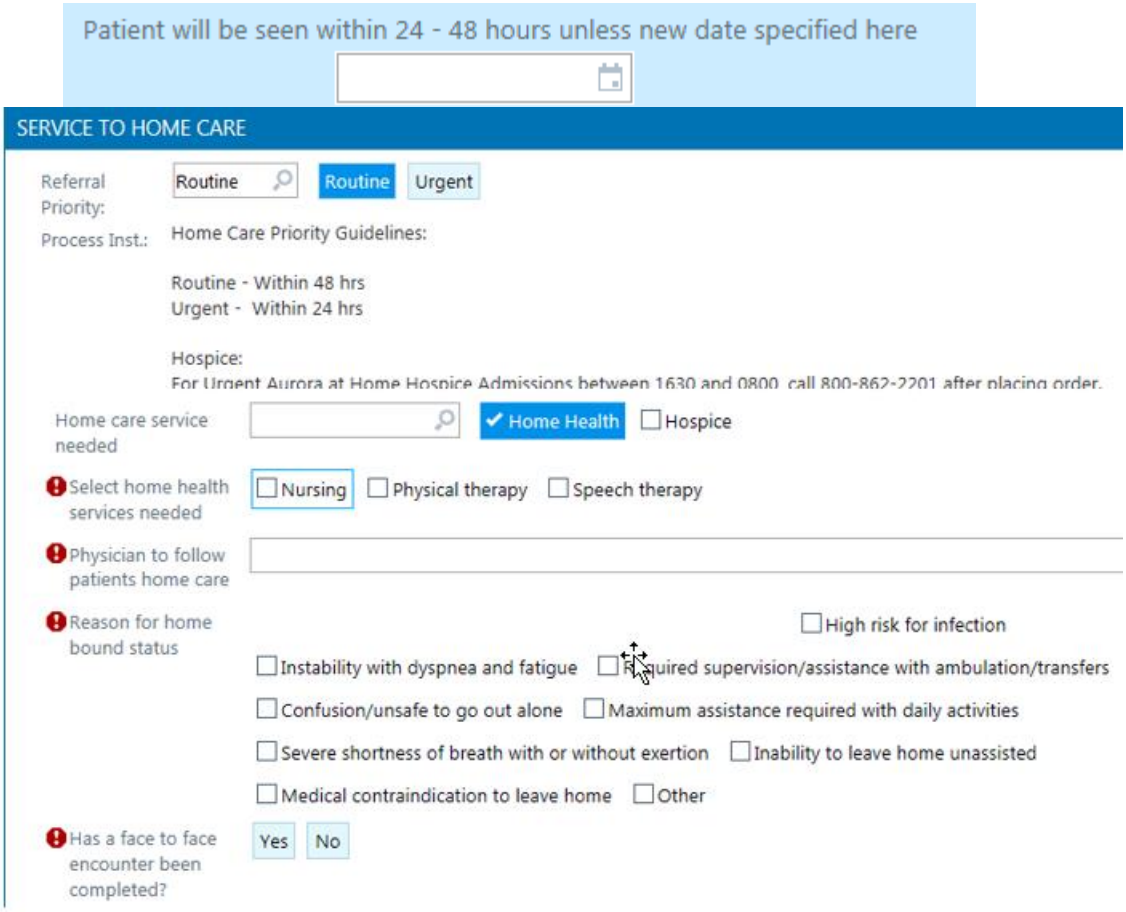


Home Health Aide:



c. *The REQUIREMENTS for all HomeCare Orders have red stops signs: You will enter :*

- name of the physican who will be following and signing orders for the Home Health Plan of Care
- reason patient is homebound – this should be reflected in your narrative visit note as well
- face to face encounter date is the date of hospital visit with patient
- the patient will be seen within 48 hrs of referral or discharge date from hospital. If you want the patient to be seen on a *different* date, enter that specific date in this field

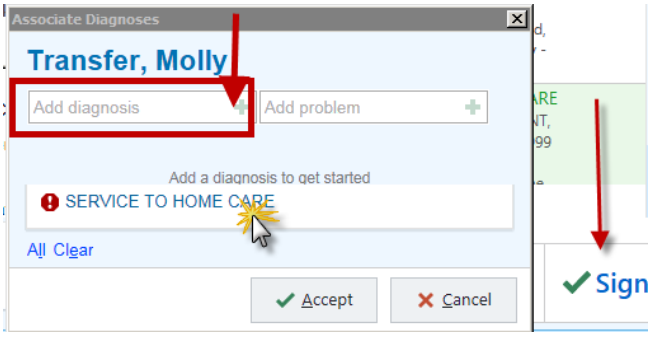


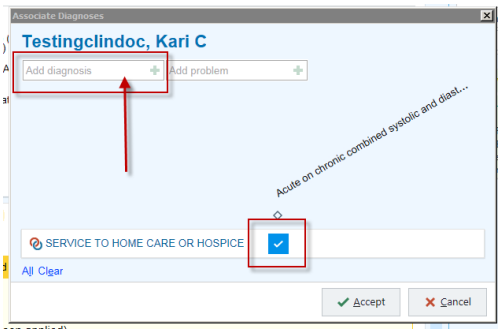
***If you are not discharging the patient home on the same day you are entering this order, remove the order. To do so, hover over the "Discharge Patient" order (it auto populates in the ordering window to the far right of your screen) and click the red x.**

IV. Click SIGN

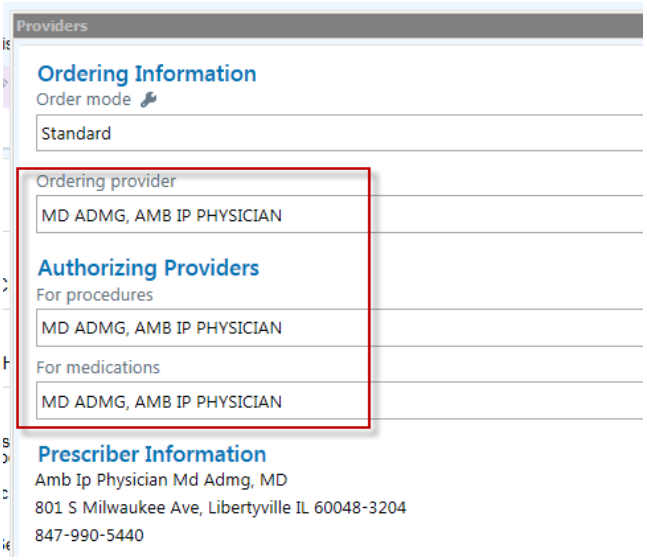
a. Enter each diagnosis associated with the Service to Homecare Order as well as the diagnosis associated with each medication and lab ordered.

b. Click on the order link, then enter dx. *(CMS requires that the diagnosis associated with the order support the reason the order is being placed. The supportive documentation should also be in your encounter narrative)*





c. If you are a non-physician provider, enter the appropriate order mode and enter the name of the ordering provider



d. When writing your progress note you can pull in all of the order details by using the SmartPhrase ".homecare"

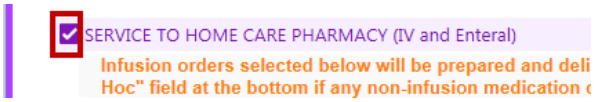
Service to Home Care Infusion and Enteral

"Service to" Order Entry Steps

I. Locate the Home Care Services Order Set (Inpatient) or Smart Set (Ambulatory)

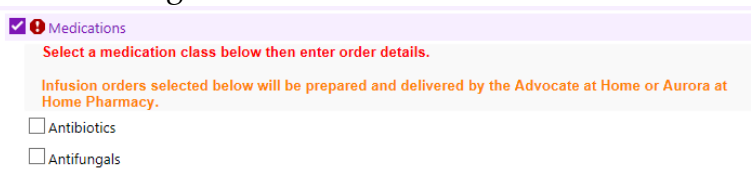
II. SELECT Service to Homecare Pharmacy (IV and Enteral) box

- All infusions orderd here will be prepared and delivered by Aurora/Advocate at Home Pharmacy to the patient's home.

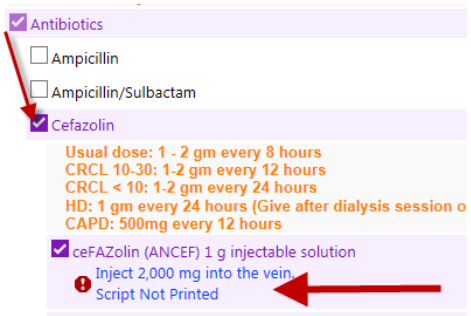


III. Enter Medication Specific details **(If medication infusion needed; if only enteral needed, skip to IV))**

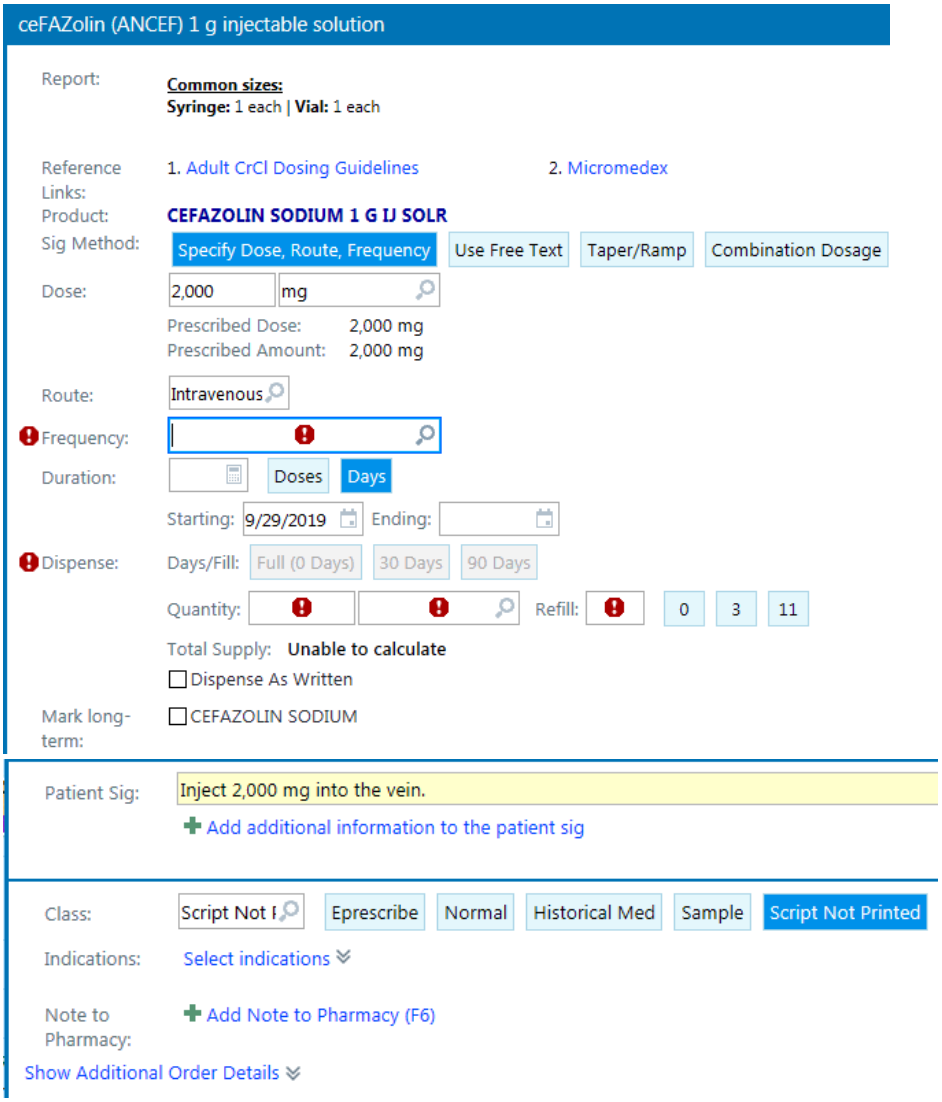
a. Click on Drug Class



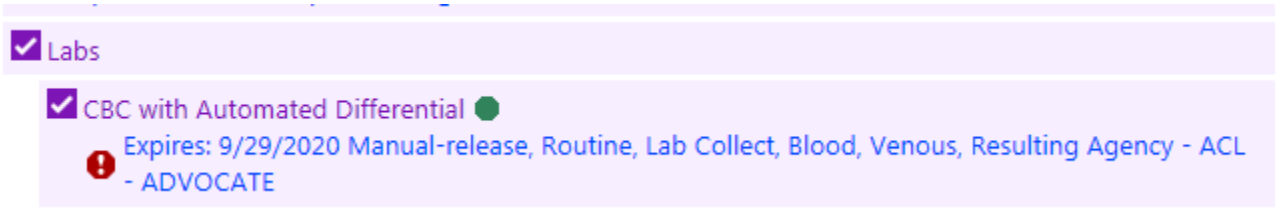
b. Select Medication, then click on blue hyperlink to enter route, dosage, details

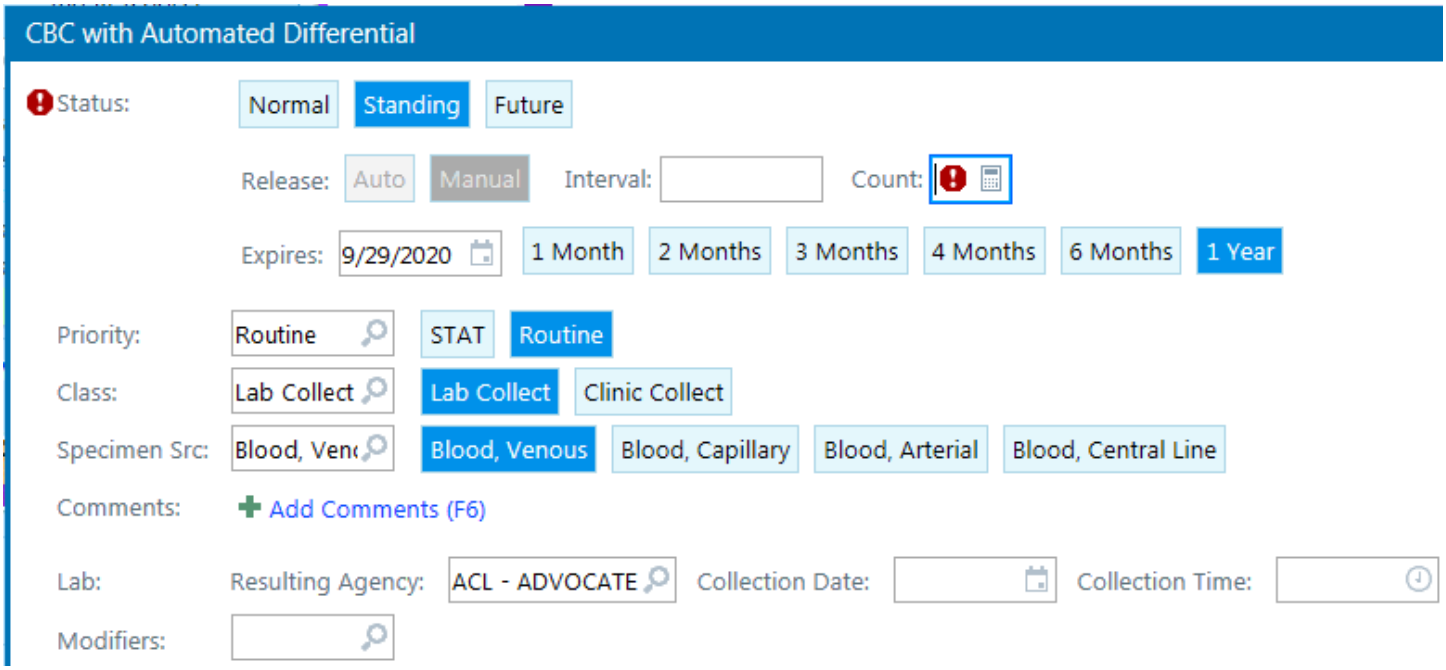


c. Enter Medication details specific to homecare dosing, route, dispense details. (Note! this script will NOT print. It is sent directly to the Advocate/Aurora at Home Referral WQ for processing by Advocate /Aurora HomeCare Pharmacy * unless user selects "other agency" – see step IV.



d. Enter lab orders. Click on blue hyperlink for each lab associated with the specific infusion ordered. This enters the lab order in Epic. Indicate the start date you want the labs to be drawn in the Comments field.

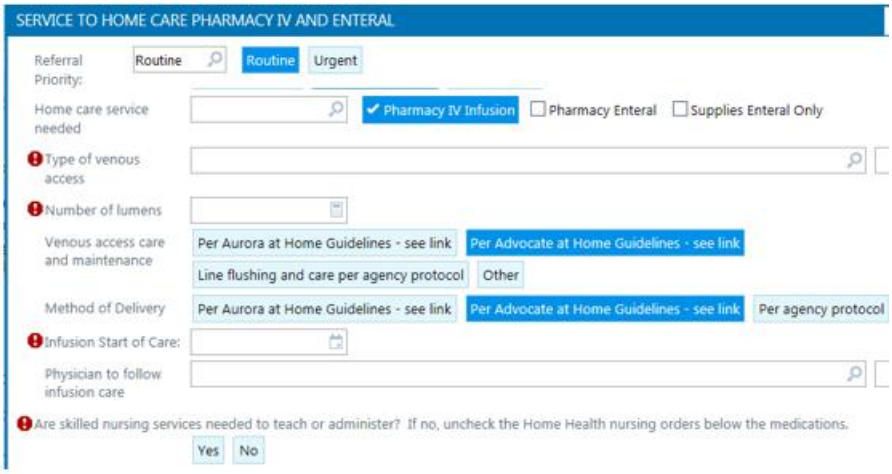




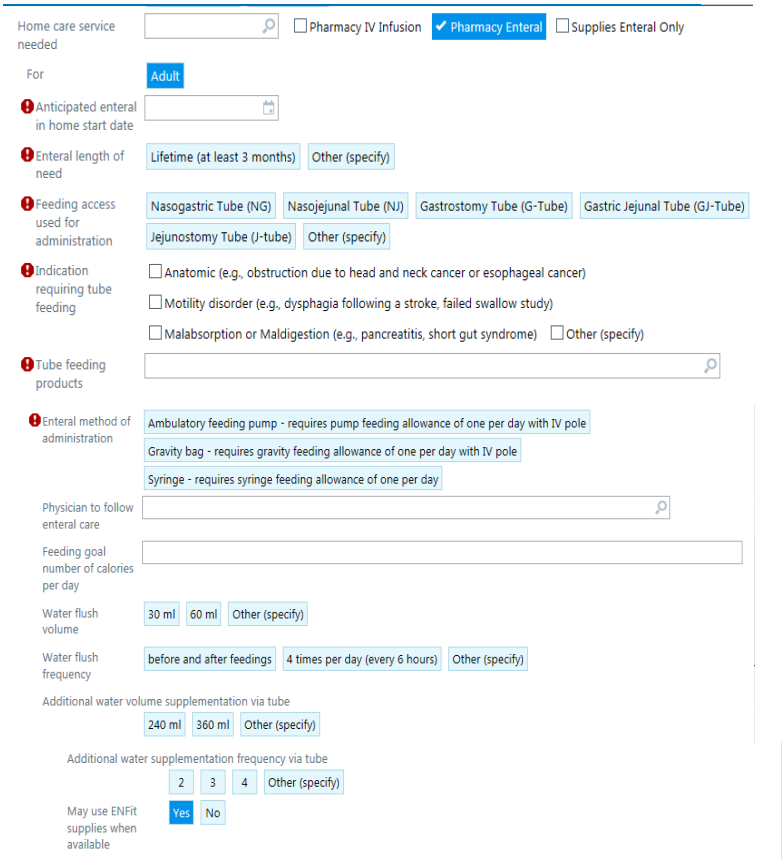
IV. Enter Home Care details

e. *Select Pharmacy IV Infusion or Pharmacy Enteral* to enter specific order details

- *Enter Pharmacy **IV** details*

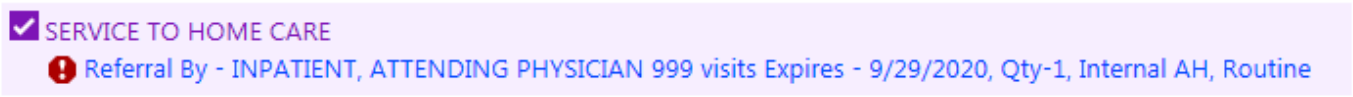


- *Enter Pharmacy **Enteral** details if Enteral product /services needed.*

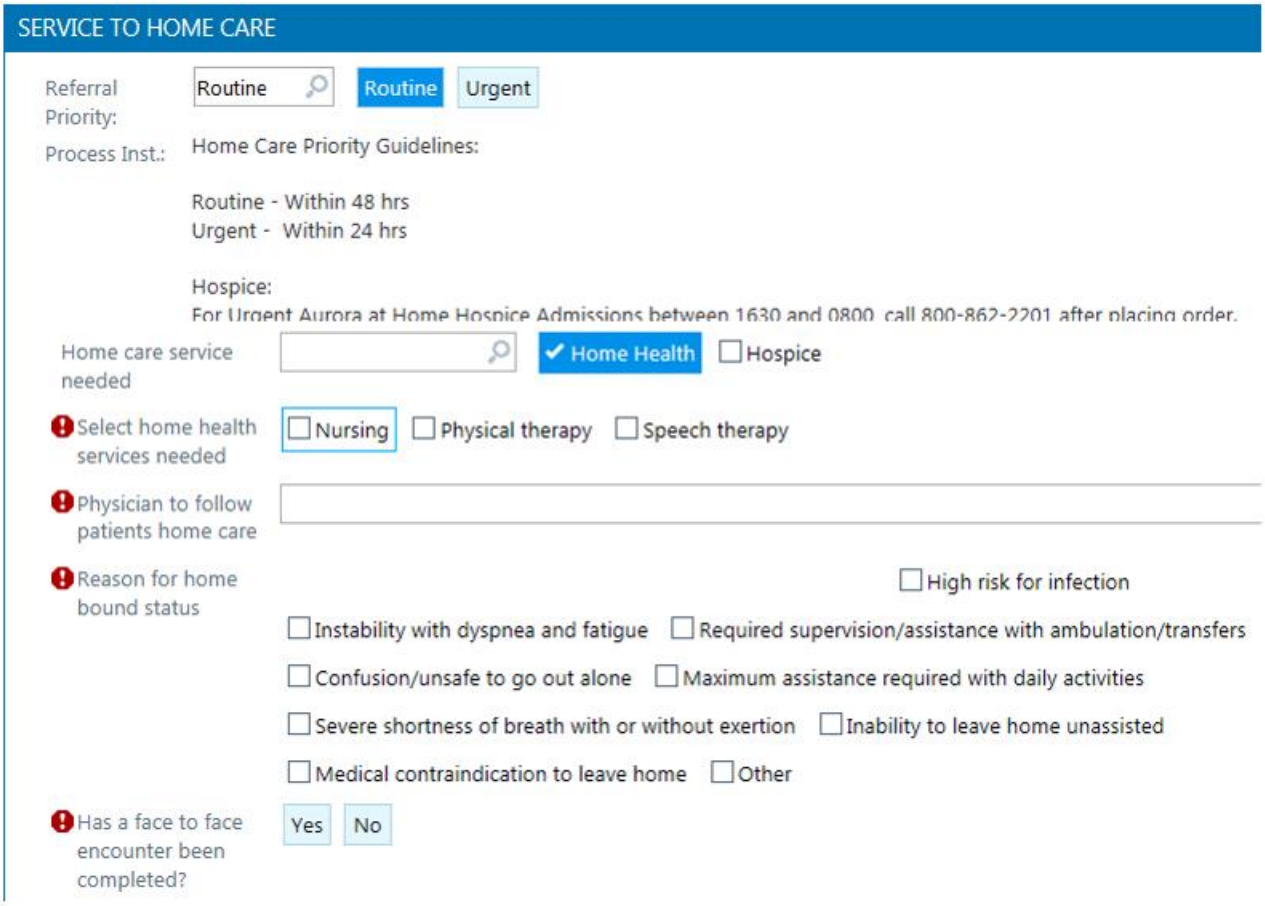


V. To Order Nursing and/or Therapy Services

a. Select the Service to Homecare box and Click on the blue Hyperlink

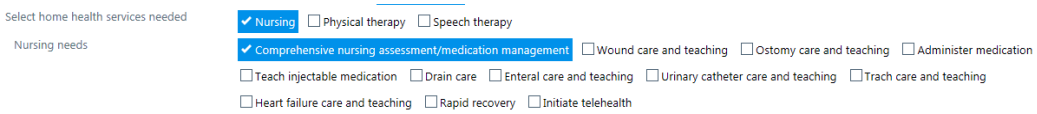


b. Select Home Health and then select the disciplines needed (Nursing or Physical Therapy and/or Speech Therapy)
REQUIREMENTS for all HomeCare Orders have red stops signs: You will also need to enter :
   - name of the physican who will be following and signing orders for the Home Health Plan of Care
   - reason patient is homebound – this should be reflected in your narrative visit note as well.
   - Face to face encounter date is the date of hospital visit with patient

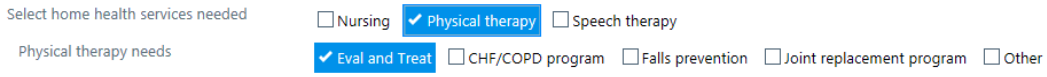


c. For each discipline selected, you can further define orders by clicking on the services needed.

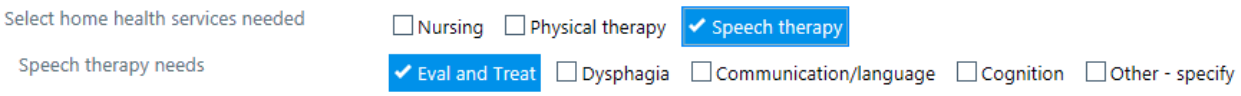
Nursing :



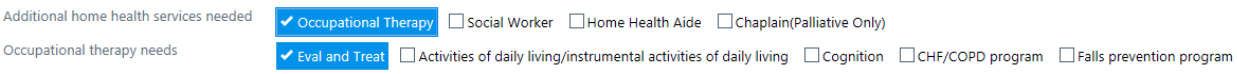
Physical Therapy:



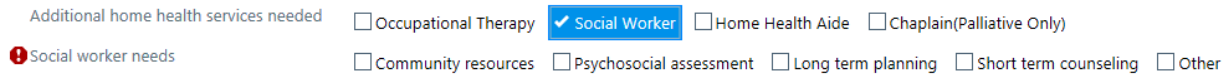
Speech Therapy:



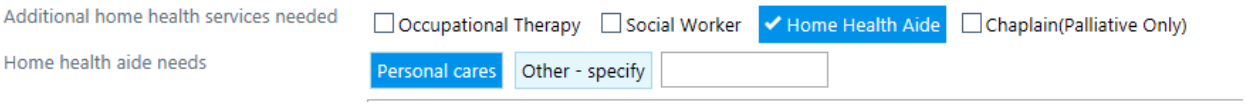
Occupational Therapy:



Social Worker:



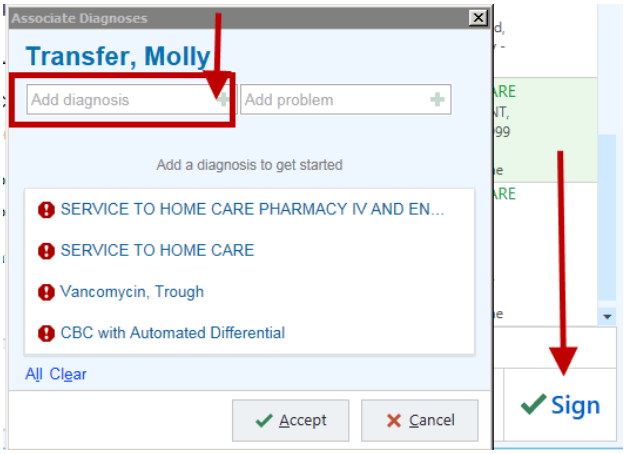
Home Health Aide:



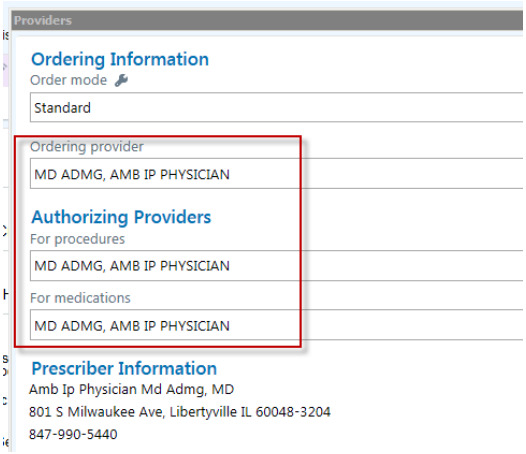
***If you are not discharging the patient home on the same day you are entering this order, remove the order. To do so, hover over the "Discharge Patient" order (it auto populates in the ordering window to the far right of your screen) and click the red x.**

IV. Click SIGN

e. **Enter each diagnosis associated with the Service to Homecare Order as well as the diagnosis associated with each medication and lab ordered.**
(CMS requires that the diagnosis associated with the order supports the reason the order is being placed. The supportive documentation should also be in your encounter narrative)



f. If you are a non-physician provider, enter the appropriate order mode and enter the name of the ordering provider

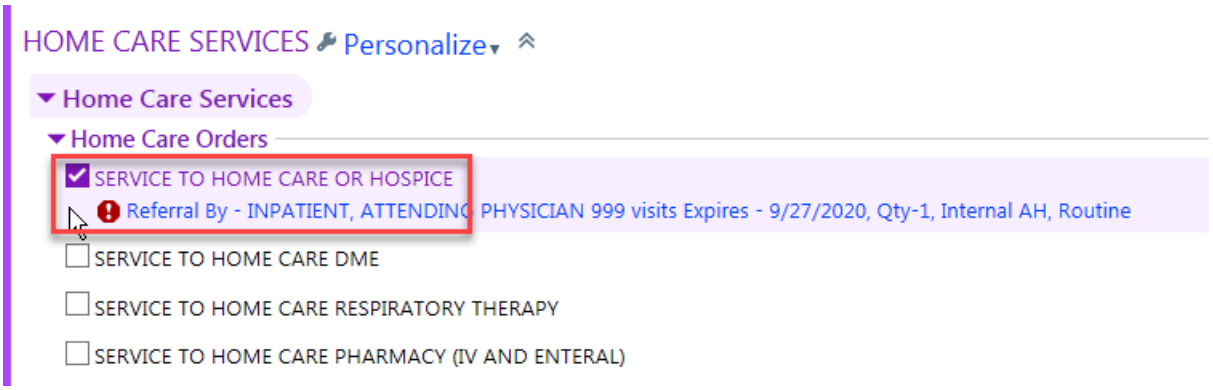


Service to Home Hospice

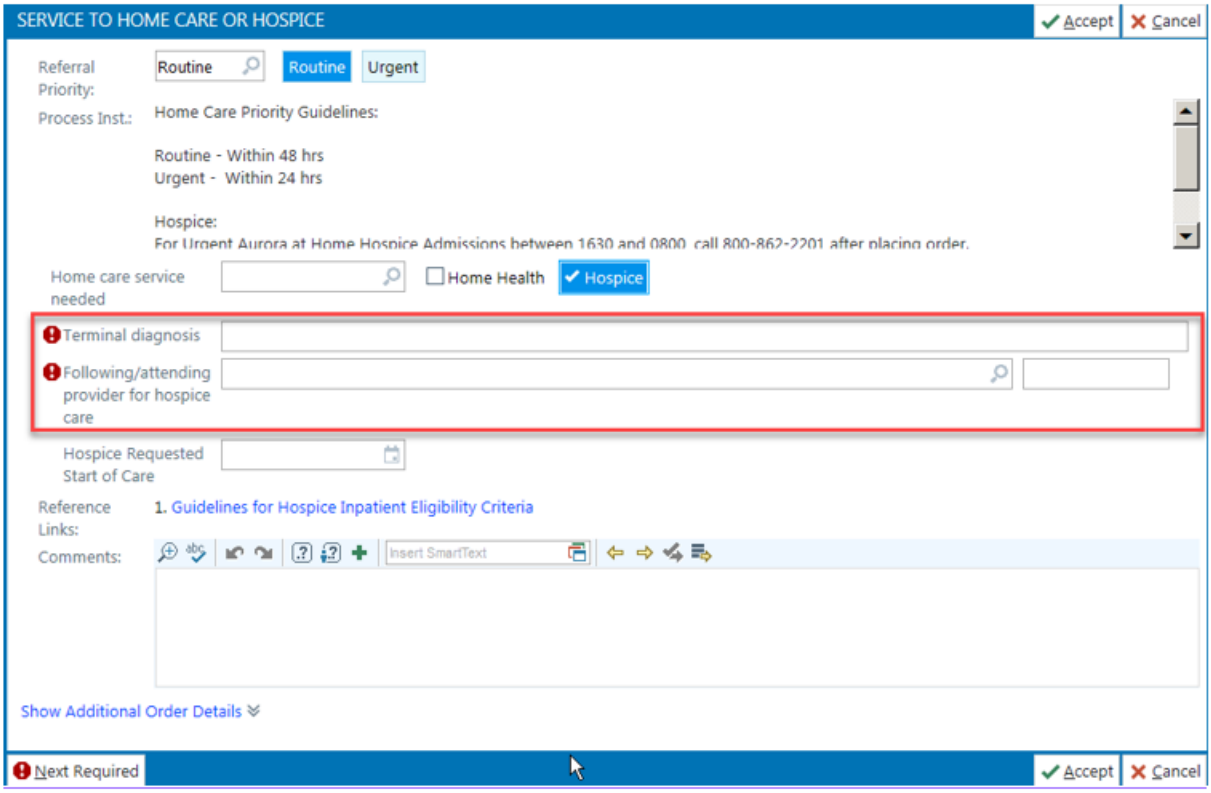
Provider: "Service to" Order Entry Steps

I. Locate the Home Care Services Order Set (Inpatient) or SmartSet (Ambulatory)

II. SELECT Service to Homecare or Hospice box

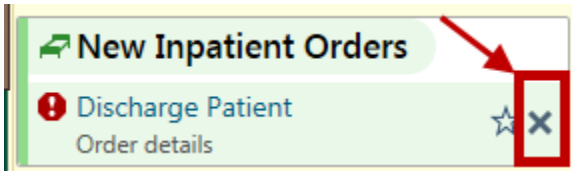


a. Complete order details, including required items and service needed.



b. Click Accept.

***If you are not discharging the patient home on the same day you are entering this order, remove the order. To do so, hover over the "Discharge Patient" order (it auto populates in the ordering window to the far right of your screen) and click the red x**.

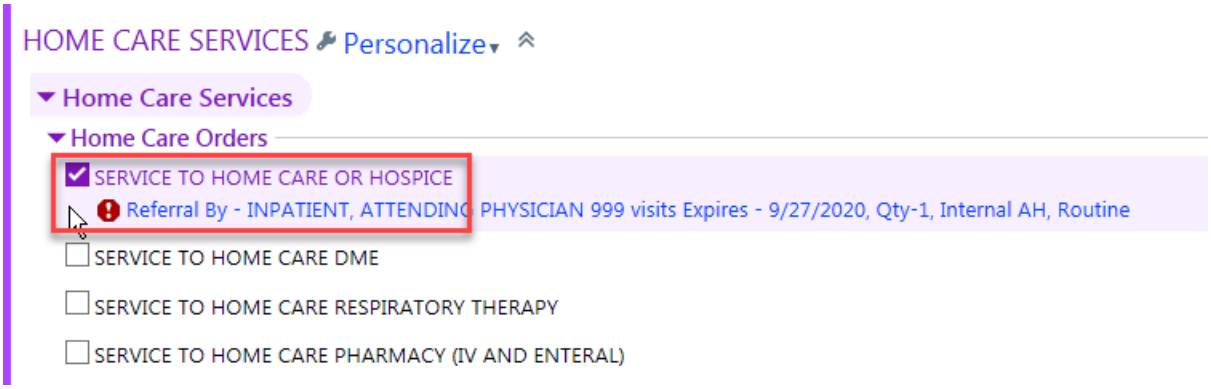


b. Select Sign. Associate a diagnosis if prompted.

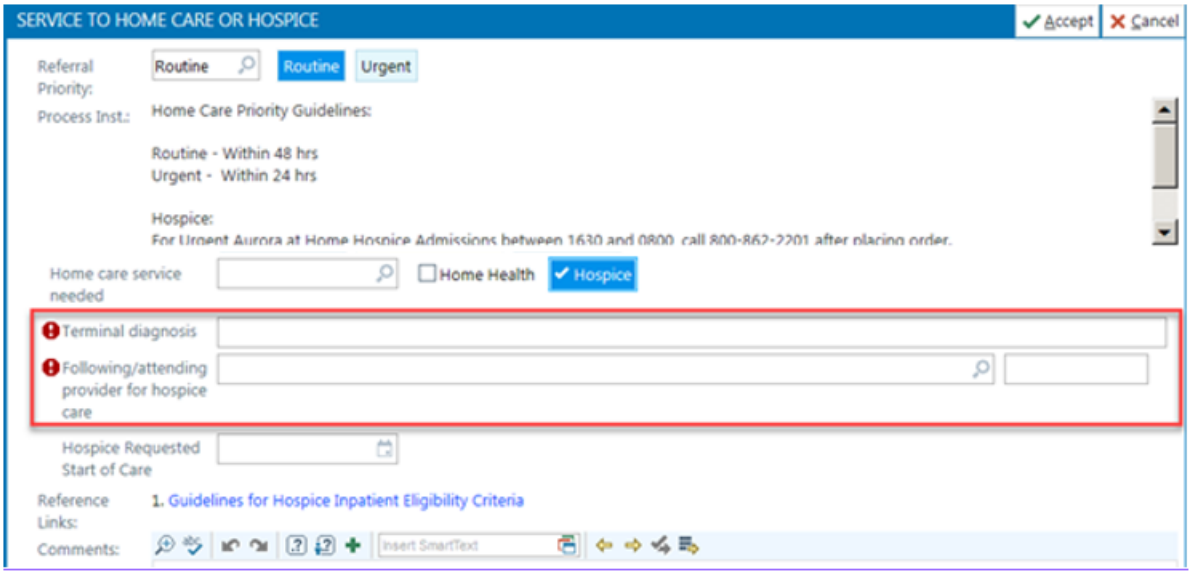
Service to Inpatient Hospice - Patient remains in the Hospital

"Service to" Order Entry Steps

I. SELECT Service to Homecare or Hospice box

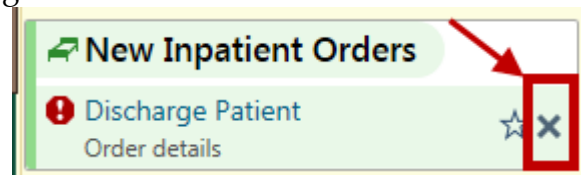


a. Complete order details, including required items and service needed.



b. Once the physician completes this order, click Accept.

- You will see a Discharge order automatically queued up in your sidebar. **Remove this order at this point, as you do not know if the patient will be accepted.**
  - Click "X" to the right of the order to remove it.



c. Select Sign. Associate a diagnosis if prompted.

d. The Service to Home Care order will be sent to the hospital Case Manager who will offer choice to the patient. They will then send to agency of choice. If choice is Advocate/Aurora at Home the hospice nurse will come to the hospital to determine if patient qualifies for inpatient hospice services.

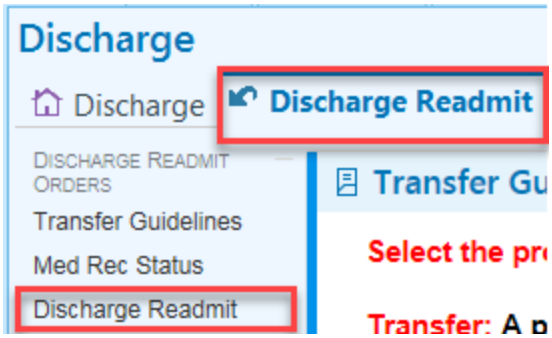
After the patient has been evaluated by a Home Care Nurse Liaison, and has accepted and consented to "Hospice in the Hospital" the hospice nurse liaison will notify Patient Access Center to request a new Pre-admission for a Hospice HAR.

The Hospice Admission nurse will also contact the attending physician to collaborate on the entering of Hospice admission orders if needed (see steps below).

Provider: "Discharge/Readmit" Steps

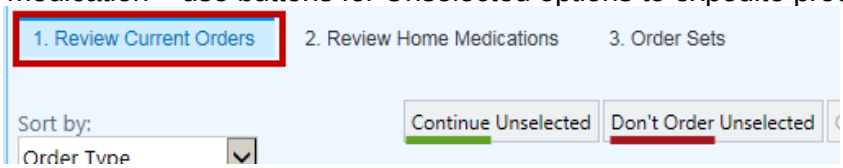
1. Go to Discharge Tab >

Click on second tab called **DISCHARGE READMIT navigator**, click Discharge readmit on the left side

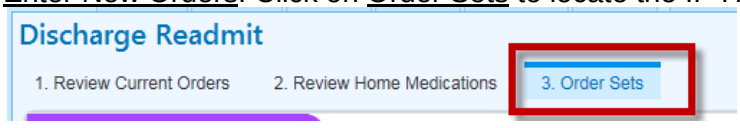


2. Reconcile Medications

✓ Review Current Orders: Decide which orders to continue or don't order. Address each medication – use buttons for Unselected options to expedite process.



✓ Enter New Orders: Click on Order Sets to locate the IP Hospice Admission Order Set

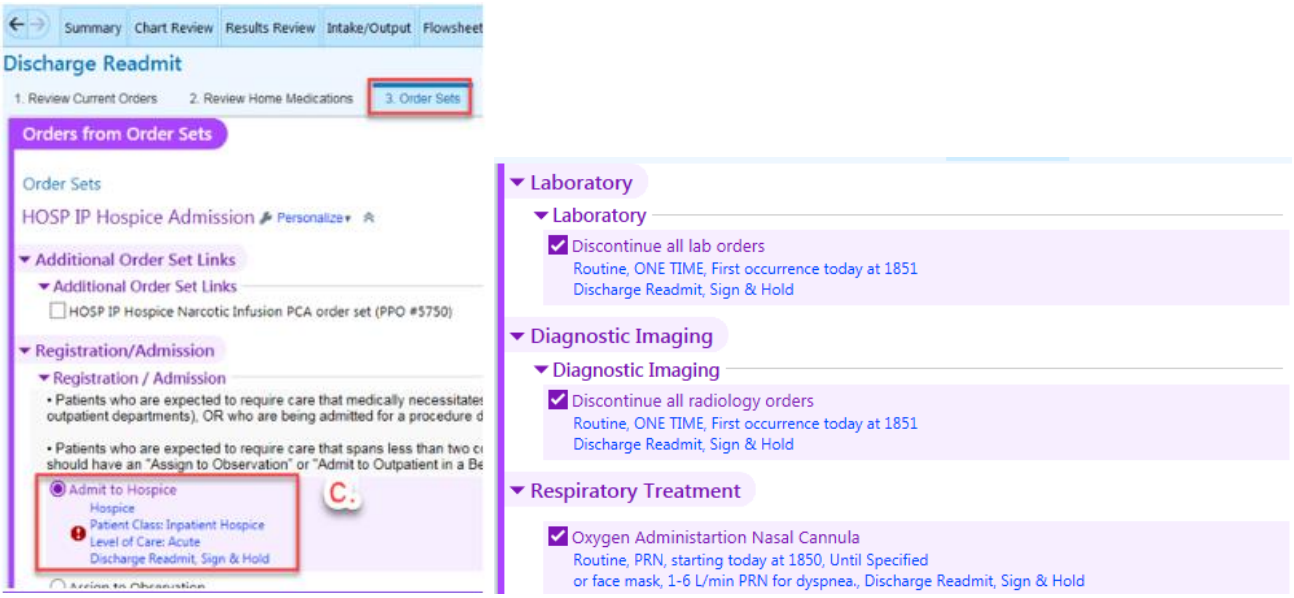


3. Click ORDER SETS tab.

a. Search "IP Hospice" in O**rde**r Set search field in the sidebar to locate IP Hospice Admission Order Set

b. Open the HOSP IP Hospice Admission Order Set (**right click to make a favorite**)

c. Click on Admit to Hospice order – enter admitting dx
d. Continue to enter appropriate orders for Hospice care. (Common orders are selected as default checked - Click on blue hyperlinks to make changes to order details as needed.)



e. Once you have the orders selected from the order set, look at your sidebar.

Click on the "Sign-Will be Released on New Admission." The Discharge Patient order is now active, but all other orders are signed and held for the nurse to release after the following step below.

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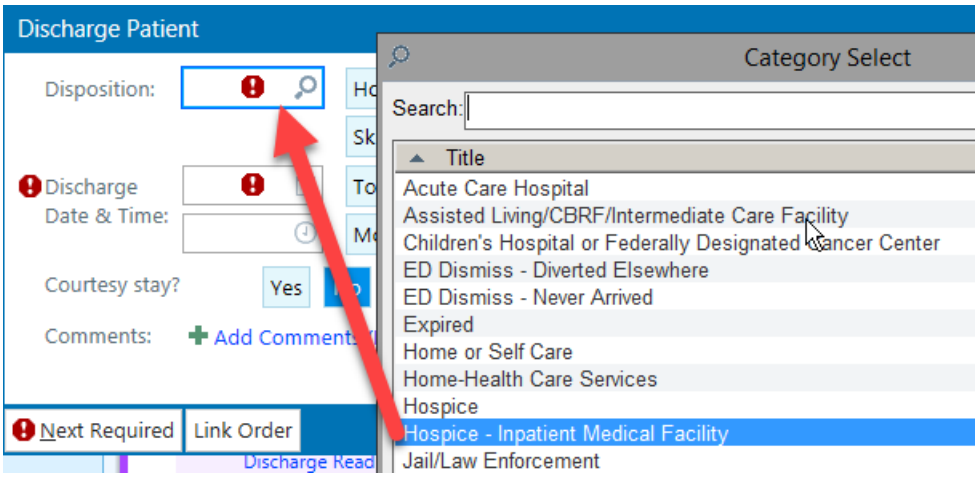
4. Fill out the Discharge Patient Order details.

In the Disposition field, enter "**Hospice – Inpatient Medical Facility**." Find this using the magnifying glass.

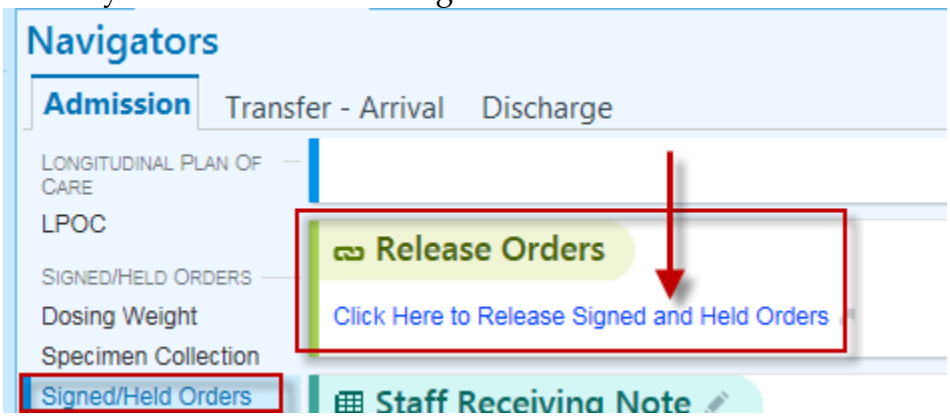


Unit Clerk/Inpatient RN: Discharge Readmit Steps

1. Once the Orders have been reconciled and the Discharge Patient order is active, and the new Hospice HAR has been created:

   - The Unit Clerk (or RN) goes to **Unit Manager**, and discharges current Inpatient from current room and bed and moves the Hospice Preadmission patient to that room.
   - After discharging the patient, the Unit Clerk or RN will need to **wait one minute before clicking Admit.**

2. RN may now RELEASE the Signed and Held orders



3. Housekeeping should also be called to let them know the bed does not need cleaning.

4. An H&P must be entered on the new Hospice HAR. The Provider must either update the H&P, or if over 30 days old, can enter a Brief H&P.

5. Required Documentation will re-trigger since this is a new Admission. This documentation should be readdressed. For ease in addressing these sections again, the nurse can have the Last Filed section opened.

The IP Nurse may contact Advocate at Home Hospice Nurse when:

- ✓ there is a change in patient condition
- ✓ When death is imminent
- ✓ When the patient expires

To access and view the Advocate at Home Hospice Nurse documentation:

- Click on Chart Review activity > Encounter tab.
- The Advocate at Home documentation will be listed with a "Type" of Home Care Visit and "Specialty" of Hospice Service.

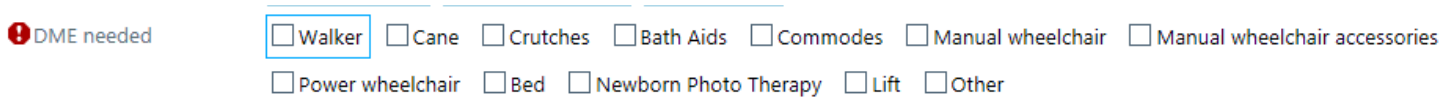
Service to Home Care – DME

"Service to" Order Entry Steps

I. Locate the Home Care Services Order Set
II. SELECT Service to Homecare DME

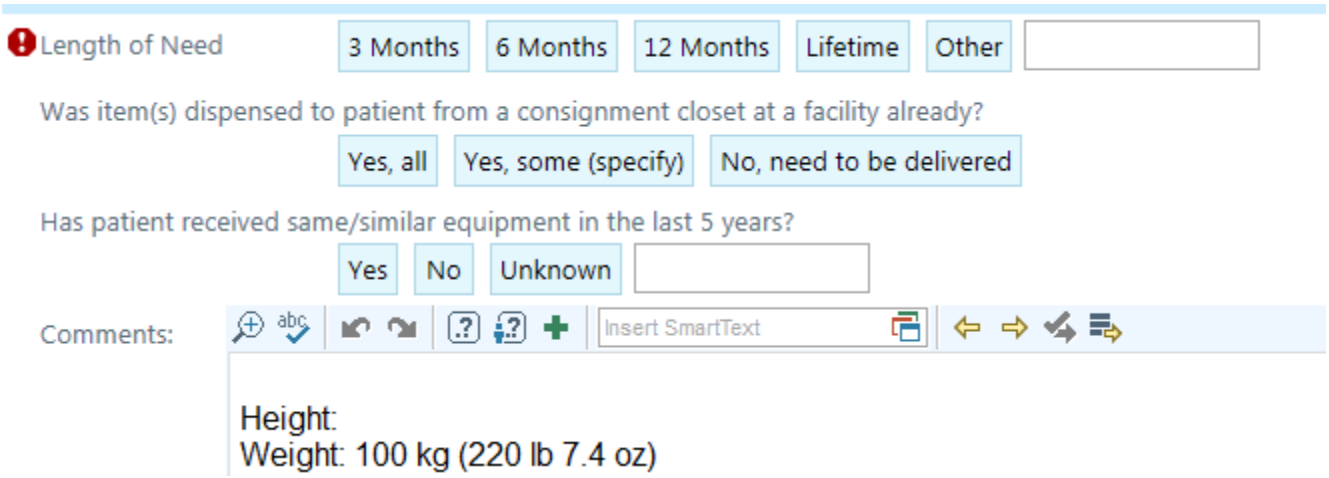
a. Select the Service to Homecare – DME box and Click on the blue Hyperlink

b. Select DME Needed – Options include:



c. Enter all order questions:

The Height and Weight will auto populate in the comments if it has been documented during a visit during the visit encounter.

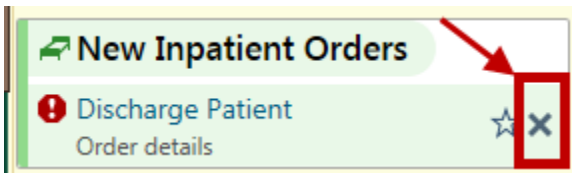


* After entering all choices, click 

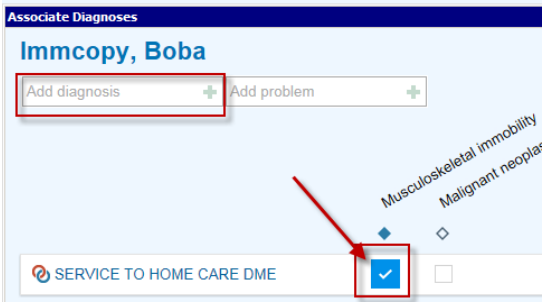
, then 

.

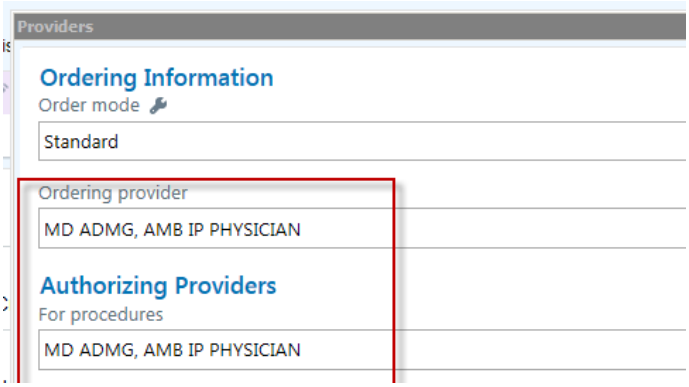
If you are not discharging the patient home on the same day you are entering this order, remove the "Discharge Patient" order (that auto displays in the ordering window to the far right of your screen) by clicking the x.



d. You will be prompted to associate the specific diagnosis pertaining to this order . Add a new dx or click the box under the corresponding dx for this order. The diagnosis ***must*** be related to the reason the DME equipment is being ordered.



g. *If you are non-provider, enter your name in the Ordering Provider field - the authorizing fields for procedures autofil if physician entering order. If a Physical Therapist enters order, enter the name of authorizing physician to send for second sign.*



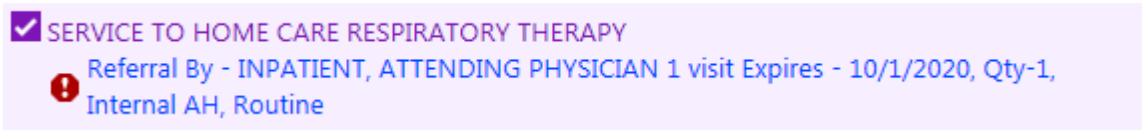
Service to Home Care Respiratory Therapy

"Service to" Order Entry Steps

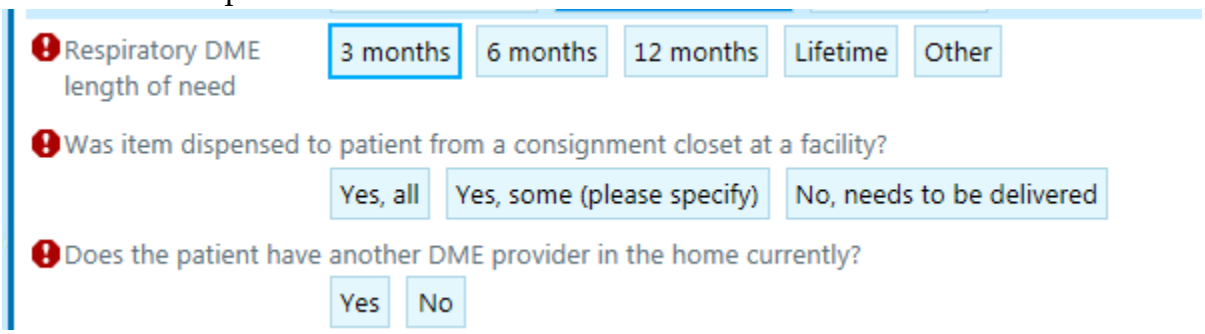
I. Locate the Home Care Services Order Set

II. SELECT Service to Homecare Respiratory Therapy

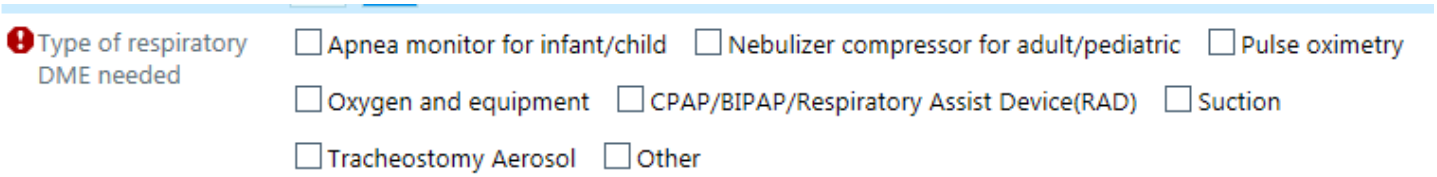
a. Select the Service to Homecare – Respiratory Therapy box and Click on the blue Hyperlink



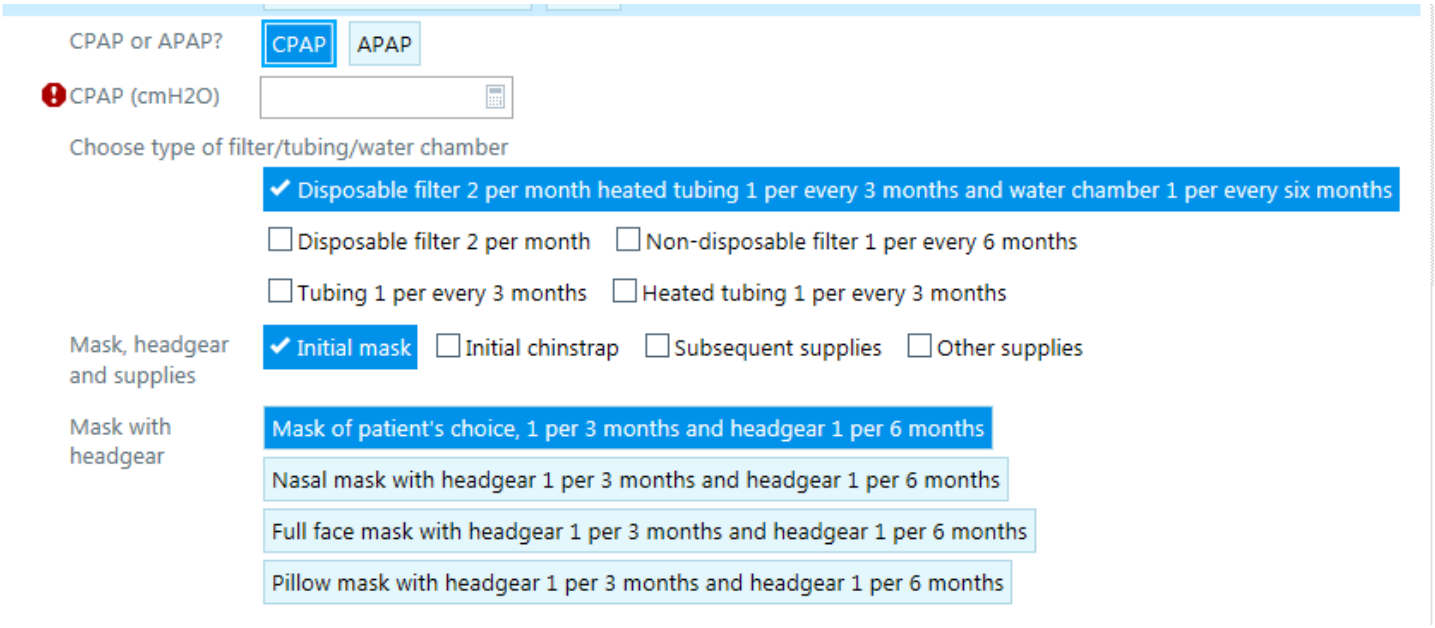
b. Enter all order questions



c. Select the type of Respiratory DME needed:



✓ Enter all information for the specific equipment selected. The required fields default based on allowances by payor.

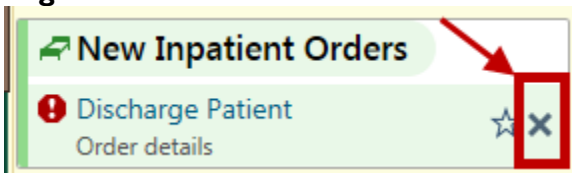


d. After entering all choices, click 

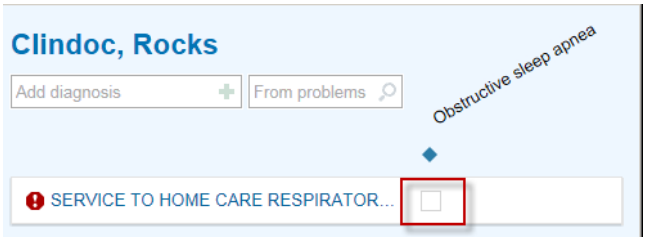
, then 

.

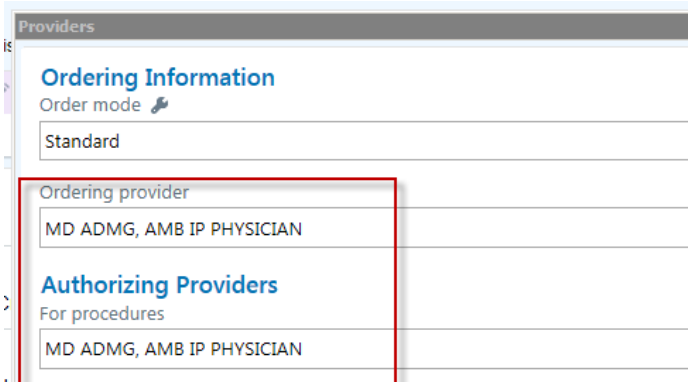
e. **If you are not discharging the patient home on the same day you are entering this order, remove the "Discharge Patient" order (that auto displays in the ordering window to the far right of your screen) by clicking the x.**



f. You will be prompted to associate the specific diagnosis pertaining to this order . Add a new dx or click the box under the corresponding dx for this order. The diagnosis ***must*** be related to the reason the DME equipment is being ordered.



h. *If a non-provider is entering the order, enter your name in the Ordering Provider field - the authorizing fields for procedures autofil if physician entering order. If a Respiratory Therapist enters order, enter the name of authorizing physician to send for second sign.*



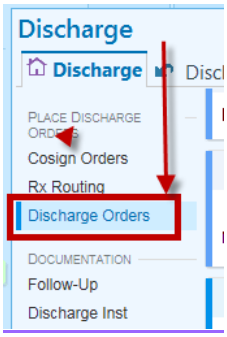
g. Upon signing of order, a referral is generated that is sent for processing.

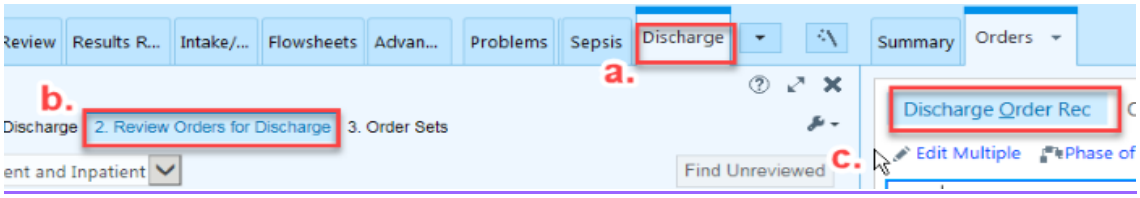
Service to Home Based Palliative Care: IL

"Service to" Order Entry Steps

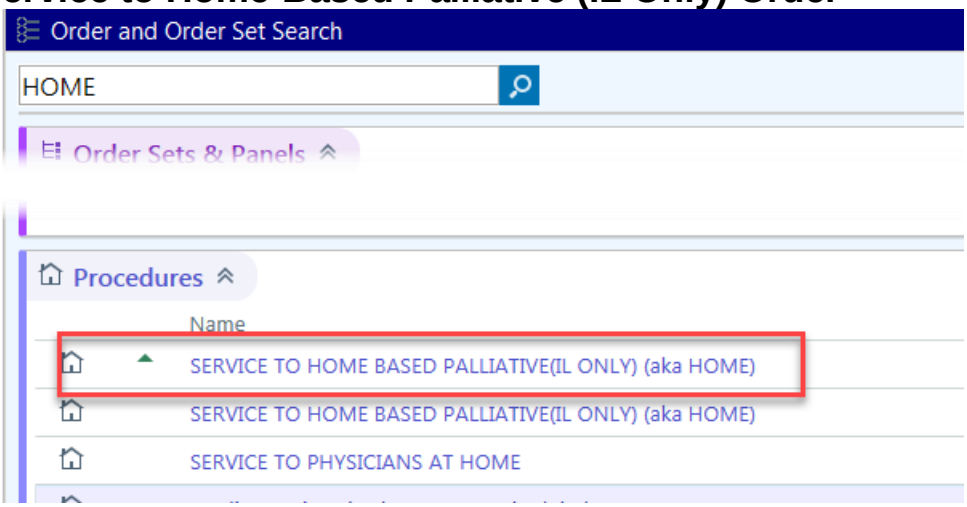
I. Locate the Service to Home-Based Palliative Order

a. Go to DISCHARGE tab then, DISCHARGE ORDERS in left side navigator
b. Click Review Orders for Discharge
c. Click Discharge Order Rec tab and enter "Home" in Discharge Order Rec field to locate the HOME-BASED PALLIATIVE Order

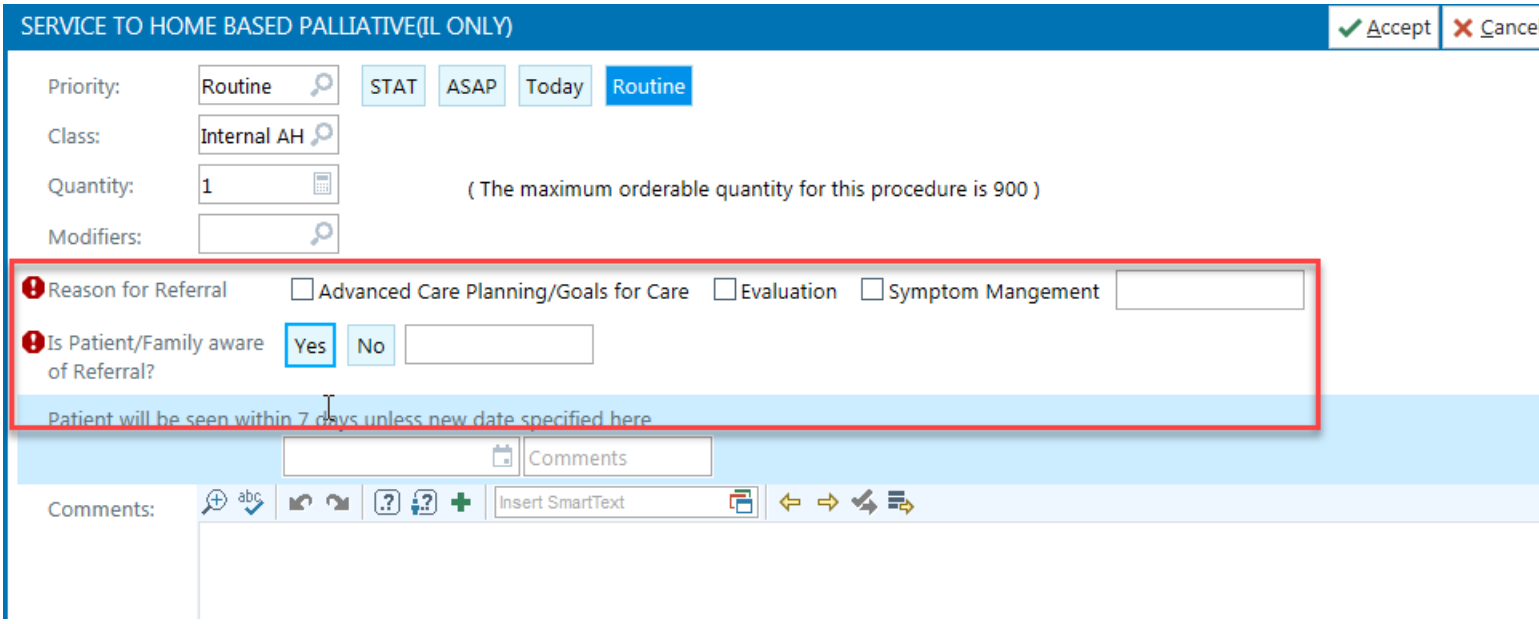




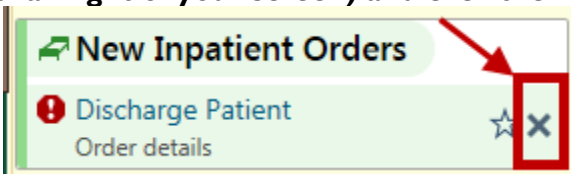
II. Select Service to Home-Based Palliative (IL Only) Order



- Click on the blue hyperlink to open the order composer to enter specific order details and all required fields



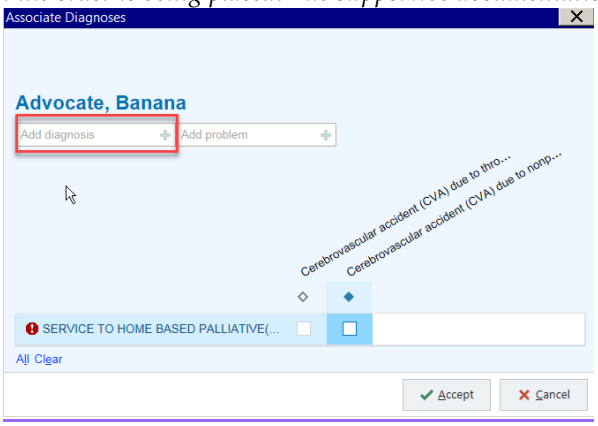
***If you are not discharging the patient home on the same day you are entering this order, remove the order. To do so, hover over the "Discharge Patient" order (it auto populates in the ordering window to the far right of your screen) and click the red x.**

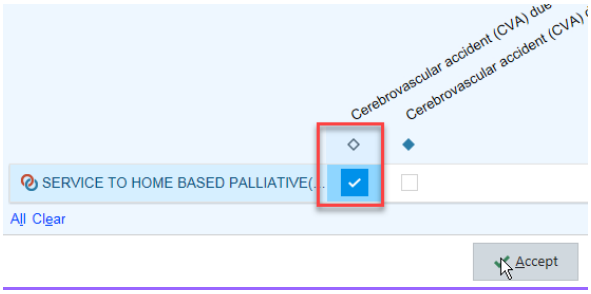


IV. Click SIGN

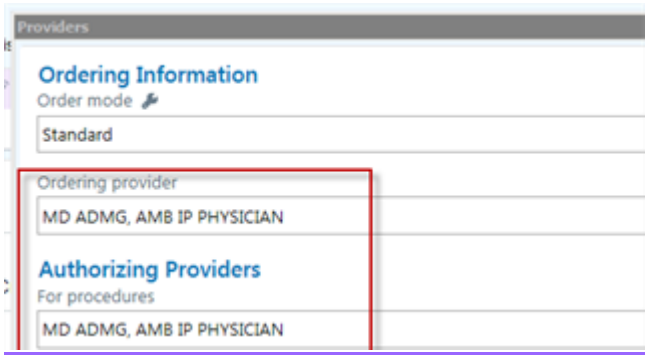
a. Enter each diagnosis associated with the Service to Home-based Palliative care Order

b. Click on the order link, then enter dx. *(CMS requires that the diagnosis associated with the order supports the reason the order is being placed. The supportive documentation should also be in your encounter narrative)*





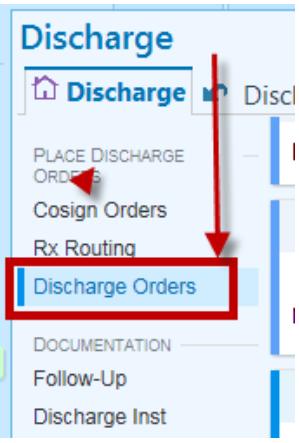
i. *If a non-provider is entering the order, enter your name in the Ordering Provider field - the authorizing fields for procedures autofil if physician entering order. If a non-provider enters order, enter the name of authorizing physician to send for second sign.*

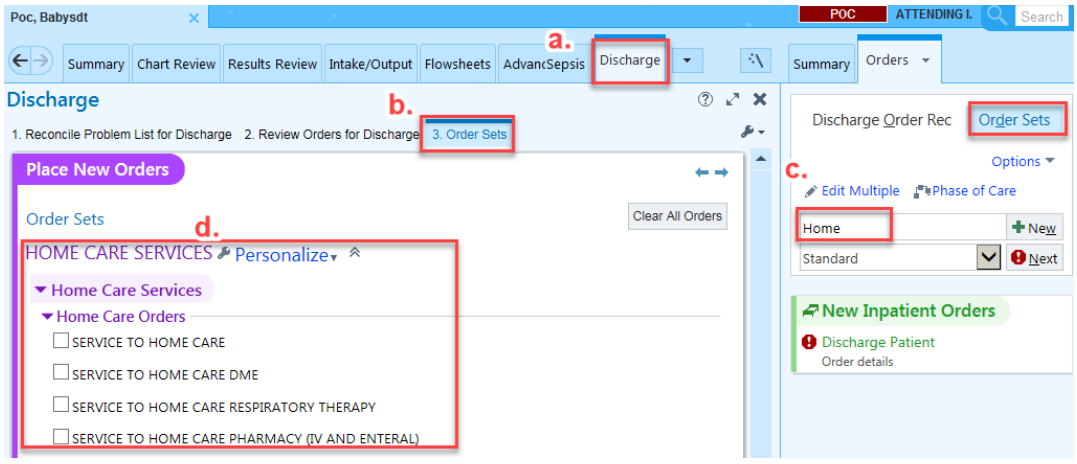

Providers
Ordering Information
Order mode
Standard
Ordering provider
MD ADMG, AMB IP PHYSICIAN
Authorizing Providers
For procedures
MD ADMG, AMB IP PHYSICIAN

Inpatient Provider: How to Order Home Health Services

Inpatient Provider: How to Order Home Health Services (Home Health, Hospice, DME, RT, and IV infusion/enteral)

1. **Find the Home Care Services Order Set**
   a. Go to **DISCHARGE** tab then, **DISCHARGE ORDERS** in left side navigator
   b. Click **ORDER SETS** tab
   c. Enter "Home" in Order Set search field to locate the HOME CARE SERVICES Order Set
   d. Open the Home Care Services Order Set. (right click to make a favorite)





2. **Choose the service you would like to order for the patient**
   - If you want home health or hospice, it is housed within the "Service to Home Care" order
3. **Complete order details, including required items and service needed.**
4. **Click Accept.**
5. You will see a Discharge order automatically queued up in your sidebar. **Remove this order** if you do not want to discharge the patient from the hospital.
   - Click "X" to the right of the order to remove it.
6. Select Sign.
7. Associate a diagnosis.
8. If you would like to review the order(s) you just placed, go to Chart Review→Other Orders

NOTE: For referrals during off hours, weekends, holidays, and those that are emergent, call Advocate at Home directly after placing the order@ 630-963-6800

Two weeks in home care can prevent a readmission

Know the numbers

There is a direct correlation between readmissions and patients who go home with no follow-up or with self-care.

- Most readmissions occur within the first **7** days after discharge
- Patients age **65** and older are most at risk
- Average number of medications upon discharge is **13**

With just two weeks of home care, your patients can be given extra support and monitoring during the post-acute recovery time to help avoid a readmission.

Home care options for your patients

RN visits

- Assess and monitor overall physical status
- Provide medication and medical education
- Coordinate ancillary services and follow-up physician appointments
- Educate and support caregivers

Physical and occupational therapy visits

- Assess home environment and provide safety education for fall prevention
- Provide therapeutic home exercise programs to promote endurance, strength and balance
- Educate and support caregivers

Home health aide visits

- Provide personal hands-on care
- Assist with needs

Social work visit

- Identify needs
- Coordinate community services
- Offer counseling
- Assist caregivers

Learn more

If you have questions about the benefits of home health care or would like to make a referral, contact the Aurora Health at Home representative at your site, place an order in Epic or call **800-862-2201**.

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Aurora Health at Home

Homebound status qualifiers

A patient is considered homebound if:

- Unable to leave home without maximum assistance and/or effort
- Unable to ambulate
- Unsteady gait with assistive device
- Unable to negotiate stairs
- Requires the assistance of 1-2 people to ambulate
- Requires an assistive device to ambulate
- Poor ambulation — prone to falls
- Post-op weakness
- Severe dyspnea on exertion
- Difficult and taxing effort to leave home
- Medical restrictions — open draining wound, leg elevated at all times
- Severe dizziness
- Confusion/disorientation
- Compromised mental status
- Impaired ability or unsafe to drive

Absences that do not affect patient's homebound status

- Absence from home to receive health care treatment
- Absence for purpose of attending a religious service
- Occasional absences for non-medical reasons, ie., a unique event — family reunion, funeral, graduation, wedding

Absences that may disqualify patient's homebound status

- Driving a car
- Leaving home against medical advice
- Leaving home for business purposes, work or attendance at school
- Leaving home frequently for non-medical reasons even if it requires difficult or taxing effort
- Leaving home several times a week (routinely) to go out for a meal

To learn more or to make a referral to Aurora Health at Home, call **1-800-862-2201.**

www.aurorahealthcare.org/services/home-care

Aurora Health Care Health at Home | We are AdvocateAuroraHealth

3/2020 MC 0133