Community Challenges

CARING FOR THE HEART FAILURE PATIENT AT HOME

Medicare Guidelines

- Homebound
- Skilled need
- Willing participant
- Appropriate caregiver
- Safe environment
- Physician willing to sign plan of care
- Patient has to have recent face to face appointment with physician
- Daily visits need an end date
- Patient home health certification lasts 60 days and if needs to be extended has to have estimated discharge date

Home Health Admission

- Identify if patient qualifies for home health
- Medicare Oasis
- Identify if patient has follow up physician appointments
- Reconcile medications
- Full assessment
- Identify signs and symptoms for patient to report to agency

Preventing hospitalizations

- Pt is aware of how to contact agency
- Telemonitors
- Front loading visits
- Multidisciplinary team
- Telephone visits
- 24 hour on call nurses/ prn visits
- Assist the patient in identifying symptoms early
- Communication with Cardiology; Medication changes, IV lasix, schedule an appointment with cardiology
- Well trained clinicians
- Patient Centered Goals

Patient Centered Goals

- Encourages patient to be in charge of his or her own care
- Help develop short term goals
- Clinician listens to patient needs and barriers to meeting goals
- Assist patient in identifying how symptom management is related to meeting goals
- Assist patient in coping with his or her symptoms

Palliative Care

- Palliative care under home health is similar but different from hospice
- Still need to qualify under Medicare guidelines

Conclusion

- Many benefits to home health and managing the heart failure patient
- Reduce hospitalizations
- Improve outcomes with multidisciplinary teamwork
- Able to communicate with cardiology on patient's behaviors in home
- Assist patient in being able to self manage care
- Questions?

References

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