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EFFECTIVE COMMUNICATION
Moving beyond the Silos in Home Heath Care

OBJECTIVES

• Identify the key stakeholders in the successful management of the home health patient.

• Formulate Strategies to create an interdisciplinary approach to case management.

• Analyze the link between effective communication and agency success.
SILO: a large, round tower on a farm for storing grain or winter food for cattle

OBJECTIVES

• Identify the key stakeholders in the successful management of the home health patient.
• Formulate Strategies to create an interdisciplinary approach to case management.
• Analyze the link between effective communication and agency success.
SILOS

• “devastate organizations, waste resources, kill productivity, and jeopardize the achievement of goals”
  – Patrick Lencioni: *Silos, Politics and TurfWars*

SILOS

• “Silos do not support communication and collaboration beyond that specialty and often contribute to communication breakdowns between disciplines as well as process inefficiencies.”

Identify the Key Stakeholders
PATIENT-CENTERED CARE

• Patient participation and involvement
• Relationship between the patient and the health care professional
• Context where care is delivered


PATIENT-CENTERED CARE

• Respect for patients
• Co-ordination and integration of care
• Information
• Communication
• Education
• Physical Comfort
• Emotional Comfort/alleviation of fear and anxiety
• Involvement of family and friends
• Transition and continuity

FORMULATE STRATEGIES

COMMUNITY CARE NETWORK

MMC
ALF/ECF
CCN
Hospice
VNAA
PATIENT CENTERED CARE

Quality of life Measure
Nottingham Health Profile | NHP

“In older persons, perceptions of one’s health may be determined in large part by one’s level of psychological well-being and by whether or not one continues in rewarding roles and activities.”


PATIENT CENTERED CARE

<table>
<thead>
<tr>
<th>NHP Items</th>
<th></th>
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</tr>
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<tbody>
<tr>
<td>Energy</td>
<td>EN</td>
<td>3</td>
</tr>
<tr>
<td>pain</td>
<td>P</td>
<td>8</td>
</tr>
<tr>
<td>Emotional reactions</td>
<td>EM</td>
<td>9</td>
</tr>
<tr>
<td>Sleep disturbance</td>
<td>SL</td>
<td>5</td>
</tr>
<tr>
<td>Social isolation</td>
<td>SO</td>
<td>5</td>
</tr>
<tr>
<td>Physical mobility</td>
<td>PM</td>
<td>8</td>
</tr>
</tbody>
</table>

Enterprise House, Manchester Science Park, Lloyd Street North, Manchester, M15 6SE UK Tel: +44 (0)161 226 4446 Fax: +44 (0)161 226 4478 Email: gr@galen-research.com
PATIENT CENTERD CARE

Deriving NHP Section Scores

Individual items should be scored 1 for a ‘yes’ response and 0 for a ‘no’ response. The total score for each section represents the summation of item scores expressed as a percentage. These are derived as follows:

- Energy \[\frac{(EN1+EN2+EN3)}{3}\] * 100
- Pain \[\frac{(P1+P2+P3+P4+P5+P6+P7+P8)}{8}\] * 100
- Emotional reactions \[\frac{(EM1+EM2+EM3+EM4+EM5+EM6+EM7+EM8+EM9)}{9}\] * 100
- Sleep disturbance \[\frac{(SL1+SL2+SL3+SL4+SL5)}{5}\] * 100
- Social isolation \[\frac{(SO1+SO2+SO3+SO4+SO5)}{5}\] * 100
- Physical mobility \[\frac{(PM1+PM2+PM3+PM4+PM5+PM6+PM7+PM8)}{8}\] * 100

For each section, scores range from 0 to 100, with a high representing greater perceived distress.

INTERDISCIPLINARY COMMUNICATION

• STAR rating
• Interoperability of health care clinicians
• “what gets measured gets done, what gets rewarded gets repeated.” John Schnatter
INTERDISCIPLINARY COMMUNICATION

SBAR

- **S**: situation
- **B**: background
- **A**: assessment
- **R**: recommendation

“best practice for *standardized communication* in healthcare”

http://www.saferhealthcare.com/sbar/what-is-sbar/

---

**SBAR**

Have ALL information AVAILABLE when reporting: chart – allergies – med list – pharmacy number – pertinent lab results

**SITUATION**

I am calling about ____________________________ [patient’s name]

The problem I am calling about is ____________________________

**BACKGROUND**

State the primary diagnosis & reason the patient is being seen for home care:

State the most pertinent medical history:

Most recent findings:

<table>
<thead>
<tr>
<th>Mental status</th>
<th>Neuro changes</th>
<th>Temp</th>
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<tbody>
<tr>
<td>B/P</td>
<td>Pulse rate/rhythm</td>
<td>Resp rate/rhythm</td>
</tr>
<tr>
<td>Lung sounds</td>
<td>Pulse oximetry</td>
<td>% Oxygen</td>
</tr>
<tr>
<td>GI/GU changes [nausea/vomiting/diarrhea/impaction/hydration]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weight [actual]</td>
<td>Loss</td>
<td>Gain</td>
</tr>
<tr>
<td>Wound status: Length cm</td>
<td>Width cm</td>
<td>Depth</td>
</tr>
<tr>
<td>Amount</td>
<td>Wound bed Treatment</td>
<td></td>
</tr>
<tr>
<td>Location of pain</td>
<td>Severity</td>
<td>Status</td>
</tr>
<tr>
<td>Musculoskeletal changes [weakness]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DNR status</td>
<td>Other</td>
<td></td>
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</tbody>
</table>

**ASSESSMENT** – What do you think is going on with the patient?

I think that the patient is ____________________________
SBAR

**RECOMMENDATION**

I suggest or request:

- PRN visit or referral: ___SN ___PT ___ST ___OT ___Aide ___MSW ___Dietician
- Visits frequency change________________________________________________________
- Schedule for a physician office visit
- Home visit by physician, nurse practitioner or physician assistant
- Pulse oximetry
- Urinalysis, C&S 5
- Lab work________________________________________________________
- X-rays________________________________________________________
- EKG________________________________________________________
- Medication changes________________________________________________________
- Wound care changes________________________________________________________
- Pain management changes__________________________________________________
- Nutrition changes_________________________________________________________
- Fluid restriction changes___________________________________________________
- Other_____________________________________________________________________
- Call physician with_________________________________________________________

**Comments**

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**ORGANIZATIONAL COMMUNICATION**

Formalized Process to address *Patient Flow*

1) Internal Diversion (primary and secondary)
2) Forecasting Tools
3) Capacity Huddles

RESULTS

• 80% reduction in declinations of emergent care transfers due to capacity limitations
• 50% reduction in the number of these patients being internally diverted.

VNSNY PROJECT

• Goal: effective care coordination
• Innovation Challenge CCIC
• “Harness the innovation of employees at the point of service”

VNSNY PROJECT OUTCOMES

• Enterprise wide interest
• Breaking down organizational silos
• Nurturing a culture of collaboration and innovation
• Education on the importance of care coordination
• Creating a unique opportunity for many to help shape the future of the organization

INTERDISCIPLINARY COMMUNICATION

• Clinical metrics across the continuum
• MMC program

GAIT VELOCITY

• Rehab Commonality

GAIT VELOCITY

## GAIT VELOCITY

### 2-Year Follow Up

<table>
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<tr>
<th></th>
<th>&gt; 1.1 m/s</th>
<th>.7-1.0 m/s</th>
<th>&lt; .7 m/s</th>
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<tr>
<td>New fall</td>
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<td>24%</td>
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<td>Hospitalization</td>
<td>8.8%</td>
<td>17%</td>
<td>52%</td>
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<tr>
<td>Need for caregiver</td>
<td>3%</td>
<td>17%</td>
<td>28%</td>
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<tr>
<td>Nursing home placement</td>
<td>0%</td>
<td>0%</td>
<td>12%</td>
</tr>
<tr>
<td>Fracture</td>
<td>3%</td>
<td>10%</td>
<td>8%</td>
</tr>
<tr>
<td>Death</td>
<td>0%</td>
<td>10%</td>
<td>8%</td>
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</tbody>
</table>

### INTERDISCIPLINARY COMMUNICATION

![GAIT Velocity Thermometer](image)
ANALYZE THE LINK

AGENCY SUCCESS

• Standardization
• Transformation
• Anticipation
• Relationship Building
AGENCY SUCCESS

• Evidence-based algorithms
• OASIS-C1

AGENCY SUCCESS

• Standardization
• Bundled Payment Systems:

• “unpredictability is a greater challenge than actual costs”

AGENCY FAILURE

- Increased fragmentation
- Decrease quality
- Lack of coordination
- Increase variation

STANDARDIZATION

Rehab Goals
1. Dynamic balance
2. Muscle performance
3. Aerobic capacity
AGENCY SUCCESS

• Transformation

• “Providers that have been successful with bundled payment programs have had to fundamentally redesign their organizational chart to incorporate providers from other departments in the care team.”


TEAM APPROACH

T: **Transition focused.** Punctuated care delivery favors a reconstructive mindset. In other words, high risk, high volume, problem prone conditions are typically treated symptomatically, as exacerbations irrupt. Congestive heart failure, Diabetes Mellitus, fall risk potential, and integumentary concerns are commonly addressed in the expensive aftermath of their ill effects. Effective transitioning promotes stabilization of chronic disease states across a continuum of care delivery platforms. Networking with hospitals, ECFs, ALFs, HHAs, medical equipment companies, outpatient clinics and non-traditional care delivery options will ensure that the right care is rendered at the right time. Accountable Care Organizations and Medical Home Models have been shown to create significant savings and enhance patient outcomes by incorporating health promotion, stabilization, and wellness concepts. 1
TEAM APPROACH

E: Evidence based. “Opinion based medicine” has created inconsistency in outcome. Conversely, Dr. David Sackett proposed that evidenced based medicine, which is the “synthesis of clinical expertise, patient values and best research evidence”, generates outcome predictability. CMS agrees, “It is anticipated that process of care implemented according to evidence-based guidelines will ultimately lead to better clinical outcomes”. Fostering clinical excellence will have the additional advantage of creating improved operational and financial outcome for your organization.

TEAM APPROACH

A: Accountable to outcome. The healthcare of tomorrow is a value, not volume, based system. Matching patient characteristics with the optimal clinician(s) will minimize redundancy and unnecessary over utilization. To achieve this objective, nurses, physical, occupational, speech therapists, social workers, and clinical managers must be operating transparently, keenly aware of each other’s skills, abilities and commitment to the greater objective of a favorable outcome. “It’s not my responsibility” or “the nurse will take care of that” is unacceptable. We are all accountable for our patient’s outcome. The transition from siloed to coordinated care is upon us. Embrace it.
TEAM APPROACH

**M: Measured success.** John William Gardner, author of, *On Leadership*, states, "Excellence is doing ordinary things extraordinarily well." 4 Stay focused on the successful completion of the plan of care. Target your patient centered goals and stay committed to achieving them. Monitor and measure your progress. Constantly examine your facilities’ care delivery and seek to improve it. Invest in technology that enhances your efficiencies, communication, and ultimate outcomes. Synergize the talents of your multidisciplinary team for the higher purpose of fantastic outcomes. Remember, “There is no ‘I’ in team”.


AGENCY SUCCESS

• Anticipation

• “For any organization to perform in an efficient manner, there has to be a common language among providers.”

HILLSIDE STRONG PROGRAM

Weekly Points By Team

<table>
<thead>
<tr>
<th></th>
<th>Week 1</th>
<th>Week 2</th>
<th>Week 3</th>
<th>Week 4</th>
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<tr>
<td>Team C</td>
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<td>2608</td>
<td>2644</td>
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<td></td>
</tr>
</tbody>
</table>

AGENCY SUCCESS

• Relationship building
• Ortho protocols
• CHF/COPD pathways
• Shared platforms
CONCLUSION

• “It’s supposed to be hard. If it wasn’t hard, everyone would do it. The hard...is what makes it great.” Jimmy Dugan

   A league of Their Own

THANK YOU

“The task of the modern educator is not to cut down jungles, but to irrigate deserts.”

C. S. Lewis