VNAA Blueprint for Excellence

Best Practices
For Home Care After Hip and Knee Joint Replacement

Visiting Nurse Associations of America
Overview of this Training

- VNAA
- Blueprint for Excellence
- Demand for Value in Home Health
- HH Hip and Knee Replacement Best Practices
- Resources
Visiting Nurse Associations of America

• National trade association for nonprofit providers of home health, hospice and palliative care and health promotion services

• Over 3,200 nonprofit providers in U.S.

• VNAA members:
  – 51% provide home health and hospice services
  – 11% are stand-alone hospice agencies
  – 32% are hospital affiliated system agencies
What is the Blueprint for Excellence?

VNAA Blueprint for Excellence is a pathway to expert practices for home health and hospice care providers, a touchstone for the expanded value and role of home health and hospice in new delivery models.

The VNAA Blueprint supports workforce development and consistency of care delivery, to achieve better health, better care and lower costs. All material addressed in this presentation is available on the VNAA Blueprint website, including live links to resources and references.
VNAA Presents a Blueprint for Best Practices in Home Health, Hospice and Palliative Care.

The VNAA Blueprint is a quality improvement and workforce training resource. It advances the use of best practices by gathering into one virtual location curriculum and training tools, as well as the relevant research supporting those tools. The VNAA Blueprint and its best practices demonstrate the value of home health, hospice and palliative care--both in lowering the overall cost of care and in improving health outcomes.
Value-Based Purchasing & Evidence-based Practices

HHS goals

• 30% of Medicare fee-for-service in alternative payment models and 85% linked to quality and alternative payment models by 2016

• 50% of Medicare fee-for-service in alternative payment models and 90% linked to quality and alternative payment models by 2018

• Comprehensive Care for Joint Replacement bundled payment
Why The Interest in Hip and Knee Joint Replacements?

- The aging of the U.S. population = more joint disease
- 51.8 million adults are diagnosed with arthritis in the U.S.
- In 2010, 719,000 total knee replacements and 332,000 hip in the US
- Demand steadily increasing: 101% increase between 1997-2007
- Cost to Medicare (CMS) has skyrocketed
Need for Home Health Hip and Knee Best Practices

- Medicare demanding improved efficiency of joint replacement procedures and to improve outcomes: new ‘bundled’ payment program for joint replacements that includes all services from hospital through rehabilitation.
- “Fast track” programs are being implemented in many hospitals to reduce hospital stays after joint replacement and return patients home rather than a post-acute care facility. (Kehlet, 2013, Husted, 2012)
- The average hospital length of stay after joint replacement has decreased from several weeks to between three to six days (Gulotta, 2011), sometimes down to 2 days or even same day discharge
- Fast Track trend likely to continue: patient satisfaction is high while LOS, ED use, reported pain and use of pain medication has decreased (Specht 2015, Raphael 2011).
VNAA Blueprint for Excellence

Clinical and Operational Best Practices for Home Health

Pathway for Hip and Knee Joint Replacement Management
Establish a Hip and Knee Management Program

Elements of a Home Health Fast Track Program:
- Prehospitalization assessment and initial plan
- Post-surgery assessment and home care plan
- Post-acute clinical care at home, including therapy
- Consistent clinical pathways and documentation
- Close coordination between physician/home care team
- Patient and family engagement
- Flexibility to accommodate patient needs and wants
- Collaboration between home care team and community supports
- Transition to next level of care
- Continuous evaluation of patient experience, outcomes, and costs
Establish a Hip and Knee Management Program

Clinical Features
• Evidence-based clinical pathways integrated with training, documentation, and performance evaluation
• Evidence-based, patient-centered physical therapy and nursing visits.
• Innovative therapy approach: consider PT only visits, joint replacement protocols, frequency of visits based on patient functional status, and protocol for transition to outpatient PT
• Proactive pain management
• Protocols for medication management
• Safety risks addressed: falls, anti-coagulation; infection
• Prevent readmissions and need for emergency care
Establish a Hip and Knee Management Program

Administrative Features
• Coordinate with inpatient facility to ensure smooth handoff to home care including medication handoffs
• Ensure expanded access to home care: evening, weekend, after hours
• Adopt tools to assist staff with assessments and patients with self-management
• Align electronic medical record program to prompt for quality indicators
• Define roles and accountabilities: Nursing, Physical Therapy, Occupational Therapy, Aides
• Develop referral pathways for social services, mental health, transportation
• Establish and communicate joint replacement program goals: increase patient mobility, improve strength and balance, and prevent complications
• Plan for coordinated handoffs to outpatient therapy
Best Practice Tip

• Build your program to address three top sources of patient dissatisfaction: scheduling, communication, and consistency of caregivers

VNANE Best Practice Tip for HH Fast Track Programs: 1) Central referral and intake line; 2) dedicated customer relationship management team; 3) collaborative target population analysis, planning, and performance reviews; 4) customization of services as needed to meet customer goals; 5) incentives to align organizational efforts with customer business imperatives
Establish a Hip and Knee Management Program

Implement Comprehensive Quality Strategy:

- Measure program results and report to joint replacement partners
- Evaluate opportunities for improvement, including cost savings and improvements in patient experience
- Use technology to manage workflow and to automate quality checks
- Train staff to ensure consistency and accountability across all types of care givers
- Review data monthly at agency and individual level
- Telephone check in with patient within the first 2 weeks of care to ensure satisfaction
Establish a Hip and Knee Management Program

Marketing and Communications

- Establish a communication program about availability of joint replacement services at home:
  - Target messages to hospitals, physicians, and patients
  - Participate in pre-op teaching workshops hosted by hospital or physician
  - Conduct pre-discharge visits
  - Develop program information for physicians and patients

- Share program cost and outcome results with hospital, ACO, managed care and physician partners

**Best Practice:** Have agency home care liaison meet with patients during preop teaching session at hospital or have physical therapy liaison meet regularly with hospital discharge planners.
Intake

Before the Home Visit at least 24 hours before the start of care:

- Get H&P and Discharge summary
- Get information on the type of surgery, restrictions related to type of surgery, long-acting pain medications administered during surgery
- Determine if patient is under a fast track protocol
- Determine if patient may be a re-hospitalization or safety risk
- Discharge medication list including pain management
- Verbal orders for treatments, labs, wound care, etc.
- Notify direct care providers of known risks.

For Fast Track or Same Day Discharges:

- Meet with the patient prior to surgery. Some agencies participate in joint surgery classes offered by hospitals
- Coordinate with hospital PT staff to ensure PT visit on day of discharge
- Ensure that medications are in the home when patient arrives
- Consider adding anxiety assessment to identify patient /caregiver capability to meet needs
Intake

Pre-visit phone call from clinician:
Pre-visit questions may include:
• “Do you have written information on how to take care of yourself after the surgery?”
• “Who is helping you”? 
• “Were you able to obtain medications you need?”
• “Have you needed pain medicine since you got home?”
• “Do you understand how to take your pain medicine?”
• “How are you getting to the bathroom (or other functional status question)”
• “Have you noticed any changes or problems with your incision or the bandage since you’ve been home?”
• “Do you feel safe being home?”
• “Are you having problems with any of your other health conditions?”

Responses to questions lead to a decision about making a same day visit. Responses should also be used to organize care before or during the first visit, for example arranging a family visit, bringing certain supplies, or assisting with DME arrangements.
Start of Care

Initial Start of Care Visit includes:

- Start or complete OASIS and a comprehensive therapy assessment
- Plan visit frequency and discuss plan of care with the patient and care givers
- Conduct general assessment of risk for re-hospitalization
- Conduct pain assessment. Use standard tool and assess at every visit.
- Conduct home safety assessment: including falls risk and emergency preparedness
- Conduct medication reconciliation
  - Assess medications specific to joint replacement: pain management and anticoagulation
- Conduct depression assessment
- Physician contact regarding orders and medication reconciliation
- Assess equipment or home modification needs, including grab bars
- Initiate referrals as needed: SN, OT, MSW or Psych RN, aide services, DME
- Verify that physician follow-up appointment is made (usually at 6 weeks)
- Patient Education with Teach-back
  - Initial self-management teaching: pain, bowel management, wound care, falls prevention, other safety teaching
  - Provide agency name and contact information and assurance of 24 hour response to calls
  - Leave patient education and zone tools for patient use
Assessment Tools

Physical function
- Timed Up and Go (TUG)
- WOMAC
- Tinetti
- 30 second chair stand
- MAHC10
- 6MWT (for assessment of cardiopulmonary)

Functional status
- SLUMS
- Mini Mental Status Exam
- Montreal Cognitive Assessment
Assessment Tools

Pain Assessment

- The Faces Pain Scale-Revised or FPS-R
- Verbal Descriptor Scale -
- 10 Point Scale
- Wong-Baker FACES Pain Scale
- Brief Pain Inventory (BPI)

Skin Integrity Assessment

- Braden Scale
Prevent Post-Surgical Complications

VTE Prevention:
- **Anticoagulant therapy:** The American College of Chest Physicians (ACCP) 2012 [guideline on anticoagulation therapy after orthopedic surgery](https://www.chestjournal.org/article/S0009-9240(12)61726-9) addresses evidence based anticoagulation therapy:
- **Compression therapy:** Intermittent pneumatic compression device (IPCD) is recommended prior to discharge with or without anticoagulation therapy. Patients are frequently discharged with compression stockings or boots
  - **VTE Assessment:** check legs for redness, swelling (DVT); evaluate shortness of breath (PE)
- **VTE Patient/Family Education:** educate on signs/symptoms of VTE, medications, importance of ambulating

Infection Prevention: Patients at risk for wound infection or periprosthetic surgical infection
- **Assessment:** check wound area for intact dressing; if assessable, evaluate redness, swelling, pain or drainage at wound site. Routine temperature check. Use a standard assessment tool such as the [Braden scale](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2479699/) for pressure ulcer risk assessment.
- **Patient/Family Education:** signs and symptoms of infection, showering / bathing protocols with the dressing, daily temp monitoring and call agency if temperature is above established set point. Use a [Zone Tool](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2479699/) for patient education and self-management.

Stiff knee after TKR: prevention of limitations in ROM includes pain management, physical therapy
- **Assessment:** range of motion and pain scales, edema assessment
- **Patient / Family Education:** pain management, exercise program, exercise program.
**Ongoing Care and Self-Management Teaching**

**On-going care** includes:
- Assess for pain at each visit
- Transition to non-narcotic as soon as possible
- Take vital signs pre and post exercise.
- Assess for edema
- Check medication status
- Evaluate surgical wound
- Monitor for surgical complications:
  - Thromboembolism or DVT
  - Infection
  - Stiffness
- Physical therapy
- Occupational therapy

**Plan of Care:** number of contacts per week based on:
- Length of rehab stay prior to home care (if any)
- In home support
- Co-morbidities
- Surgical complications
- Patient ability to adhere to plan
- Fast track status
- Any physician specific protocols
- Accessibility to outpatient rehab
Ongoing Care and Self-Management Teaching

Patient and Caregiver Engagement:

• Make sure patient knows when to expect services.
• Case manager writes agency specific visit schedule for each discipline. Post on refrigerator or other central location.
• Communicate - any changes in schedule should be communicated to patients in a timely manner.
• Educate patient and caregiver on when to alert agency staff. Zone tools are helpful.
• Plan for emergencies – make sure the patient and caregivers know how to contact Agency, PCP/orthopedist and 911.
Best Practice Tip

VNANE Best Practice to Enhance Home Care Customer Experience / Satisfaction

- Staff education and training about patient experience, reports and influencers of satisfaction
- Telephone calls to each new patient 24 hours before start of care
- Telephone check in with patient within the first 2 weeks of care, to ensure satisfaction with quality of care
- Agency-specific calendar that case manager writes the visit schedule for each discipline. Posted on refrigerator
- Telephone call before visiting
- Weekly/monthly measurement reports: team/clinician measures reviewed with supervisors “critical for improvement”
- Spotlighting of positive stories
- Recognizing the very low margin for error in home care

Based on Press Ganey’s “The Banner Story: Improving Home Care Patient Satisfaction to Stay Ahead in a Competitive Market”
Physical Therapy

Start of Care:
- Determine physician prescription for weight bearing, joint precautions, or positioning
- Assess functional status and mobility
- Assess pain level, noting that pain management is essential to enable the patient to engage in PT activities
- Use PT objective tests and measures

Goal Setting: Implement physical therapy plan with emphasis on:
- Walking, balance, stairs
- Fall prevention, safety
- Flexion, extension and range of motion to prevent stiff knee
- Patient-identified goals relating to function or pain
Physical Therapy

**Therapy:** interventions/treatments based on initial assessment including:
- Gait training on various surfaces
- Range of motion (ROM) and Strength
- Practice ADLs (sit, stand, toileting, bathing, stairs)
- Exercises for balance in different positions – supine, prone, sit, side, stand
- Site specific rehabilitation exercises

**Physical Therapy Teaching:**
- Pain management, emphasize the importance of medicating before PT and use of heat or cold therapy
- Exercises for the patient to do on his/her own with caregiver
- Correct crutch, walker or cane usage on flat surfaces and stairs
- Joint precautions (such as not crossing legs and standing techniques) and weight bearing limitations
- Recommended ROM limitations or goals for specific functional tasks
- Provide and review patient education and information (may be developed by the agency or are publicly available. See for example [Mass General's Patient Rehabilitation materials](http://www.massgeneral.org/patientcare/hospital/nursing).)

### Hip Exercises*

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<th>Exercise</th>
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<tbody>
<tr>
<td>Quad Sets</td>
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<td>Glut Sets</td>
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<td>Ankle Pumps</td>
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<td>Hip &amp; Knee Flexion (Heel Slide)</td>
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<td>Hip Abduction</td>
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<td>Knee Extension (Long Arc Quad)</td>
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<td>Short Arc Quad</td>
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<tr>
<td>Standing Hip Flexion</td>
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<td>Squats</td>
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### Knee Exercises

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<tbody>
<tr>
<td>Ankle pumps</td>
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<tr>
<td>Quad sets</td>
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<tr>
<td>Short arc quads</td>
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<tr>
<td>Heel slides</td>
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<tr>
<td>Long arc quad</td>
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<tr>
<td>Straight leg raises</td>
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*Please note: These exercises are not exhaustive and may vary based on individual needs and conditions.*
Occupational Therapy

Occupational Therapy (OT)
- OT consult for patient training and education on functional bathroom transfers with use of DME as needed
- OT can recommend equipment such as: reacher, sock aid, stocking aid, long handled shoe horn, dressing stick, hand held shower, grab bars, shower chair, raised toilet seat
- OT will provide teaching and training for ADL skills while maintaining joint precautions
- OT teaching and training on adaptive devices will allow for greater independence while following surgical precautions.
- OT will assess for Home Health Aide needs and develop a care plan.
- OT will educate, train and teach patient on positioning strategies for pain management.
Self-Management Teaching

Patient/caregiver teaching should include:
- Signs and symptoms of surgical wound infection, VTE
- Pharmacologic pain management – narcotic and non-narcotic
- Non-pharmacological pain management including ice and positioning for comfort.
- Bed mobility
- Transfers (bed, toilet, chair, shower, care, floor)
- ADL/IADL skills
- Edema management
- Urgent and emergent response

Leave behind patient education materials and tools
Utilize teach back method to verify learning
Transitional Planning

Care transitional planning should include:

- Identify any follow up home care services needed
- Refer to outpatient rehab and coordinated handoff
- Hand off up to date medication list and care plan to next providers of care
- Discharge summary to physician if requested/required
- Patient able to describe the plan for follow up care including physician visit and rehabilitation
Measurement

OASIS Outcome and Process measures:
- Frequency of pain interfering with activity or movement
- Improvement in Ambulation
- Improvement in Bed Transferring
- Improvement in Bathing
- Surgical wound improvement

Claims and Survey Measures:
- Incidence of major falls
- Emergency care needed (with or without hospital admission)
- Unplanned re-hospitalizations
- Provides care in a professional way (HHCAHPS)
- How well did the team communicate with patients (HHCAHPS)
- Did your team discuss medications, pain and home safety with you (HHCAHPS)
- Would you recommend the agency to friends and family (HHCAHPS)
Non-Standard Measures

Self-Care and Functional Status
- Patient/caregiver are able to verbalize how and when to contact the agency after hours.
- Patient/caregiver can demonstrate/verbalize understanding of pain management.
- Patient demonstrates ability to take medications correctly.
- Patient able to verbalize medication actions/side effects to report/administration schedule.
- Patient/caregiver can verbalize home safety precautions.
- Patient demonstrates progress towards goals.
- Patient/caregiver able to demonstrate self-care.

Physical Therapy Measures
- Baseline range of motion and discharge ROM.
- Activity status.

Measurement and Evaluation
Best Practice Tip

Use Measures for Improvement!

• Measurement is a driver of accountability and improvement
• Review performance on all Home Health Compare and Home Health Star Ratings measures for patients in the Hip and Knee Joint Replacement Program.
• Generate measurement reports weekly or at minimum, monthly to be reviewed by team members, including clinicians.
• Develop criteria for improvement directly related to Home Health Compare and Star Ratings.
• Show your results to staff, payers, providers and patients!
Resources

Value Base Purchasing for Joint Replacement

- VNAA Healthcare Transformation e-Toolkit
- American Physical Therapy Association CCJR Resource Page
- Centers for Medicare and Medicaid Services Comprehensive Care for Joint Replacement

Transitions of Care

- Alliance for Home Health Quality and Innovation: Improving Care Transitions Between Hospital and Home Health: A Home Health Model of Care Transitions
Resources

Patient Information

- Ohio State University: Exercises after Hip Replacement
- Massachusetts General Hospital: Physical Therapy Exercises after Knee Replacement
- Massachusetts General Hospital: Physical Therapy Exercises after Hip Replacement

Falls Prevention

- VNAA Blueprint for Excellence: Falls Prevention
- Preventing Falls Among Older Adults Centers for Disease Control and Prevention
- CDC Compendium of Effective Fall Interventions: What Works for Community-Dwelling Older Adults, 3rd Edition
- National Council on Aging – Falls Prevention Resources
VNAA Blueprint Attributes

Consistency  
Value  
Viability  
Patient-Centered Commitment
Blueprint for Excellence

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