**Basic Scenario – Home Health (2)**

John Doe is a 67 year old white male with a history of asthma, diabetes and hypertension. With his wife’s help, he has managed his conditions at home for many years. A year ago, through a rural telehealth grant from the U.S. Department of Health and Human Services, John and his doctor have remote chronic disease management support tools. [C.2.2.1.7] A home monitoring device tracks his blood pressure and blood glucose levels. The monitoring device also records John’s answers to question prompts regarding daily diet and exercise. These data are sent directly to his EHR in his doctor’s office [C.1.1.12; C.2.2.3; S.3.1.4 *]. John also regularly uses a Peak Flow Meter and emails his levels to the doctor. [C.1.1.11] The EHR-S periodically sends John reminders about his medications, diet, and home allergen control. [C.2.2.3] John’s doctor tracks all his data through the EHR-S and calls him when he sees a need to adjust John’s medications. John and his wife sometimes read online patient information about his conditions. [C.2.6.5; C.3.2.4.]

Suddenly, John develops a fever, chest congestion, and a dry non-productive cough. He is admitted to the High Plains Medical Clinic in High Plains, Montana. [See Acute Care scenario.] He is diagnosed with pneumonia resulting from influenza. Following his discharge from University Hospital, John is transferred to Big Sky Village Skilled Nursing Facility and ultimately changes his primary residence to an assisted living facility within the Big Sky Village complex. [See Nursing Home scenario.]

Everywhere Home Care received a referral request, via the web, and pager alert, from Big Sky Village using a product with a secure information link between the acute and post acute providers. [C.3.2.1.] Everywhere Home Care confirms acceptance of the referral from Big Sky Village and patient data is transmitted. [C.1.1.7, I.1.6.0.].

Physician orders are for Skilled Nursing services to provide education re: COPD management, safety instructions, instructions on his oxygen equipment and utilization, respiratory assessments, including monitoring his oxygen saturation levels, and for physical therapy evaluation for his reconditioning home exercise plan and fall prevention plan. [C.1.4.2.]

As part of the intake process, the agency staff checks the HIQH (Health Insurance Query for Home Health agencies) to avoid billing conflicts with overlapping home health episodes and verify both Medicare part A and part B coverage. [S.3.3.2] HIQH is an online inquiry transaction citing information pertinent to determining primary HHA status. They ensure that a referral was made to a DME for oxygen delivery and if not initiate a referral to the patients preferred DME vendor.

On admission to the agency, Advance Directives, Patient Bill of Rights, HIPAA, agency specific service agreement, and consents are reviewed, signed, and noted in John’s EHR. [C.1.5.1.] A comprehensive assessment, including the patient’s medical history (provided by the patient and/or caregiver), physical assessment, and completion of OASIS (Outcome and Assessment Information Set required by CMS for all patients like

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John is performed by the skilled nurse, and the data are entered into the EHR. [C.1.2.2.] The EHR synthesizes the data collected to develop a Plan of Treatment (which includes a listing of the patient’s diagnosis, medication profile, safety measures, physical limitations, activities permitted, allergies, mental status, prognosis, treatment orders for all disciplines involved in the episode of care, goals, rehab potential, and discharge plans), patient specific disease based pathway (standardized disease based pathways incorporate industry and agency specific best practices guidelines). [C.1.2.2.] The resulting plan will be available to the Physical Therapist to import via modem to a CE device, notebook, or laptop computer, at the time of her initial evaluation visit.[S.3.1.1]

The OASIS assessment is encoded and transmitted to the state agency. [S.3.2.1, I.1.6.0.] The values are used to establish a Case-mix adjustment and then converted to a HIPPS (Health Insurance Prospective Payment System) code which is transmitted to the intermediary for payment purposes. [S.3.2.2., S.3.3.5., I.6.0]

The patient’s past medical history of insulin-dependant Diabetes Mellitus and the initial assessment indicated an elevated blood glucose level and inconsistency in patient’s compliance with administering his insulin at appropriate times. Due to this assessment John’s telehealth monitor was upgraded to include an audible alarm each day to remind him to monitor his blood glucose, take his insulin, and reinforce the education regarding disease process, medication, &/or procedures for administering his medication. This data will be transmitted to both John’s primary care provider and the home health agency’s server and will become an integrated part of the shared patient’s record [C.1.1.0, C.1.1.12, I.1.6.0.]

Ongoing assessments/interventions continue throughout the care with coordination of services for laboratory draws, delivery of medications, obtaining home equipment, community resource referrals for support groups, and financial assistance. [C.1.4.1.; C.1.4.2.] All data collected on the patient becomes a integrated record showing ongoing changes in the level of care and performance. All entries show “who” made the entry, when, and “how” (for example, skilled nurse entry with unique ID, transcribing secretary, interface entry from other database, telehealth entry). [C.1.1.12, I.1.2.6.]

As goals are met, plans are made to discharge John from home health. [C.1.2.3] A pulse oxymeter device is added to his home monitoring device and he will continue on the previous installed telehealth monitoring devices. [C.1.4.2] John’s doctor recommends additional online educational resources for John and his wife, including a reputable online support group of diabetes patients. [C.2.6.5.]

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