# Complex Care / Palliative / Telehealth

# Fact Sheet

**NEW NAME: <u>Advanced Illness Management Department ((AIM))</u>**

Complex Care, Palliative Care and Telehealth are included in this department

## NEW REFERRAL PROCESS!!!!!

We have a new process for Telehealth and Goals of Care referrals. You will no longer need to call a hotline or telehealth line to make a referral. Simply fill out the designated call log template in the quick notes and email the call log through Outlook (just like the palliative care referral). If you have any questions, please feel free to call x4788.

*Goals of Care Referrals:*

Insurance: No restrictions, we accept all insurances

Where is visit documented?

In the VNA Episode: Goals of Care are mostly performed under the VNA episode and can be a joint visit with the primary clinician or replace a skilled nursing visit.

In the Palliative Episode: Goals of Care occurring in facilities are documented in the palliative care episode and are not billable. A Call log is entered in the VNA episode with the title "VNA / MVH"

Frequency: In the community, Goals of Care can be a onetime visit if goals are established, multiple visits and / or phone call follow up if needed.

Communication: Care Transition Nurse (Marnie) places her note in a call log for the care team to view. She will also call the primary nurse with outcome / plan. When indicated, she will assist with transition to Hospice, collaborate with care transition liaisons and community physicians to establish plans / provide updates.

Who to refer:

- All CHF and COPD Program patient should receive a goals of care visit.
- Patients with ESRD, ALS, Metastatic CA, Advanced Dementia / Alzheimers, Pancreatic CA, Glioblastoma, Small Cell Lung CA, Patients with multiple hospitalizations or who have multiple co-morbidities

How to Make a Referral:

1. Obtain referral from MD and update clinical orders
2. Complete the quick note template labeled "goals of care".

***Goals of Care Evaluation request***

***DX:***

***Insurance:***

***Reason for Goals of Care Evaluation:***

***Has Goals of Care discussion occurred? { } Yes { } No***

***Who should be present for the visit?***

***Indicate any other Pertinent Information:***

3. In Outlook, email:
   To: Goals of Care Referral
   Subject: patient name and MRN
   Body: paste quick note.

**Telehealth**

Insurance: Telehealth is a free service provided to patients active with VNA. Currently, we do not bill any insurance for Telehealth.

Private Pay: Telehealth is available as a private pay service for a fee of $150 per month. Clients receive the same care as agency patients.

Facts about our Equipment:

- Our wireless equipment does NOT use patients WIFI or phone service. We use our own carrier to transmit readings.
- Equipment available includes: Monitor, scale, blood pressure cuff and pulse oximeter. Please note that we recommend that patients use their own equipment if available. All pieces do not have to be installed.
- Scale and monitor must remain plugged in to function properly. The blood pressure cuff requires batteries that are provided. The pulse oximeter requires charging, the charger is always provided (located in BP case).
- Equipment cannot be installed:
    - Homes with insect infestations such as bed bugs, cockroaches, mice, etc.
    - Hoarding / unsafe conditions for installation or potential equipment damage
    - Patients that have communicable disease such as MRSA or C. difficile

Installation:

- The technician extension is x 4107, Nextel 978-802-8798 for assistance
- Technician calls patient the day the referral is received to schedule an installation within 72 hours.
- Trouble shooting equipment is also performed by the technician. If patient has scheduled skilled visit, technician may call clinician to assist while in home.

Removal:

- Telehealth equipment must be removed by the discharging clinician. Equipment check list is always provided behind monitor to ensure all equipment is removed (including chargers).
- Ensure all equipment is bagged properly, bags are provided when installed but can also be found in your office.
- Returned equipment should be placed in designated area only.

Who to Refer:

- All CHF and COPD patients should be assessed for telemonitoring.
- Any patient that would require interim monitoring of vital signs.

Monitoring:

- Telehealth is intended to monitor short term (roughly 4-6 weeks) with intention to teach self- monitoring and encourage patients to purchase equipment for ongoing monitoring upon discharge from telehealth.

- Telehealth nurses continually assess patient appropriateness for telemonitoring and discharge as appropriate.

**How to make a telehealth Referral**

1. Obtain order from MD and update clinical orders
2. Complete quick note template labeled "Telehealth Referral"

***Telehealth Referral Template***

***DX:***

***Equipment in Home: Scale { } BP Cuff { } Patient Oximeter { }***

***Safety: Patient safe to test independent { } with help { }***

***Who will help?***

***Orders obtained by?***

***Orders entered in POC { }***

***Who should we schedule installation with?***

***Special Instructions:***

3. Send Outlook Email
   To: Telehealth Referral
   Subject: Patient name and medical record number
   Body: paste telehealth referral call log

# Palliative

Program Structure: The Palliative Program provides supportive services on a consultative basis for patients within or referred to our VNA. The Palliative Team collaborates with the VNA Care Team as well as the community physicians.

Insurance: Medicare patients

Disciplines: Nurse Practitioner, LICSW, Health Coach

Requirements:

Community Patients – require a VNA episode
Facility Patients – Palliative Only

Nurse Practitioner Evaluations: Nurse Practitioners assist with Goals of Care / Advanced Directives, complex pain and symptom management such as nausea, vomiting, constipation, dyspnea, loss of appetite, weight loss, cachexia and insomnia. **The Nurse Practitioner does not support chronic pain management.**

LICSW: Can Assist with Goals of Care, provide emotional support, counseling to patients and families who are having difficulty in facing debilitating / terminal illness.

Care Transition Nurse: Provides Goals of Care evaluations and clinical assessments (previously outlined in Goals of Care referral)

Referral Process:

1. Obtain MD order
2. Complete quick note template labeled "VNA for Palliative Consult"

***Complete below then send Outlook Email to: Palliative-Referrals***
***Enter patient Name and Medical Record number in the Subject Line***

***Complete the Following***

***DX:***

***Reason for Referral including Symptom Management needs:***

***Has Goals of Care discussion occurred? { }Yes { }No***

***Name of MD who ordered Palliative Consult:***

***Indicate any other Pertinent Information:***

3. Send Outlook Email
   To: Palliative -Referrals
   Subject: Patient name and medical record number
   Body: paste Palliative referral quick note