



# Mihom News

## Community Based Transitions: Bridging the Gap Across Healthcare



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The rising cost of healthcare has brought about the need to find ways to decrease hospital admissions. Medicare hospital re-admissions, especially within 30 days, cost billions of dollars each year and consequently direct adjustments to DRG payments for preventable readmissions. This will cause hospitals to seek out ways to provide for a smooth transition of their patients into all community settings. Community partners including home health agencies, skilled nursing facilities and long term care facilities ,strive to do their part in reducing identified common transition problems. These problems include: lack of understanding of post- hospital discharge instructions, lack of knowledge regarding red flags, and medication lists that do not match up. Therefore, efforts are being focused on strategies which improve the transition of care process, especially in these settings. It is essential that each member of the healthcare settings develop strategies that maximize their efforts to bridge the gap, in order that the rate of preventable hospital re-admissions is reduced. For example, hospitals now begin their medication reconciliation during the admission process and it is accessible to physicians so that they are aware of what their patients are actually taking when they first arrive in the hospital. Additionally, a final medication reconciliation check list is completed by the physician just prior to discharge. This is especially important because today's medicine is highly specialized and therefore, the primary care provider may not be aware of medications that were prescribed by a consultant, such as a pulmonologist or cardiologist.

Technological advances are paramount in allowing for improvements in communication across hospital settings. The Electronic Medical Record, better known as the EMR, is one intervention designed to improve communication between hospitals and physicians. Currently, however, it does not allow for sharing of information across all healthcare settings, but it is predicted that in the future it will be possible for a hospital for example in Florida to share documents with a hospital in New York, without any delay. Treatment in the emergency room could especially be greatly impacted if this were possible because treatment decisions have to be made quickly and at times are based on limited information if the patient or family member is unable to give a complete

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**We're on the Web!**  
[www.mihom.com](http://www.mihom.com)



### Inside this issue:

## Patient Advocacy Chronicles

**Question:** Question: I am an outdoors type of guy and I love to be out in the sun especially during summer. However, my friend was diagnosed with a form of skin cancer years ago due to too much time out in the sun and I am concerned that I

may be putting myself at risk also. How do I protect myself and which steps do I take to minimize the risk of skin cancer?

**Answer:** Skin cancer is the most common type of cancer in the United States. Ultra-violet (UV) rays from the

sun are the main cause of skin cancer. UV damage can also cause wrinkles and blotches on your skin.

You can take steps to protect your skin:

- ◆ Stay out of the sun between 10 am and 4 pm

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medical history to physicians. This year in particular, many physician offices that previously did not use an EMR system, are investing in software programs that accomplish EMR documentation because of government driven incentives to do so and to avoid penalties. The EMR also eliminates the lack of medical information being provided due to illegible handwriting of medical records by providers. It also allows for information to be expedited from one physician to another, which fosters their collaboration. In the home health setting, telehealth allows for home health agencies to monitor the status of their patients in between nursing visits by communicating vital signs such as blood pressure, weight, pulse, and pulse oximetry to the agency for review by a nurse. This information can be communicated to the physician to prompt medical treatment if needed. Home health agencies use the device to aid in the reduction of hospital re-admissions because they are alerted of patient status changes more readily than before using home tele-monitoring devices.

Analysts identify that patients with chronic diseases, such as chronic pulmonary obstructive disease ( COPD) , diabetes and heart disease have complex care needs and are more likely to contribute to the statistics for hospital re- admission within a 30 day time period. These patients often require services from different practitioners in multiple settings. Yet, practitioners in each setting often operate independently. This potential for fragmentation of care is heightened by the fact that clinicians are usually restricted to single settings, such as hospitals, skilled nursing facilities or ambulatory clinics. During transitions, these patients are at risk for medical errors. One specific transitional care model recently implemented by Medicare allows for nurse practitioners and physician assistants, as well as physicians to make “transitional care” visits into other settings that allow for a bridge that will close the gap of care from the discharge from a hospital to home or to an assisted living facility, for example. We consulted Medetric Wood, Advanced Registered Nurse Practitioner (ARNP) for her expertise on this subject matter. She is a Board Certified Geriatric Nurse Practitioner. She graduated from Florida Atlantic University and has been in practice as a nurse practitioner for 7 years . Mrs. Wood works for Practitioner Link, a company that provides training for nurse practitioners and physician assistants and then places them in skilled nursing facilities. In her private practice, Geriatric Solutions, practitioner Wood provides direct medical services in skilled nursing facilities. She also does transitional

visits into homes. She speaks to patients via phone initially and then goes out to the home or facility post discharge from the hospital. The design is similar to the traditional “house call” that physicians used to do many years ago, enabling her to fill in the gap between hospital discharge and physician follow- up visit in the office. She does not take the place of home health nursing visits, as she is a nurse practitioner who makes one visit to do an exam and can order any necessary lab tests that assist in managing the patient in the interim. She can then communicate her assessment to the physician, which facilitates needed medication adjustments that would normally not occur until the patient presents in the office for their follow-up appointment. Practitioner Wood explains”, the Transitional Care Model (TCM) emphasizes coordination and continuity of care, prevention and avoidance of complications, and close clinical treatment and management”. Within 72 hours of discharge from the hospital or SNF setting, the patient is seen by a ARNP or physician assistant (PA) who provides services to streamline post- discharge plans of care in order to prevent acute hospital and emergency department use and minimize health status decline. Mrs. Woods adds, “Older adults with two or more risk factors, including history of recent hospitalization or sub-acute admission, multiple chronic conditions or medications, and poor ratings of self-health are eligible for this service. Transitional care visits can be done in a variety of settings. For example, an NP can see a patient in the hospital setting within 24 hours of admission, in the home within 24-48 hours of discharge from the hospital or skilled nursing facility, as well as in the office within 30 days of discharge from an acute or sub-acute setting.

**If you have any questions for the Practitioner, she may be contacted at:  
2531 SW Fondura Road  
Port St. Lucie, FL 34953  
(850) 322-1895**





# Creamy Potato Salad

## INGREDIENTS:

- 6 Med. Potatoes. 3 Hard Boiled Eggs**
- 1/2lb fresh bacon crumbled into bits**
- 1 cup thinly sliced celery**
- 1/2 cup finely chopped onion**
- 1/3cup sweet pickly relish**
- 1 1/4 cups Mayonnaise (Hellmans)**
- 2 teaspoon celery seeds**
- 2 teaspoons apple cider vinegar**
- 2 teaspoons prepared Dijon mustard**
- Lawry's seasoning salt to taste**
- White Pepper to taste**

## DIRECTIONS:

**Cook Potatoes in boiling salted water until tender. Drain Well, Peel and cube potatoes to desired size.**

**In large bowl, combine potatoes, celery onion relish and bacon bits.**

**Add Mayo, celery seed, vinegar, mustard and seasonings. Mix but not to hard. You don't want Mashed Potatoes. Fold in chopped egg. Cover and Chill**

**Decorate with parsley!**



## Patient Advocacy Chronicles (cont from page 1)

- ◆ Use sunscreen with SPF 15 or higher
- ◆ Cover up with long sleeves and a hat
- ◆ Check your skin regularly for changes

**Question:** How likely is it that I can develop melanoma if my mother was diagnosed with it 5 years ago?

**Answer:** You may be at risk if your family has a history of melanoma. You should have annual dermatologic exams and suspicious lesions examined. Continued medical surveillance is essential for early detection of recurrence, and includes an individually prescribed scheduled for skin self-examination, clinician examination, chest x-ray, and/ or serum chemistry studies.

**Question:** What other risk factors should I be aware of?

**Answer:** Other risk factors include immune-suppression, having light skin and blonde or red hair, sun sensitivity/inability to tan, having blue or green eyes, excessive childhood sun exposure and blistering sunburns during childhood, a personal history of other types of skin cancer (e.g. basal cell carcinoma, squamous cell carcinoma), genetic factors, and older age.

**Question:** Is MOHS surgery good for removal of melanoma?

**Answer:** Not routinely. MOHS surgery was primarily developed and intended for application in contiguously growing skin cancer of the non-melanoma type. It is ideal for

squamous cell carcinoma, basal cell carcinoma and other less common non-melanoma cancers of the skin. In particular, it is indicated for the cancers that are in location prone to recurrence such as the face, and in particular the eyes, ears, nose, and lips. When skin cancer invade these areas, you don't see very much on the surface but the tumors may go in many different directions. It is also indicated for recurrent tumors those previously treated by other means ---and larger, aggressive tumors that tend to have larger subclinical extensions.

**For additional information, go to melanoma center,**

<http://www.melanomacenter.org/>



# AUTUMN

Best Care from Mihom to Yours...

O S T G K Z O F P J F F X J T  
 X C X H C W I T C H E S A B U  
 R A H I A M I F Z A I C H U R  
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 M Z A Y R R E B N A R C R R H  
 I H L D Y Y U G N W N J W T T

- BROOM
- CORNUCOPIA
- CRANBERRY
- FEAST
- GOBLINS
- HALLOWEEN
- HARVEST
- INDIANS
- JACK O LANTERN
- MAYFLOWER
- PILGRIMS
- PUMPKINS
- SCARECROW
- THANKSGIVING
- TRADITION
- TREATS
- TRICKS
- TURKEY
- WITCHES



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Our Services include:

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- ♥ Physical Therapy      Occupational Therapy ©
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- ♥ Home Health Aide      Hourly Private Duty ©
- ♥ In-home Telemonitoring

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