Visit Initiation/Frontloading

VNAA Best Practice for Home Health
Learning Objectives

• To identify 3 reasons that patients need frontloading
• To identify two types of frontloading
• To identify the criteria for patients to receive frontloading during the first two weeks of home care
Research Says.....

– What we know

• Hospital readmissions are a driving factor in escalated healthcare costs

• 19.6% of fee-for-service Medicare patients are readmitted within 30 days of hospital discharge. (3)

• Calculated cost of avoidable readmissions is $17.4 billion and rising. (3)
Transition: Hospital to Home

- Vulnerable time emotionally and physically for patients
- Patients may lack support or understanding of their complex plan of care
- Many patients have multiple chronic conditions
- Patients have not returned to baseline physical state and lack awareness or recognition of debilitated state
- May experience a cognitive decline
- Most have multiple medications—often prescribed by several physicians
- Patients may be feeling overwhelmed, uncertain, confused, irritated, anxious, overconfident
What is a “Best Practice?”

– A practice considered most appropriate under circumstances
– A technique or methodology proven to be reliable in achieving the desired outcome based on experience and/or research
– Agency must approve tools, assessments, protocols, care paths etc. so care is consistent
– VNAA has identified frontloading as a “best practice”
Frontloading

• Definition:
  – Strategy whereby the agency increases the visit frequency or services at the beginning of care in order to reduce the potential for unplanned rehospitalizations. (1)

• VNAA Learning Collaborative:
  – Best Practice
    • 2 skilled nursing visits or at least 1 visit and 1 phone call within 48 hours of homecare admission
    • Homecare admission occurs within 24 hours of hospital discharge
Research Says....

• One fourth of all hospitalizations of home health patients occur within 7 days after home care admission and 58% occur within 3 weeks after admission. (4)

• What does your data say? When are your patients most vulnerable for rehospitalization?
Frontloading

• Admit within 24 hours of hospital discharge
• 2 skilled nursing visits or at least 1 visit and 1 phone call within 48 hours of homecare admission
• Use of telehealth monitoring
Frontloading

• Admission Visit:
  – Goal: Keep patient at home—out of the hospital—until next day’s visit
  – Assess if meets criteria for homecare
  – Head to toe assessment
  – Begin assessing person’s health literacy
  – Utilize motivational interviewing in establishing POC goals
  – Reconcile medications
  – Utilize teach-back method when educating:
    • Important signs and symptoms
    • Patient emergency care plan—who to call, when
    • New medications—route, dose, potential side effects, reason for medication
    • Self-management and safety in the home
Visit 2

• Goal: Patient safety and education
• Coaching/motivational interviewing
• Teach back
• Care plan development including patient self-management goals
• Completion of OASIS
Frontloading: Visit 2

• How to keep patient safe at home?
  – OASIS “Walk” and completion
  – Based on previous day’s assessment, teaching and patient retention
    • Skilled nursing assessment & interventions
    • Continued medication teaching
    • Continued health literacy assessment
    • Continued motivational interviewing establishing specific short and long term goals
  – Ensure MD follow-up appointment scheduled and transportation access
    • Within 7-14 days (or sooner based on MD and/or hospital protocol)
TOOLS FOR USE DURING INITIATION VISITS
Ask Me 3

Good Questions for Your Good Health

Ask Me 3

Every time you talk with a health care provider, ask these questions:

1. What is my main problem?
2. What do I need to do?
3. Why is it important for me to do this?

Asking questions can help you be an active member of your health care team.
Personal Health Record

(several available online or electronically)
Additional Tools: Teach Back, Coaching, Self-Management
Research Says…

• Few published reports on frontloading:
  – Study 1(3): Providing 60% of planned SN visits in first 2 weeks of home healthcare episode
    – Heart failure patients-decreased rehospitalization by more than half (39.4%-16%) with fewer SN visits (15.5 vs. 9.5) and equal clinical outcomes and patient satisfaction
    – Insulin-dependent patients with diabetes-no significant differences for outcomes with patients with diabetes
  – Study 2(2): Frontloading home care services in the immediate post hospitalization period
    – Effective in decreasing rehospitalization rates for patients with heart failure by 39.4%
Engage your Staff Values and Goals

• “Provide quality care”
• “Keep people safe at home, out of the hospital”
• “Help people get healthier and give the education for them to stay healthy”
• “Establish meaningful relationships with patients and their caregivers”
• Ask your clinicians? Engage your clinicians!
Frontloading

• Research & Experience:
  – Frontloading gives an opportunity to also implement other best practices
    • Assess health literacy
    • Utilize motivational interviewing in establishing POC
    • Utilize teach-back method in education process
    • Medication reconciliation
    • Assure MD appointment within 7 days of hospital discharge
    • Educate on important signs/symptoms
Frontloading

Barriers

- Readiness for change
  - Clinicians and Management
- All patients? Certain diagnoses?
- Staffing, staffing, staffing
- Managerial oversight of weekend visits
- Patient resistance to multiple visits during the first few days back home.

Opportunities

- Kotter’s 8 Steps of Change
- Use of PDSA
  - Small tests of change, data collection
- Use of telehealth monitoring
- Use of other skilled disciplines
- Staff engagement
- Celebrate Success!
Kotter’s 8 Steps of Change

“Kotter’s Eight Steps of Change”

1. Increase Urgency
2. Build the Guiding Team
3. Get the Right Vision
4. Communicate for Buy-in
5. Empower Action
6. Create Short-term Wins
7. Don’t Let Up
8. Make it Stick

Creating a climate for change
Engaging and enabling the whole organization
Implementing and sustaining change

Creating the Climate for Change

1. Create sense of urgency with focus on values
   • Quality care

2. Identify key players to lead the change
   • Trusted clinicians & managers

3. Communicate the clear vision
   • SMART goals

4. Empower the change
   • Identify and remove barriers
   • Encourage communication & feedback from clinicians

5. Celebrate short-term wins
   • Data collection & feedback
   • Boost morale & optimism

6. Don’t let up!
   • Leadership involvement
   • Build upon success
   • Hardwire Change

7. Anchor the new culture
   • Prove the new way is better than the old
   • Visible success
   • Reinforce new norms & values
   • Reinforce new culture
Frontloading

• Supportive resources
  – Use of telehealth monitoring
  – Use of other skilled disciplines (i.e. PT, OT)