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HHQI National Campaign Government Task Leader, Office of Clinical Standards and Quality, CM

**Debora A Terkay**  
Nurse Consultant - Home Health and Hospice, Survey and Certification Group, Division of Continuing Care Providers, Centers for Medicare & Medicaid Services, State Operations (CMSO)
QUICK START GUIDE

PURPOSE OF QUICK START GUIDE: A brief guide and introduction to the Best Practice Intervention Package (BPIP) contents.

INTRODUCTION: An introduction to the Home Health Quality Improvement National Campaign. Each BPIP will have an introduction, but this specific BPIP reviews:

- The reason for the campaign
- Contrasts in the current campaign with the 2007 effort
- Features of the current campaign

Leadership Track (page 11): Designed for agency leadership and the quality or implementation team. Although this section is designed for leadership and the implementation team, it is divided in sections so that it can be printed and shared with other staff. (e.g. Team Tips) Each BPIP will have a leadership track.

- A Guide for using the BPIPs
- Best Practice Intervention Schedule and Suggested Timeline
- Team and Education Tips
- Checklist for Agency Leadership (Select interventions)
- Tools and Resources
- Links to Success stories
- Organizational Culture
- Physician Perspective

DISCIPLINE TRACKS: These 2-page guides are designed for the following disciplines:

- Skilled nurse (page 35)
- Therapist (page 38)
- Medical social worker (page 41)
- Home health aide (page 44)

The content is very similar between the discipline tracks since they are designed to be interdisciplinary. They will relate to specific best practice(s). The tracks contain a discipline specific checklist. We suggest printing front/back for ease of distribution or sending electronically to staff. Each BPIP will have discipline tracks.

ADDITIONAL CONTENT associated with the BPIP. These are not in the BPIP but the BPIP may contain links to them. All can be found on the BPIP Web page if logged in to retrieve the BPIP:

- Webinars
- Podcasts
- Case Studies

- Additional tools and resources
- References
INTRODUCTION

WHY IS THE HOME HEALTH QUALITY IMPROVEMENT (HHQI) NATIONAL CAMPAIGN SO IMPORTANT?

It is:

- A grassroots, cross-setting, patient-centered movement with stakeholders, designed to improve the quality of care home health patients receive.
- A special project funded by Centers for Medicare & Medicaid Services (CMS).
- FREE!

You will:

- Have the opportunity to learn from leaders and clinicians utilizing best practices for reducing avoidable acute care hospitalizations, improving management of oral medications, reducing fall risk and improving care coordination.
- Have access to many tools and resources designed for specific improvement topics (ACH, Medications, Falls, Care Transitions).
- Receive individualized HHQI Reports to help your agency set and achieve goals.

We will:

- Provide your agency with the opportunity to actively participate in efforts to reduce health care costs while simultaneously improving patient outcomes.
- Identify ways to target medically necessary services toward persons with chronic diseases.
- Provide you the opportunity to participate in a national campaign with thousands of other home health agencies (HHAs).
- Offer ideas and resources for care coordination with other providers.

INSIGHTS

- Identify ways to target medically necessary services toward persons with chronic diseases.
- Provide you the opportunity to participate in a national campaign with thousands of other home health agencies (HHAs).
What is *different* about the current HHQI Campaign compared to the 2007 HHQI Campaign?

<table>
<thead>
<tr>
<th>2007 HHQI Campaign</th>
<th>Current HHQI Campaign</th>
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<tbody>
<tr>
<td>Focused on reducing ACH</td>
<td>Focusing on reducing ACH and improving management of oral medications</td>
</tr>
<tr>
<td>Monthly BPIPs</td>
<td>Quarterly BPIPs</td>
</tr>
<tr>
<td>Individualized HHQI reports received through mail</td>
<td>Individualized HHQI reports obtained through a secure login on the <a href="http://www.homehealthquality.org">www.homehealthquality.org</a> Web site</td>
</tr>
<tr>
<td>Limited participant contact with HHQI Campaign staff</td>
<td>A direct link to campaign leaders through HHQInfo</td>
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**Additional features:**
- Focus upon delivery of care across settings
- Social networking opportunities through MyHHQI (e.g. Twitter, Facebook)
Social Networking

Social networking is the use of electronic tools to make online connections and develop a community of like-minded stakeholders. The resources included in MyHHQI are free for all campaign participants, and designed to share campaign information and best practices in various formats. Visit the MyHHQI page at www.homehealthquality.org to learn more.

Follow the Campaign on Twitter

Join supporters on Facebook

View HHQI Photos

Watch HHQI videos
DID YOU KNOW?

- The national average of home care patients who are admitted to the hospital is now 29%, meaning more than 1 out of every 4 home care episodes ends in a hospitalization.

- Hospitals now publicly report their risk-standardized, 30-day readmission measures for certain diagnosis groups, such as acute myocardial infarction (AMI), heart failure (HF) or pneumonia (PN).

Some of the objectives for the measuring and reporting readmission rates of hospitals are not only to provide information to consumers and create incentives for hospitals and health systems, but also to enable hospitals to:

- Evaluate the entire spectrum of care they and their affiliated providers offer to patients
- Identify systemic or condition-specific changes which will provide safer and more effective care
- Invest in interventions that reduce complications of care
- Assess the readiness of patients for discharge more effectively
- Improve patient discharge instructions
- Reconcile medications
- Improve effectiveness in transitioning patients to outpatient care or other institutional care

More information on the readmission measures can be located on www.qualitynet.org.

Comparing 30-day hospital readmission rates to home health agency acute care hospitalization rates

- Hospital readmission rates are specific for diagnosis and measured within 30 days after a hospitalization.
- Home health acute care hospitalization rate is measured by number of acute care hospitalizations per patient episode of care.
- **Suggestion:** investigate number of home health hospital readmissions that correlate to hospital readmission rates and share these with hospital Quality Improvement (QI) departments, discharge planners and other staff as appropriate.
  - **Example:** Calculate the number of hospitalizations in your patient population that occur within 30 days of hospital discharge for specific diagnosis groups: HF, AMI, and PN. Break down the calculation per facility to directly work with individual hospitals.
**Care Transitions**

- The term “care transitions” refers to the movement patients make between health care practitioners and settings as their condition and care needs change during the course of a chronic or acute illness.
- For example, during the course of an acute exacerbation of an illness, a patient might receive care from a Primary Care Physician (PCP) or specialist in an outpatient setting, then transition to a hospital, physician and nursing team during an inpatient admission before moving on to yet another care team at a skilled nursing facility. Finally, the patient might return home, where he or she would receive care from a home care team.
- Each of these shifts from care providers and settings is defined as a care transition.


**Opportunities for Improving Care Transitions**

The United States has a 17.6% rate of hospital readmissions within 30 days of discharge. The process by which patients move from hospitals to other care settings is increasingly problematic as hospitals shorten lengths of stay and as care becomes more fragmented. Medicare patients report greater dissatisfaction related to discharges than to any other aspect of care the CMS measures. The Medicare Payment Advisory Commission estimates up to 76% of readmissions within 30 days of discharge may be preventable.

http://www.cfmc.org/caretransitions/

**Why the Information and Focus on Care Transitions?**

Home Health Care is pivotal to helping reduce hospital readmissions. A patient may be receiving care at home and require emergency services and transition to emergency room. Home care agency staff are key participants in the communication of health care information. Awareness of the importance of accurate communication will help provide a seamless patient transition. Accepting accountability for accurate information at transfers and any necessary follow up is a responsibility for all health care providers.

**Insights**

Home care should have a key role in transitions and should consider functioning as the “transition coach” for hospitals.

Paula Suter, RN, MA
Director, Center of Excellence for Chronic Care Management
Baptist Home Health Network
Little Rock, Arkansas
One goal for this campaign is to improve care transitions by:
  - Improving communication across settings
  - Understanding causes for readmissions
  - Identifying ways to improve communication at time of patient transfers.

Currently CMS is funding **CARE TRANSITIONS PROJECTS** in 14 states.
  - The goal of this project is to improve the care for Medicare beneficiaries as they move from one care setting to another.
  - The projects are community-based in targeted zip codes that include groups of providers comprised of HHAs, nursing homes, hospitals and physician practices as well as key community stakeholders.
  - The projects seek to reduce the 30-day readmission rate that often arises out of inefficient and poorly planned transitions.
  - In addition, the project aims to improve the inter-relationship and communication of information between providers including home health.

**Home health agencies that are participating in the Care Transitions project are working with other providers to find collective ways to communicate patient information when the patient is being transitioned from one care setting to another.** Care Transitions also includes palliative care and end of life care as an additional focus when providing comprehensive care. The campaign will incorporate the findings and resources of the Care Transitions project as they become available.

**INSIGHTS**

The Care Transitions project includes improvement in completion and **accuracy of Continuity of Care (CoC) form to transition information between settings.**

*Colleen Rose PT, COS-C*
*Quality Manager, Visiting Nurse Association of Rhode Island*
Best Practice:

Leadership Track

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LEADERSHIP

Welcome to the HHQI National Campaign!

The primary educational resource for the HHQI Campaign is the **Best Practice Intervention Package (BPIP)**. The BPIPs will be posted quarterly and help guide your agency in specific best practices. The BPIPs are broken down into leadership tracks, which are directed towards leadership and PI/QI teams, and individual discipline tracks. The discipline tracks are 2 page educational guidelines for **each discipline area**. This BPIP will introduce (or **re**introduce) the best practices of **hospitalization risk assessment** and **emergency care planning**.

It is a time to regroup for many home health agencies. OASIS-C has begun and while there is still much to do related to the OASIS changes, it is also a time to evaluate improvement efforts **and** either adopt new resources and processes or revise older ones.

The BPIPs will be more streamlined and focused on best practice application principles. Many of these principles (or insights) have been acquired from home health leaders, nurses and therapists. You will see them throughout the BPIP with some being repetitive **because the interventions work for so many home care agencies**. So review the information shared by clinicians who are already implementing and maintaining a **best practice** principle and adapt it to your own agency!
A GUIDE FOR UTILIZING THE BPIP

1. Begin each quarterly BPIP by having the leadership in your agency review the leadership track.
   a. Be selective with tools and interventions
   b. Utilize/modify existing tools as appropriate

2. Check the BPIP timeline and incorporate these dates into your agency calendar.

3. Utilize a team approach with representation from all levels of staff.

4. Although a team guides the effort, try to involve all staff in selecting tools and changing processes.

5. Encourage your staff to actively participate by visiting the campaign Web site at www.homehealthquality.org and becoming a campaign supporter.

6. Share your data reports with all staff monthly. Become educated and familiar with what the data reports mean and why they are important. Use the reports to promote quality improvement and data transparency at each case conference or staff meeting. Educate the staff on how the data actually relates to the work they perform on a day to day basis. Relate it to how the interventions promoted in the BPIPs may improve the ACH and management of oral medication rates within their agency.

HHQI Data Reports

- Individualized HHQI reports will be obtained through a secure login on the www.homehealthquality.org Web site
- Look for email notification when data registration is open
- First reports will be posted Feb 2010 (look for them at the end of the month!)
**Best Practice Intervention Schedule**

<table>
<thead>
<tr>
<th>Release Date</th>
<th>Topic</th>
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<tbody>
<tr>
<td>January 28, 2010</td>
<td>Fundamentals of Reducing Acute Care Hospitalization</td>
</tr>
<tr>
<td>April 28, 2010</td>
<td>Medication Management</td>
</tr>
<tr>
<td>July 28, 2010</td>
<td>Fall Prevention</td>
</tr>
<tr>
<td>October 28, 2010</td>
<td>Cross Setting I (Working and Aligning with Other Health Care Providers/Communication)</td>
</tr>
<tr>
<td>January 28, 2011</td>
<td>Cross Setting II (Chronic Care/Telehealth)</td>
</tr>
<tr>
<td>April 28, 2011</td>
<td>Cross Setting III (Medical Homes and Pioneering Ideas)</td>
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**Best Practice Intervention Timeline**

<table>
<thead>
<tr>
<th>HHA BPIP Implementation Timeline</th>
<th>Release Date 1/28/2010</th>
<th>Within 2 weeks /__/2010</th>
<th>Within 4 weeks /__/2010</th>
<th>Within 6 weeks /__/2010</th>
<th>Within 8-10 weeks /__/2010</th>
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<tbody>
<tr>
<td>Download BPIP Package</td>
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<td></td>
<td>Implementation of New tools/process changes</td>
<td>Begin evaluation of process changes</td>
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<tr>
<td>Team will select tools/resources</td>
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<td>QI Resource: Encourage Improvement Efforts</td>
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<td>Revise Process as necessary</td>
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<td>Test of change on small group (e.g. Plan/ Do/ Study/ Act)</td>
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<tr>
<td>Plan staff education</td>
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**TEAM TIPS**

An implementation team should include:

- Leadership including QI lead or QI team member
- Make it **interdisciplinary**--include representative from nursing, therapy, home health aide, and medical social work
- By having all disciplines represented, the employees will have increased motivation to support the quality improvement measures.
- Include **frontline staff**
- Consider adding a **patient representative** to your team!
- Specialized professionals as you see fit (example: a pharmacist when reviewing the medication BPIP relating to oral medications, a hospital / nursing home social worker / physician when reviewing the care settings BPIPs, etc.)

**EDUCATION TIPS**

Below are a few suggestions to help implement the usage of Best Practice Intervention Packages in your agency.

It is understood our patients have different learning styles, but so do those who provide the care.

**Visual Learners:**

- **Posters** located in strategic and high-traffic areas (supply rooms, restrooms, charting areas, mailbox areas)
- Paycheck memos
- Review **FAQs** at [www.homehealthquality.org](http://www.homehealthquality.org)
- Send weekly updates in the form of short e-mails to your employees
- Copy and distribute the **Discipline Tracks** (Either electronically or paper)
- **BPIP Webinars**—Encourage the staff to attend these presentations
- Post information updates on agency home page for clinicians or in electronic newsletters
- Copy and distribute the Case Studies (use as an individual or group self-study)

**Auditory Learners:**
- Audio recordings / Podcasts – Have CD's burned and available for the staff to “grab and go”
- Webinars – Encourage the staff to attend these or listen to the recorded session.
- Live Chat Sessions: Promote employee participation by asking the staff to enter questions to be answered during the Live Chat
- Regular cell phone reminders
- Quarterly Meetings discussing the plan for implementation
- Discuss the Case Studies as a team learning activity

The amount of learning accomplished relates directly to the willingness and motivation of the learner, the environment of the setting and is dependent upon:

- Leadership buy-in
- Interactive and enjoyable educational sessions
- Total engagement of participants (clinicians) without distractions (e.g. cell phones)
- Removal of barriers to participation and attendances (e.g. attention to time and location)

*When planning your method of communication, try to remember we learn...*

| 10% of what we READ |
| 20% of what we HEAR |
| 30% of what we SEE |
| 50% of what we SEE and HEAR |
| 70% of what is DISCUSSED with others |
| 80% of what is EXPERIENCED PERSONALLY |
| 95% of what we TEACH TO SOMEONE ELSE |

William Glasser
Visiting Nurse Services of New York Insights:

- Ensure each patient has a primary care physician who will be handling their care going forward.
- Ensure each patient has an appointment with this primary care physician within two weeks of discharge.
- Reconcile all medications within 24 hours of Start of Care. Alert a manager about patients that have medication discrepancies that may be difficult to resolve.
- Provide patients with a paper copy of an accurate medication list in patient friendly language.
- Provide patients and caregivers with an Action Plan that includes signs and symptoms of deterioration and information about what to do if a situation starts to deteriorate.
- Front load contacts for patients who score at high risk for rehospitalization. Provide additional visits and/or contact for first two weeks of care.
- Discuss reason for hospitalization with patient and document patient stated goals. Encourage patient self management by aligning home care goals with patient goals.

Sally Sobolewski, MSN, RN
Director of Performance Improvement
Visiting Nurse Service of New York

It is important to understand the scope of this campaign. The Home Health Quality Improvement National Campaign will focus on reducing avoidable acute care hospitalizations (ACH) and improving management of oral medications.

Reducing the rate of avoidable acute care hospitalizations in the home care setting has been compared to putting pieces of a puzzle together.

Many “puzzle pieces” such as emergency preparedness, medication management, Telehealth, immunizations, fall risk, wounds, and disease management must be considered when an agency actively works on reducing ACH.

The adopted theme of this campaign is “The Evolution of Care.” As health care providers, we are truly at a crossroads in the delivery of patient care in our country. Health care debates continue while our attention is directed towards the impact on home health care.
Home care leadership has an opportunity to become an even bigger part of care delivery, but must step up to the challenge. We are seeing the impact of chronic illnesses on health care systems. Thus, home care leaders must recognize their home care agency, whether large or small, and must evolve to meet these challenges.

The initial focus of this campaign will be a review and renewal of the fundamentals of reducing avoidable acute care hospitalizations. The final BPIPs will address cross setting opportunities for improving care coordination as this is an essential part to improving chronic care delivery. Many home care agencies have effectively implemented best practices to improve patient outcomes since the first HHQI National Campaign.

Two agencies were featured in video segments presented at the January 13, 2010 HHQI Summit. Leaders from these HHAs have shared some of their insights for this campaign. (See sidebars on pages 17 and 18.)

- 7 out of 10 deaths among Americans each year are from chronic diseases. Heart disease, cancer and stroke account for more than 50% of all deaths each year.
- In 2005, 133 million Americans – almost 1 out of every 2 adults – had at least one chronic illness.

Cathleen Reed
Director of Home Health & CQI
Columbia Montour Home Health & Hospice
Bloomsburg, Pennsylvania

Columbia Montour Home Health Services/VNA
Insights:
Best practices to help reduce hospitalizations

1. Conduct a risk for hospitalization assessment on all patients at SOC/ROC. If score is high risk, either make daily phone contact with the patient for 14 days or place a vital signs monitoring system in the home.

2. Visit more frequently at the beginning of the episode.

3. At SOC, provide the patient and family with easy to read signs and symptoms of exacerbation of disease process(es) and when to call the agency. With their permission, post it in a highly visible area of the home.

4. Obtain orders for other disciplines, if a single discipline is ordered, in order to establish a thorough head-to-toe treatment plan.

5. Conduct a thorough medication (prescription and OTC) review at SOC/ROC/Recert. Contact the physician with any medication concerns.

CDC, Chronic Disease and Health Promotion
CHECKLIST FOR AGENCY LEADERSHIP

How to use:
1. Review this checklist and select a few interventions that are appropriate for your agency. Remember, these activities are designed for agencies with varied degrees of best practice implementation.
   - Select 3-4 interventions to begin
   - Improvement team should make intervention selection with staff input
   - Depending on the size of your agency, plan on small trials with new tools and processes, evaluate effectiveness and then move to all agency implementation

   [Remember steps of Outcome Based Quality Improvement (OBQI) and Plan/Do/Study/Act (PDSA)]
   - Add to intervention selection as team/staff sees other areas for improvement

2. Utilize the ‘assigned to’ and ‘notes’ if needed.

3. Refer to the BPIP timeline to plan implementation of the selected interventions.

4. You may want to revisit this list after a few weeks and consider additional interventions.

5. The checklist is placed on the next page—so the checklist can be printed without the additional Leadership Information if so desired.

INSIGHTS

- **Frontload visits**: 50% of our readmissions are in the first 2 weeks of the episode
- Keep your hospitalization rates in front of the staff! (graphs, etc)
- Our nurses understand it is more work for them if the patient is hospitalized. They want to keep the patient home!
- Patient education is key—we have had good success with the ZONE tools!

Susan Testa BSN, MSA
Quality Improvement Manager
Home Health Outreach
Auburn Hills, Michigan
<table>
<thead>
<tr>
<th>CHECKLIST FOR AGENCY LEADERSHIP</th>
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<td><strong>SUGGESTED ACTIVITIES</strong></td>
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<td><strong>Assigned</strong></td>
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<td><strong>TO:</strong></td>
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<td><strong>NOTES</strong></td>
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<td><strong>DATE</strong> (IF SELECTED)</td>
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<tr>
<td><strong>COMPLETION</strong></td>
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<tr>
<td>o Incorporate a hospitalization risk assessment into all SOC/ROC assessments. If you are currently using one, confirm changes are made to insure compatibility with OASIS-C.</td>
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<tr>
<td>o Implement risk stratification tools to determine interventions and confirm use: Higher Risk patients should receive more resources (e.g. Telehealth).</td>
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<td>o Establish a nurse review process for all ‘therapy only’ cases to ensure identification of nursing needs and medication review, potential complications, interactions, etc.</td>
</tr>
<tr>
<td>o Review the BPIP Insights (tips from other home care leaders and clinicians). See which insights occur frequently and consider implementation:</td>
</tr>
<tr>
<td>o Frontloading visits</td>
</tr>
<tr>
<td>o Early and Frequent patient education</td>
</tr>
<tr>
<td>o Telehealth</td>
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<tr>
<td>o Calls on days with no visit</td>
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<tr>
<td>o CALL FIRST!!! (see posters)</td>
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<tr>
<td>o Utilize computerized health record features to link to best practices. <em>(See Success Story: Complete Home Care)</em></td>
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<tr>
<td>o Create an agency high-risk alert system to ensure that all staff, including evening, weekend and on-call, is informed of high-risk patients.</td>
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<tr>
<td>o Evaluate the high-risk patient groups by disease group and consider interventions related to diagnosis.</td>
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<tr>
<td>CHECKLIST FOR AGENCY LEADERSHIP</td>
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<td><strong>SUGGESTED ACTIVITIES</strong></td>
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<th><strong>NOTES</strong></th>
<th><strong>DATE OF COMPLETION</strong></th>
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- Utilize the educational information available on [www.homehealthquality.org](http://www.homehealthquality.org)
  - Podcast
  - Recorded Webinar
  - FAQs about the campaign

- Develop and post a graph of:
  - agency ACH rate in comparison with state and national rates
  - trending of ACH and Emergent Care Use
  - patient hospitalizations per day of the week / weekend / time of day

- Work with IT to have high-risk status appear on chart for all disciplines to see every visit.

- Educate all staff in identifying hospitalization risk and emergency care planning (nurses, therapists, home health aide, social workers, intake staff, weekend and on call staff, etc.).

- Case conference every high-risk patient and evaluate need for additional services or disciplines.

- Confirm patients have access to the necessary supplies/equipment (e.g. thermometer, blood glucose machine supplies) to self assess and report abnormal findings as instructed.

- At the next staff meeting, discuss the need to revisit hospitalization risk to assess if each discipline (nurses, therapists, home health aides, social workers) is ‘on the same page’ and believe agency is capturing all patients who are at risk. Incorporate each discipline’s expertise in this evaluation and provide educational support as necessary (example: HHA may need additional information as to which symptoms to report).
<table>
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<tr>
<th>SUGGESTED ACTIVITIES</th>
<th>ASSIGNED TO:</th>
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<th>DATE (IF SELECTED)</th>
<th>COMPLETION</th>
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<tr>
<td>o Seek the advice of therapists in such areas as falls prevention, identifying risk factors related to mobility, transfers, ADLs/IADLs.</td>
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<tr>
<td>o Select 1 or 2 of the success stories to share with staff. Also, share your agency success stories with the staff (when symptoms are noted early rather than late, when a hospitalization was avoided, etc.).</td>
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<td>o Review the care of any recently hospitalized patient and determine if all interventions were appropriate. Examine and discuss any delays in care and communication breakdowns.</td>
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<td>o Focus audit activities on charts of clinicians who have high rehospitalization rates to identify causal factors.</td>
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<td>o If not already in place, develop a process to assure Primary Care Physician follow up appointment is scheduled and completed.</td>
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<td>o Evaluate communication of hospitalization risk between the staff. Are all staff aware of which patients are at high-risk? Is there a plan for interventions?</td>
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<td>o Share your risk assessment tool with discharge planners, hospital case managers or nursing home providers to provide awareness of your endeavor to improve patient care, and to potentially screen and identify high-risk patients before discharge from the hospital.</td>
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<td>o Utilize decision support tools in the Patient Emergency Plan (PEP) to guide consistency of care. (Example:  is your agency utilizing the PEP with high risk patients or all patients?)</td>
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### INSIGHTS

5 best practices we try to follow:
- Utilize call first procedure, educate patients on S/S of exacerbation and when to notify a nurse.
- Frontload patients who are at high risk for hospitalization and follow closely until improvement is seen.
- Utilize multiple disciplines (PT, OT, HHA) in the home for patients at high risk for hospitalization.
- Implement SN PRN visits with any/all concerns reported by patient of family, and then triage the situation to evaluate severity before sending to the ER.
- Build good rapport with physician, patient and family by keeping all informed of patient progress/decline to build confidence in ability of nursing staff to care for patient in home setting.

Lisa Hollis, RN  
Director of Nursing  
CMC Home Health  
Calico Rock, Arkansas

### CHECKLIST FOR AGENCY LEADERSHIP

<table>
<thead>
<tr>
<th>SUGGESTED ACTIVITIES</th>
<th>ASSIGNED TO:</th>
<th>NOTES</th>
<th>COMPLETION DATE (IF SELECTED)</th>
</tr>
</thead>
<tbody>
<tr>
<td>o Implement process to inform the patient/caregiver about calling the agency, including: Who, what, when, where and how? (e.g. verify that the patient has access to a phone and can successfully place a call to the agency or 911.)</td>
<td></td>
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</tr>
<tr>
<td>o Give PEP instructions both on paper and verbally. (Confirm documentation.)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>o To provide standardization, agency could complete PEP based on AHA and ADA guidelines for standardization of information (in areas that are blank on forms).</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Verify all disciplines are referring to the patient emergency plan (PEP) on EVERY VISIT or CALL to reinforce ‘who to call when’.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Institute follow up calls to patients to assess understanding of their PEP and if a patient had a recent hospitalization, determine what could be changed to prevent future hospitalizations from the patient perspective.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**SELECTED TOOLS AND RESOURCES**

The selected tools for improving avoidable acute care hospitalization are the

- **Hospitalization Risk Assessment (HRA)**
- **Patient Emergency Plan (PEP)**

The completion of the hospitalization risk assessment should be part of a comprehensive assessment to identify those patients who are at risk for hospitalization. Risk assessment forms may be paper-based or integrated into point-of-care systems.

- A **structured communication process** should be established to communicate identified patients at **high-risk for hospitalization to appropriate staff**, including on-call staff.
- **Interventions selected** for the care plan to assist the patient in reducing avoidable hospitalizations and emergent care episodes are based upon the risk assessment findings.

Awareness of the patient’s risk factors will assist a clinician in developing a more specific **patient emergency plan**.

**Emergency care planning** is the overall process of helping the patient understand when symptoms need to be reported and to whom they need reported. The **Patient Emergency Plan** is the plan that is given to the patient with instructions and directions by the patient’s nurse and/or therapist.

- The **patient emergency plan** must be written in the language and at a level the patient will understand.
- The instructions should be written with **large, clear font** with relevant guidelines that enable patients to determine **how to respond to a change in health status**.

---

Additional Resources available at


- ZONE tools (May want to utilize with **Call Us First/Call the Nurse First**)
- GMCF ACH Risk Assessment
- STOP WATCH (Early warning assessment for home health aides/caregivers)

**Posters:**

- **Call Us First** (Additional format available on [HHQI Web site](http://www.homehealthquality.org/hh/campaign/bpip/default.aspx))
- **Call the Nurse First** (included with the All Care Home Care success story)
Hospitalization Risk Assessment

Purpose: Screening tool to identify those at risk for hospitalization.

Patient Name: ________________________________________ Record # _______________
Date: ___________________

Prior pattern: Check all that apply
- [ ] > 1 Hospitalizations or ER visits in the past 12 months (M1032)
- [ ] History of falls * (M1032 and M1910)

Chronic conditions: Check all that apply (M1020/1022/1024)
- [ ] HF (M1500 and M1510)
- [ ] Diabetes
- [ ] COPD
- [ ] Chronic skin ulcers (Wound consult if indicated for any wounds)
- [ ] HIV/AIDS

Risk Factors: Check all that apply
- [ ] Discharged from hospital or skilled nursing facility (M1000)
- [ ] More than 2 secondary diagnoses (M1022 and 1024)
- [ ] Low socioeconomic status or financial concerns *
- [ ] Lives alone (M1100) ★
- [ ] Inadequate support network (M1100)
- [ ] ADL assistance needed ★ (M2100 and M2110)
- [ ] Home safety risks ★
- [ ] Dyspnea (M1400) ★
- [ ] Help with managing medications needed (M2020)
- [ ] Non-compliance with medication regimen ★ ★
- [ ] Confusion (M1710) ★
- [ ] Pressure ulcer (M1300, M1302 and M1306) ★
- [ ] Stasis ulcer (M1330)★
- [ ] Overall Poor Status/Prognosis (M1034)
- [ ] Low literacy level ★
- [ ] Depression (M1730) ★

Consider Therapy referral (PT, OT, ST) ★
Consider MSW referral
cConsider Hospice referral
Consider RN referral, if not ordered

Total # of checked boxes is ____. Your agency may want to select a threshold score to target patients at high risk.
(For example: 5 or greater risk factors may indicate that the patient is at risk for hospitalization. Note: This number is for convenience only and has not been tested or validated. The agency may modify the score based upon the needs of their patient population.)

Carry out patient specific interventions as appropriate/ordered, if patient is at risk for hospitalization:
(Coordinate with M2250)

<table>
<thead>
<tr>
<th>Referrals:</th>
<th>Medication Management</th>
<th>Patient/family education</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] SN</td>
<td>[ ] Medication Reconciliation</td>
<td>[ ] Enrollment into a disease management program (specify):</td>
</tr>
<tr>
<td>[ ] PT</td>
<td>[ ] Assess patient’s: knowledge, ability, resources and adherence</td>
<td></td>
</tr>
<tr>
<td>[ ] OT</td>
<td>[ ] Education</td>
<td></td>
</tr>
<tr>
<td>[ ] ST</td>
<td>[ ] Front-loading Visits</td>
<td></td>
</tr>
<tr>
<td>[ ] MSW</td>
<td>[ ] Front Line</td>
<td></td>
</tr>
<tr>
<td>[ ] HHA</td>
<td>[ ] Immunizations (M1040, M1045, M1050, M1055)</td>
<td></td>
</tr>
<tr>
<td>[ ] Dietary Consultant</td>
<td>[ ] Influenza</td>
<td></td>
</tr>
<tr>
<td>[ ] Other:</td>
<td>[ ] Pneumococcal</td>
<td></td>
</tr>
<tr>
<td>[ ] Hospice/Palliative Referral</td>
<td>[ ] Phone Monitoring</td>
<td></td>
</tr>
<tr>
<td>[ ] Individualized Patient Emergency Care Plan</td>
<td>[ ] Care Coordination (Physicians, hospitals, nursing homes…)</td>
<td></td>
</tr>
<tr>
<td>[ ] Fall Prevention Program</td>
<td>[ ] Telemonitoring</td>
<td></td>
</tr>
<tr>
<td>[ ] Other:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Notify the following, as appropriate, if patient is at risk for hospitalization:

- [ ] Physician
- [ ] Interdisciplinary Team
- [ ] On Call Staff
- [ ] Payer: (e.g. Managed Care Organizations)

- [ ] Correlate with M2250 for physician notification of specific parameters/interventions
- [ ] Patient/family/caregiver
- [ ] Agency Case Manager
- [ ] Other:

Clinician Signature: __________________________ Date: ________________

Adapted from Personal Touch Home Care, VA 6/25/04 Professional Practice Model.
Revised 12/21/09 to correlate with OASIS-C.

The following articles provide more information on risk assessments:

This material was prepared by the West Virginia Medical Institute, the Quality Improvement Organization supporting the Home Health Quality Improvement National Campaign, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. Publication number: 950W-WY-JH-BBK-0127104. App. 01/10.
**MY EMERGENCY PLAN**

<table>
<thead>
<tr>
<th>WHAT TO DO?</th>
<th>CALL MY HOME HEALTH AGENCY WHEN:</th>
<th>CALL 911 WHEN:</th>
</tr>
</thead>
</table>
| **I hurt**  | • New pain OR pain is *worse* than usual  
• Unusual bad headache  
• Ears are ringing  
• My blood pressure is above: _____/_____  
• Unusual low back pain  
• Chest pain or tightness of chest RELIEVED by rest or medication | • Severe or prolonged pain  
• Pain/discomfort in neck, jaw, back, one or both arms, or stomach  
• Chest discomfort with sweating/nausea  
• Sudden severe unusual headache  
• Sudden chest pain or pressure & medications don’t help (e.g. Nitroglycerin as ordered by physician), OR  
• Chest pain went away & came back |
| **I have trouble breathing** | • Cough is worse  
• Harder to breathe when I lie flat  
• Chest tightness RELIEVED by rest or medication  
• My inhalers don’t work  
• Changed color, thickness, odor of sputum (spit) | • I can’t breathe!  
• My skin is gray OR fingers/lips are blue  
• Fainting  
• Frothy sputum (spit) |
| **I have fever or chills** | • Fever is above ________ F  
• Chills/can’t get warm | • Fever is above ________ F with chills, confusion or difficulty concentrating |
| **I fell** | • Dizziness or trouble with balance  
• Fell and hurt myself  
• Fell but didn’t hurt myself | • Fell and have severe pain |

This plan is a guide only and may not apply to all patients and/or situations. This plan is not intended to override patient/family decisions in seeking care.

Developed by Quality Insights of Pennsylvania in conjunction with Carol Siebert, MS, OTR/L, FAOTA, American Occupational Therapy Association and Karen Vance, OTR/L, BKD Healthcare Group and American Occupational Therapy Association. Based on MyEmergency Plan created by Delmarva in conjunction with OASIS Answers, Inc.
<table>
<thead>
<tr>
<th>WHAT TO DO?</th>
<th>CALL MY HOME HEALTH AGENCY WHEN:</th>
<th>CALL 911 WHEN:</th>
</tr>
</thead>
</table>
| ![Smiling Face]     | • One of my arms or legs is sore  
• My back is stiff / sore  
• I’m walking slower                                                                 | • Suddenly my face, arm or leg is weaker / numb / won’t move  
• Suddenly one hand grip is weaker or dropping things such as a spoon  
• When “sticking out” my tongue is not in the middle of mouth  
• When I smile, my mouth is uneven  
• When I raise my eyebrows, they are uneven  
• My face is numb or drooping |
| ![Frowning Face]    | • Bloody, cloudy, or change in urine color or foul odor  
• Gums, nose, mouth or surgical site bleeding  
• Unusual bruising                                                                 | • Bleeding that won’t stop  
• Bleeding with confusion, weakness, dizziness and fainting  
• Throwing up bright red blood or it looks like coffee grounds  
• Large amount of bright red blood |
| ![Confused Face]    | • Confused  
• Restless, agitated  
• Can’t concentrate                                                                 | • Sudden difficulty speaking  
• Unable to remember important names (my own, spouse, children)  
• Suddenly I am unable to read. I can hear others talking but can’t understand what they are saying |

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# What to Do?

<table>
<thead>
<tr>
<th>WHAT TO DO?</th>
<th>CALL MY HOME HEALTH AGENCY WHEN:</th>
<th>CALL 911 WHEN:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>My weight or appetite changed</strong></td>
<td>• I don’t have an appetite&lt;br&gt;• Lost ___ lbs in _____ days&lt;br&gt;• Gained ___ lbs in 1 day OR ___ lbs in ___ days&lt;br&gt;• Feet/ankles/legs are swollen</td>
<td></td>
</tr>
<tr>
<td><strong>I don’t feel right</strong></td>
<td>• Weaker than usual&lt;br&gt;• Dizzy, lightheaded, shaky&lt;br&gt;• Very tired&lt;br&gt;• Heart fluttering, skipping or racing&lt;br&gt;• Blurred vision</td>
<td>• Sudden numbness or weakness of the face, arm or leg&lt;br&gt;• Sudden difficulty speaking/slurred words&lt;br&gt;• Suddenly can’t keep my balance</td>
</tr>
<tr>
<td><strong>I feel sick to my stomach</strong></td>
<td>• Throwing up&lt;br&gt;• New coughing at night</td>
<td>• Can’t stop throwing up&lt;br&gt;• Throwing up blood</td>
</tr>
<tr>
<td><strong>Bowel troubles</strong></td>
<td>• Diarrhea&lt;br&gt;• Black/dark OR bloody bowel movement&lt;br&gt;• No bowel movement in _____ days&lt;br&gt;• No colostomy/ileostomy output in _______hours/days</td>
<td></td>
</tr>
<tr>
<td><strong>Trouble urinating</strong></td>
<td>• Leaking catheter&lt;br&gt;• No urine from catheter in _____ hours&lt;br&gt;• Have not passed water in _____ hours&lt;br&gt;• Urine is cloudy</td>
<td></td>
</tr>
</tbody>
</table>

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### WHAT TO DO?

#### CALL MY HOME HEALTH AGENCY WHEN:

- Burning feeling while urinating
- Belly feels swollen or bloated

#### CALL 911 WHEN:

- I have a plan of hurting myself or someone else

#### I am anxious or depressed

- Always feeling anxious
- Loss of appetite
- Unable to concentrate
- Trouble sleeping
- Loss of hope
- Constant sadness

#### My wound changed

- Change in drainage amount, color or odor
- Increase in pain at wound site
- Increase in redness/warmth at wound site
- New skin problem
- Fever is above _______F

#### I have Diabetes and I’m . . .

- Thirsty or hungry more than usual
- Urinating a lot
- Vision is blurred
- I’m feeling weak
- My skin is dry and itchy
- Repeated blood sugars greater than _________mg/dl

- Fruity breath
- Nausea/throwing up
- Difficulty breathing
- Blood sugar greater than ______mg/dl

---

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### WHAT TO DO?

<table>
<thead>
<tr>
<th>CALL MY HOME HEALTH AGENCY WHEN:</th>
<th>CALL 911 WHEN:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Shaky</td>
<td>- Low blood sugar not responding to treatment</td>
</tr>
<tr>
<td>- Sweating</td>
<td>- Unable to treat low blood sugar at home</td>
</tr>
<tr>
<td>- Extreme tiredness</td>
<td>- Unconsciousness</td>
</tr>
<tr>
<td>- Hungry</td>
<td>- Seizures</td>
</tr>
<tr>
<td>- Have a headache</td>
<td></td>
</tr>
<tr>
<td>- Confusion</td>
<td></td>
</tr>
<tr>
<td>- Heart is beating fast</td>
<td></td>
</tr>
<tr>
<td>- Trouble thinking, confused or irritable</td>
<td></td>
</tr>
<tr>
<td>- Vision is different</td>
<td></td>
</tr>
<tr>
<td>- Repeated blood sugars less than</td>
<td></td>
</tr>
<tr>
<td>______mg/dl</td>
<td></td>
</tr>
</tbody>
</table>

**Take:**  3 glucose tablets, OR ½ glass of juice, OR 5-6 pieces of hard candy, OR _______________________

**Wait:** 15 minutes & re-check blood sugar

**IF** your blood sugar is still low and symptoms do not go away: Eat a light snack:

½ peanut butter OR meat sandwich, ½ glass milk

**Wait:** 15 minutes & re-check blood sugar

### CALL 911 WHEN:

<table>
<thead>
<tr>
<th>CALL 911 WHEN:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Low blood sugar not responding to treatment</td>
</tr>
<tr>
<td>- Unable to treat low blood sugar at home</td>
</tr>
<tr>
<td>- Unconsciousness</td>
</tr>
<tr>
<td>- Seizures</td>
</tr>
</tbody>
</table>

### Other problems

<table>
<thead>
<tr>
<th>CALL 911 WHEN:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Feeding Tube clogged</td>
</tr>
<tr>
<td>- Problems with my IV/site</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CALL 911 WHEN:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Sudden loss of vision in one or both eyes</td>
</tr>
</tbody>
</table>

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This plan is a guide only and may not apply to all patients and/or situations. This plan is not intended to override patient/family decisions in seeking care.
Every visit, every contact, remind your patients...

CALL ME FIRST!

We can help our patients avoid unplanned hospitalizations if we know they need our help.

Every time you see or speak with a patient, remember to say

“CALL ME FIRST!”
The culture of an organization will significantly impact an organization’s improvement efforts. There are many aspects to the evaluation of organizational culture: communication, leadership and teamwork. While all facets of culture are important, the impact of communication will be echoed throughout the HHQI National Campaign. Communication, while affecting not only your organization, but your patients and health care partners, is essential to establishing an environment where staff readily adopts improvement changes. To ensure patient safety and to retain qualified staff, communication efforts should address all levels of staff. Improvement in communications during care transitions is a paradigm shift in thinking for our health care system.

Certain generic questions arise during discussions of culture and communication, such as:
- Does your organization foster open communication?
- Does staff feel comfortable approaching leadership?

However, transforming an organization’s culture to one of open communication is more than taking a survey and just discussing communication. It is the mindset, mission, and personality of your agency. Adopting strategies and best practices will only ‘Band-Aid’ improvement efforts if the culture doesn’t truly promote communication.

Begin with an open discussion of core beliefs at your agency. Perhaps discuss these at your next leadership and staff meetings along with discussion of best practices. The discussion may reaffirm you are indeed an organization that promotes communication between staff, leadership and across providers. Or maybe the discussion will lead you to a weak area which could benefit from the implementation of improvement strategies. Of course, it is known that these strategies are not going to be helpful if not supported by everyone.

http://www.managementhelp.org/org_thry/culture/culture.htm
*Why Hospitals Should Fly* John J. Nance, JD

"What we need is a cultural revision where everyone cares that this patient does not require readmission". ~ Norma Jean (a home health nurse)
SUCCESS STORIES

The success stories for this package take us back to the video vignettes for the HHQI 2007 Summit. Each of the agencies that had a patient featured during the 2007 summit has discussed the changes their agencies have experienced over the past 3 years. They have presented different challenges and successes from which we can all learn. Below are brief descriptions which are link to the full success story. Click on the link to learn from agencies that have had great success.

**All Care Home Care:** This agency improved their ACH rate by intensive emergency care planning. One of their customized posters is included.

**Complete Home Care:** The leaders at this agency share how they have maximized their computerized health record to assure best practice compliance.

**VNA Community Care:** This agency is participating in very innovative ways to manage chronic care patients.

**HomePlus:** This agency shares how they have strived to have some of the best ACH rates in the country. Links to the ZONE tools, included a customized ZONE tool for Hypertension, are included.

INSIGHTS

“Best practices and strategies must be part of the normal day-to-day activities. Simply applying the nursing process (assess-plan-implement-evaluate) will help avoid unnecessary hospitalizations and improving a patient’s abilities with medication management and other outcomes.”

*Kathy Seymour, RN*
*Director of Performance Improvement*
*Eddy Visiting Nurse Association*
*Troy, New York*
As health care professionals, we all want to deliver high quality care to our patients. But sometimes our hard work can lead to myopia that prevents us from seeing the big picture. Issues related to avoidable hospital readmissions and poor transitions across care settings are in the headlines and represent a source of concern and unnecessary waste of our health care dollars.

Collaborating with providers from other care settings including hospitals, nursing homes, home health agencies and primary care physicians along with community stakeholders is essential in promoting safe and effective transitions from one care setting to another. We know that Home Health care provides, as part of its mission the overarching goal of keeping patients in the environment that wish to remain in – “their home.”

The interventions and tools contained in the BPIPs will assist agencies in promoting seamless transitions from one care setting to another. The downstream benefit of these efforts will be not only the reduction of avoidable acute care hospital readmissions but hopefully sustainable and replicable strategies that achieve high-value quality health care for Medicare beneficiaries.

The current HHQI National Campaign strives to offer fresh insights into care delivery by promoting more effective communication among all health care providers.

Our patients care about their own well-being, especially when it comes to unnecessary hospitalizations that create financial and emotional burdens for themselves and their families. With more than one in four home health patient episodes resulting in hospitalization, we need to center our quality improvement efforts on reducing this rate. Home health quality improvement interventions can provide the tools to begin this process. Working together, we can strive to broaden our perspectives and improve our communication across care settings while focusing on what matters most: our patients.

David R. Wenner, DO, FAAFP
Medical Director
Quality Insights of Pennsylvania

“When we provide support and services to help people to stay at home...we’ve really done a huge service to the patient and to their family. There’s such family stress around being able to keep their chronically ill and lower mobility loved ones at home. When physicians work with home health, we are often providing that intervention that helps keep somebody at home. It’s very gratifying when the family and the patients thank you for the effort.”

Steven Landers MD, MPH
Director, Center for Home Care and Community Rehabilitation, Cleveland Clinic
Best Practice:

Nurse Track

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Skilled Nursing Track:
Focus on Acute Care Hospitalization

As you are aware, home care nursing provides unique patient care opportunities. One opportunity is being able to affect whether your patient has an avoidable acute care hospitalization (ACH). A new Home Health Quality Improvement Campaign has been initiated on January 13, 2010 where its initial focus is reviewing ways for home health staff to refocus their efforts to decrease this occurrence.

The national average of home care patients who are admitted to the hospital is now 29%, meaning more than 1 out of every 4 home care episodes ends in a hospitalization. What is your agency’s rate?

**TOOLS AND RESOURCES FOR REDUCING ACH**

There are many tools, resources and processes that can help with reducing avoidable acute care hospitalization rates. We’ll just focus on a few.

The starting point to improving hospitalization rates is the **Hospitalization Risk Assessment (HRA)** tool. Your agency may already be using an HRA. It is essential that appropriate interventions are selected for the patient after completing the HRA. These may include frontloading visits, Telehealth, and emergency care planning.

A structured communication process should be established to communicate identified patients at high-risk for ACH to appropriate staff, including on-call staff.

Another tool associated with decreasing hospitalization is the **Patient Emergency Plan (PEP)**. The PEP is a tool which clinicians give to and review with the patient, so the patient is aware of ‘who to call when’. Again, your agency may already be using some type of PEP.

OASIS-C includes an assessment question that evaluates Hospitalization Risk: **M1032**. If your agency utilizes an additional hospitalization risk assessment (HRA), **confirm that** the HRA coordinates with **M1032**!
Emergency care planning is the overall process of helping the patient understand when symptoms need to be reported and to whom they need to be reported. Every hospitalization and emergency room visit cannot be prevented. The intent of this campaign is to assist in preventing those which are avoidable. Utilize the HRA to identify those patients at ‘high-risk’ and the PEP so the patient calls the right provider at the right time so the patient can receive the right care every time!

*Sample tools can be obtained on www.homehealthquality.org either individually or in the Best Practice Intervention Package (BPIP) complete package. Ask your leadership for a copy!

SN Checklist: Do you:

- Assess for hospitalization risk?
- Plan interventions appropriately for high-risk patients?
- Consult with other clinicians, including the Primary Care Physician (PCP) while planning interventions?
- Case conference your high-risk patients?
- Utilize other risk assessments (pressure ulcer risk, fall risk)?
- Review the PEP with the patient at each visit until the patient and caregiver understand it very well?
- Utilize the PEP for patient self-management. Patient needs to understand when to call PCP after home care discharge!
- Instruct the patient caregiver and home health aide in the patient emergency plan/symptoms to look for and 'who to call when'?
- Utilize tools or training for other disciplines (HHAs) to recognize a change in patient condition and know who to alert?
- Assess for patients for use of Telehealth for daily monitoring?

Insights

- Upload Visits Upfront
- Teach and train patients from SOC to understand they need to be able to self-manage at discharge
- Use Case Management so the same nurse and therapist who initiate the patient’s care will keep the patient throughout their care.
- Case Conference frequently!

Caridad Lorenzo, Director of Professional Services Baptist Health Home Care Miami, Florida

Colleen Rose PT COS-C, Quality Manager, Visiting Nurse Association of Rhode Island
Best Practice:

Therapy Track

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The national average of home care patients who are admitted to the hospital is now 29%, meaning more than 1 out of every 4 home care episodes ends in a hospitalization. What is your agency’s rate?

**Tools and Resources for Reducing ACH**

There are many tools, resources and processes that can help with reducing avoidable acute care hospitalization rates. We’ll just focus on a couple.

The starting point to improving hospitalization rates is the implementation of the Hospitalization Risk Assessment (HRA) tool. Your agency may already be using an HRA. It is essential that appropriate interventions are selected for the patient after completing the HRA. These may include frontloading visits, Telehealth, and emergency care planning.

A structured communication process should be established to communicate identified patients at high-risk for ACH to appropriate staff, including on-call staff.

Another tool associated with decreasing hospitalization is the Patient Emergency Plan (PEP). The PEP is a tool which clinicians give to and review with the patient, so the patient is aware of ‘who to call when’. Again, your agency may already be using some type of PEP.

OASIS-C includes an assessment question that evaluates Hospitalization Risk: **M1032**. If your agency utilizes an additional hospitalization risk assessment (HRA), confirm that the HRA coordinates with **M1032**!

Do you Facebook? Consider becoming a fan of the HHQI campaign on our Facebook page. Also follow HHQI updates on Twitter.
**Emergency care planning** is the overall process of helping the patient understand when symptoms need to be reported and to whom they need to be reported.

Every hospitalization and emergency room visit cannot be prevented. The intent of this campaign is to assist in preventing those which are avoidable. Utilize the HRA to identify those patients at ‘high-risk’ and the PEP so the patient calls the **right provider** at the **right time** so the patient can receive the **right care every time**!

*Sample tools can be obtained on [www.homehealthquality.org](http://www.homehealthquality.org) either individually or in the Best Practice Intervention Package (BPIP) complete package. Ask your leadership for a copy!*

**Therapy Checklist:**  
**Do you:**

- Assess for hospitalization risk?
- Plan interventions appropriately for high-risk patients?
- Consult with other clinicians, including Primary Care Physician (PCP), while planning interventions?
- Consult with a RN to assess the medication regimen including compliance, side-effects, interactions and consult with nurse when appropriate?
- **Case conference** your high-risk patients?
- Utilize other risk assessments (pressure ulcer risk, fall risk)?
- Review the PEP with the patient **at each visit** until the patient and caregiver understand it very well?
- Instruct the patient, caregiver and home health aide in the patient emergency plan/ symptoms to look for and ‘**who to call when**’?
- Assess for patients for use of Telehealth in home for daily monitoring.

**Insights**

- Utilize the input of **all disciplines** when evaluating the patient on admission.
- Spend time cross training staff on admission assessments to provide a better and more thorough assessment. For example, therapists are taught how to do a complete medication assessment.
- Make the admission assessment a complete assessment, including three positional BP’s to evaluate for fall risk and a head-to-toe skin assessment.
- Utilize pen lights to assess skin. Patient homes do not always have the best lighting!
- **Know which patients are at risk.** Customize Telehealth for patient specific diagnosis symptoms and concerns to alert of possible decline in health which may cause a rehospitalization that could be prevented.
- **Teach with a multidisciplinary approach.** Our electronic records are in “real time” so we can communicate in real time. Our patients receive education consistently, whether from the nurse, the therapist or the CNA. One-time teaching doesn’t work with patients.
- Implement multidisciplinary team meetings to discuss **all patients weekly**. This allows for an awareness of other perspective of interventions.
- Utilize case management model: 1-2 RN/LPN, 1 Therapist per patient to promote consistency of staff.

*Colleen Rose PT COS-C  
Quality Manager, Visiting Nurse Association of Rhode Island*
Best Practice:

Medical Social Worker Track

This material was prepared by the West Virginia Medical Institute, the Quality Improvement Organization supporting the Home Health Quality Improvement National Campaign, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. Publication Number: 9SOW-WV-HH-BBK-012710. App. 01/10.
As you are aware, home care nursing provides unique patient care opportunities. One opportunity is being able to affect whether your patient has an avoidable acute care hospitalization (ACH). A new Home Health Quality Improvement Campaign has been initiated on January 13, 2010 where its initial focus is reviewing ways for home health staff to refocus their efforts to decrease this occurrence.

The national average of home care patients who are admitted to the hospital is now 29%, meaning more than 1 out of every 4 home care episodes ends in a hospitalization. What is your agency’s rate?

**TOOLS AND RESOURCES FOR REDUCING ACH**
There are many tools, resources and processes that can help with reducing avoidable acute care hospitalization rates. We’ll just focus on a couple.

The starting point to improving hospitalization rates is the implementation of the Hospitalization Risk Assessment (HRA) tool. Your agency may already be using an HRA. It is essential that appropriate interventions are selected for the patient after completing the HRA. These may include frontloading visits, Telehealth, and emergency care planning.

A structured communication process should be established to communicate identified patients at high-risk for ACH to appropriate staff, including on-call staff.

Another tool associated with decreasing hospitalization is the Patient Emergency Plan (PEP). The PEP is a tool which clinicians give to and review.
with the patient, so the patient is aware of ‘**who to call when**’. Again, your agency may already be using some type of PEP. **Emergency care planning** is the overall process of helping the patient understand when symptoms need to be reported and to whom they need to be reported.

Every hospitalization and emergency room visit cannot be prevented. The intent of this campaign is to assist in preventing those which are **avoidable**. Utilize the HRA to identify those patients at ‘high-risk’ and the PEP so the patient calls the **right provider** at the **right time** so the patient can receive the **right care every time**!

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**MEDICAL SOCIAL WORKER CHECKLIST:**

**Do you:**
- Know how your agency assesses for patient hospitalization risk?
- Know if your agency utilizes **PEP**?
- Participate in **case conferences** about high-risk patients?
- Know the agency process for emergency care planning?
- Activate referrals and support services when patient identified at high risk?

**INSIGHTS**
- Teach and train patients from SOC to understand they need to be able to **self-manage at discharge**
- Use **Case Management** so the same nurse and therapist who initiate the patient’s care will keep the patient throughout their care.
- Case Conference frequently!

*Caridad Lorenzo, Director of Professional Services
Baptist Health Home Care
Miami, Florida*
Best Practice:

Home Health Aide Track

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Home Health Aide Track: Focus on Acute Care Hospitalization

As you are aware, home care nursing provides unique patient care opportunities. One opportunity is being able to affect whether your patient has an avoidable acute care hospitalization (ACH). A new Home Health Quality Improvement Campaign has been initiated on January 13, 2010 where its initial focus is reviewing ways for home health staff to refocus their efforts to decrease this occurrence.

**TOOLS AND RESOURCES FOR REDUCING ACH**

There are many tools, resources and processes that can help with reducing avoidable acute care hospitalization rates. We'll just focus on a couple.

The starting point to improving hospitalization rates is the implementation of the **Hospitalization Risk Assessment (HRA)** tool. Your agency may already be using an HRA. It is essential that appropriate interventions are selected for the patient after completing the HRA. These may include frontloading visits, Telehealth, and emergency care planning.

A structured communication process should be established to communicate identified patients at **high-risk for ACH to appropriate staff.**

Another tool associated with decreasing hospitalization is the **Patient Emergency Plan (PEP).** The PEP is a tool which clinicians give to and review with the patient, so the patient is aware of **‘who to call when’**. Your agency may already be using some type of PEP.

Every hospitalization and emergency room visit cannot be prevented. The intent of this campaign is to assist in preventing those which are avoidable. Utilize the HRA to identify those patients at ‘high-risk’ and the PEP so the patient calls the **right provider** at the **right time** so the patient can receive the **right care every time**!
HOME HEALTH AIDE CHECKLIST:

Do you:

☐ Know if your agency assesses for patient hospitalization risk?
☐ Know if your agency utilizes a Patient Emergency Plan (PEP)?
☐ Understand what symptoms should be reported to the nurse/therapist?
☐ Report concerns about patient medications that you may have observed? (Examples: medications not taken, pill containers found in the bed, table, etc., worrisome patient comments such as “I didn’t take my Lasix this morning because I have to use the bathroom too much at night.”)
☐ Participate in case conferences about high-risk patients?
☐ Know where the PEP is located and make sure it is accessible to the patient/caregiver?
☐ Review the Patient Emergency Plan so you understand which symptoms to report to the nurse/therapist?

INSIGHTS

“Our home health aides have a strong sense of when to notify the supervisor of a change in patient status. Our loop of communication is well-established between the nurse and home health aide!”

Susan Testa BSN, MSA
Quality Improvement Manager
Home Health Outreach
Auburn Hills, Michigan