How-to Guide: Improving Transitions from the Hospital to Home Health Care to Reduce Avoidable Rehospitalizations

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The Institute for Healthcare Improvement (IHI) is an independent not-for-profit organization that works with health care providers and leaders throughout the world to achieve safe and effective health care. IHI focuses on motivating and building the will for change, identifying and testing new models of care in partnership with both patients and health care professionals, and ensuring the broadest possible adoption of best practices and effective innovations. Founded in 1991 and based in Cambridge, Massachusetts, IHI mobilizes teams, organizations, and increasingly nations, through its staff of more than 100 people and partnerships with hundreds of faculty around the world.

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I. Introduction

Delivering high-quality, patient-centered health care requires crucial contributions from many parts of the care continuum, including the effective coordination of transitions between providers and care settings. Poor coordination of care across settings results in rehospitalizations, many of which are avoidable. Importantly, working to reduce avoidable rehospitalizations is one tangible step toward achieving broader delivery system transformation.

The Institute for Healthcare Improvement (IHI) has a substantial track record of working with clinicians and staff in clinical settings and health care systems to improve transitions in care after patients are discharged from the hospital and to reduce avoidable rehospitalizations. IHI gained much of its initial expertise by leading an ambitious, system-redesign initiative called Transforming Care at the Bedside (TCAB). Funded by the Robert Wood Johnson Foundation, TCAB enabled IHI to work initially with a few high-performing hospital teams to create, test, and implement changes that dramatically improved teamwork and care processes in medical/surgical units. One of the most promising TCAB innovations was improving discharge processes for patients with heart failure (see the TCAB How-to Guide: Creating an Ideal Transition Home for Patients with Heart Failure for a summary of the “vital few” promising changes to improve transitions in care after discharge from the hospital and additional guidance for front-line teams to reliably implement these changes).

In 2009, IHI began a strategic partnership with the American College of Cardiology to launch the Hospital to Home (H2H) initiative. The goal is to reduce all-cause readmission rates among patients discharged with heart failure or acute myocardial infarction by 20 percent by December 2012. H2H leverages an array of national initiatives intended to reduce readmissions and catalyze action to improve patients’ care transitions.

IHI is also leading a groundbreaking multi-state, multi-stakeholder initiative called STate Action on Avoidable Rehospitalizations (STAAR). The aim is to dramatically reduce rehospitalization rates in states or regions by simultaneously supporting quality improvement efforts at the front lines of care, while working in parallel with state leaders to initiate systemic reforms to overcome barriers to improvement. Since 2009, STAAR’s work in Massachusetts, Michigan, and Washington has been funded through a generous grant provided by The Commonwealth Fund, a private foundation supporting independent research on health policy reform and a high-performance health system. Additionally, the state of Ohio has funded its own participation in STAAR beginning in 2010.
The Case for Creating an Ideal Transition Home and Reducing Avoidable Rehospitalizations

Hospitalizations account for nearly one-third of the total $2 trillion spent on health care in the United States.\(^1\,^2\) In the majority of cases, hospitalization is necessary and appropriate. However, experts estimate that 20 percent of US hospitalizations are rehospitalized within 30 days of discharge.\(^1\,^2\) According to an analysis conducted by the Medicare Payment Advisory Committee (MedPAC), up to 76 percent of rehospitalizations occurring within 30 days in the Medicare population are potentially avoidable.\(^3\) Avoidable hospitalizations and rehospitalizations are frequent, potentially harmful, and expensive, and represent a significant area of waste and inefficiency in the current delivery system.

Poorly executed care transitions negatively affect patients’ health, well-being, and family resources and unnecessarily increase health care system costs. Continuity in patients’ medical care is especially critical following a hospital discharge. For older patients with multiple chronic conditions, this "handover" takes on even greater importance. Research shows that one-quarter to one-third of these patients return to the hospital due to complications that could have been prevented.\(^4\) Unplanned rehospitalizations may signal a failure in hospital discharge processes, patients’ ability to manage self-care, and the quality of care in the next community setting (office practices, home health care, and skilled nursing facilities).

Interventions to Reduce Rehospitalizations

Opportunities abound for improving care when patients leave the hospital setting. A 2006 survey found that over 60 percent of patients reported that no one in the hospital talked to them about managing their care at home, and the same survey found that over 80 percent of patients who required assistance with basic functional needs failed to have a home health care referral.\(^5\) In addition, direct communication between hospital providers and ambulatory providers is poor; in 2007, Kripalani and colleagues found that direct communication occurred infrequently (for 3 to 20 percent of cases), and discharge summaries were available to the ambulatory provider in only 12 to 34 percent of cases.\(^6\) A 2009 analysis of Medicare rehospitalizations revealed that half of patients who were readmitted within 30 days had not seen a physician between the time of discharge and the day of readmission. The analysis also found that the risk of rehospitalization is highest in the days following discharge, suggesting that follow-up within days, not weeks, should be standard practice.\(^7\)
A large body of research has focused on methods to improve the hospital discharge process and promising post-discharge support interventions. IHI’s comprehensive literature review and scan of current best practices identified the following high-leverage interventions:8

- Effective patient and caregiver education and self-management training during hospitalization and following discharge; anticipatory guidance for self-care needs at home post-discharge;5,9-11

- Reliable referrals for home health care visits;5

- Effective management and communication of medication regimens whenever changes occur;12,13

- Timely and clinically meaningful communication (handovers) between care settings;6,14

- Early post-acute care follow-up (by care coordinator, coach, telephone nurse, or clinician);15-17 and

- Proactive discussions of advance care planning and/or end-of-life preferences, and reliable communication of those preferences among providers and between care settings.

Evidence suggests specific interventions reduce avoidable rehospitalizations: improving discharge planning and transition processes out of the hospital; improving transitions and care coordination at the interfaces between care settings; enhancing coaching, education, and support for self-management; redesigning primary care; and providing supplemental services for patients at high risk of recurrent hospitalization.18-21

How-to Guide: Improving Transitions from the Hospital to Home Health Care to Reduce Avoidable Rehospitalizations

Based on the growing body of evidence and IHI’s experience to date in improving transitions in care after a hospitalization and in reducing avoidable rehospitalizations, IHI has developed a conceptual roadmap (Figure 1) that depicts the cumulative effect of key interventions to improve the care of patients throughout the 30 days after patients are discharged from a hospital or post-acute care facility.
The transition from the hospital to post-acute care settings has emerged as an important priority in IHI’s work to reduce avoidable rehospitalizations. Transitions in care after hospitalization involve both an improved transition out of the hospital (and from post-acute care and rehabilitation facilities) as well as an activated and reliable reception into the next setting of care such as a home health care agency, primary care practice, or a skilled nursing facility.7,16,22 As one study noted, “Although the care that prevents rehospitalization occurs largely outside of the hospital, it starts in the hospital.”7 The How-to Guide: Improving Transitions from the Hospital to Post-Acute Care Settings to Reduce Avoidable Rehospitalizations is designed to support hospital-based teams and their community partners to co-design and reliably implement improved care processes to ensure that patients who have been discharged from the hospital
have an ideal transition to home or to the next community care setting. IHI provides additional
How-to Guides for home health care agencies, clinical office practices, and skilled nursing
facilities. These How-to Guides are designed to assist clinicians and staff in home health care
agencies, office practices, and skilled nursing facilities in developing processes that ensure a
timely and reliable transition into community care settings:

- How-to Guide: Improving Transitions from the Hospital to Post-Acute Care Settings to
  Reduce Avoidable Rehospitalizations, June 2012

- How-to Guide: Improving Transitions from the Hospital to Skilled Nursing Facilities to
  Reduce Avoidable Rehospitalizations, June 2012

- How-to Guide: Improving Transitions from the Hospital to the Clinical Office Practice to
  Reduce Avoidable Rehospitalizations, June 2012

The How-to Guide: Improving Transitions from the Hospital to Home Health Care to Reduce
Avoidable Rehospitalizations, June 2012, focuses on creating an ideal reception into home
health care in the first 48 hours after discharge.
II. Getting Started

This section provides guidance to leaders in home health care agencies who have decided that improving the individual’s transition in the first 48 hours to home health care is a strategic priority for their agency. The intention of this How-to Guide is to build upon previous improvement work in home health care, such as the Best Practice Intervention Practices (www.homehealthquality.org/hh/default.aspx, please be sure to log into the HHQI website before accessing any of their links) and the Collaboration for Homecare Advances in Management and Practice (www.champ-program.org/) from the Visiting Nurse Service of New York.

The process changes recommended are, for the most part, considered normal care in home health care. However, we know that there are many challenges and barriers that home healthcare staff face in being able to perform these activities each and every time for each patient. The intent of this How-to Guide is to support home health care agencies in improving their care delivery processes in the first 24-48 hours of admission to home health care to very high levels of reliability – so that each patient receives the care they need when and how they need it, each and every time.

Step 1. The home health care agency CEO organizes an internal improvement team and officially sponsors the team to engage in this improvement work.

Step 1a. The CEO or Executive Director of the home health care agency selects an Executive Sponsor and a Day-to-Day Leader to lead the improvement work in the agency.

The role of the Executive Sponsor is to link the aims of improving transitions in care and reducing readmissions to the strategic priorities of the organization. The Sponsor provides oversight and guidance to his or her improvement teams’ work. Depending on the size and organizational structure of the home health care agency, typical Executive Sponsors may include Chief Executive Officers, Chief Operating Officers, Chief Nursing Officers, Medical Directors, or Chief Quality Officers. The Executive Sponsor selects a Day-to-Day Leader who will coordinate project activities; participate in improving cross-setting care processes with partners in office practices, hospitals, and nursing facilities or on an official cross-continuum
Institute for Healthcare Improvement
How-to Guide: Improving Transitions from the Hospital to Home Health Care to Reduce Avoidable Rehospitalizations

team; provide guidance to the front-line improvement team(s) (see Step 1b); and communicate progress to the Executive Sponsor on a regular basis. The Day-to-Day Leader is often a quality improvement leader, a nurse director, or a director of case management.

When framing the improvement initiative, Executive Sponsors may want to explore the following strategic questions for improving transitions and reducing rehospitalizations:

- Is improving transitions in care and reducing the home health care agency’s acute care hospitalization rate a strategic priority for the executive leaders at the agency? Why?
- What is the agency’s understanding of the opportunities to improve transitions and reduce rehospitalizations?
- What will help the agency achieve success in quality improvement initiatives?
- Are there initiatives to reduce readmissions already underway or planned in the organization, and how could they be better aligned?
- How much experience do executive leaders, mid-level managers, and front-line teams have in process improvement? What resources (e.g., expertise in quality improvement, data analysis) are available to support improvement efforts?
- How will oversight be provided for the improvement projects?
- Who are the key stakeholders who need to be involved in a project to improve transitions and reduce acute care hospitalizations within 30 days of a prior hospital discharge?
- Has the financial impact of the initiative been considered?

The Executive Sponsor will provide guidance for the quality improvement initiative to achieve breakthrough levels of performance. The following IHI white paper can provide valuable guidance for leaders in setting the improvement work up for success. The white paper, *Execution of Strategic Improvement Initiatives to Produce System-Level Results*, contains four components:^23

1. Setting priorities and breakthrough performance goals;
2. Developing a portfolio of projects to support the goals;
3. Deploying resources to the projects that are appropriate for the aim; and
4. Establishing an oversight and learning system to increase the chance of producing the
Home health care leaders can also foster relationships with care partners who refer patients to them. While home health care agencies can and should focus improvement efforts on improving internal care processes, much of the work of improving care transitions relies on working with partner hospitals, office practices and skilled nursing facilities. The Home Health Quality Improvement National Campaign Best Practice Intervention Package, Cross Setting 1 (www.homehealthquality.org/hh/default.aspx), offers this good advice:

“Develop relationships with your referral stream
- Where do your patients come from and where do they go next?
- Develop standard referral, communication and transfer processes.
- Develop mechanisms for accountability to those processes.
- Explore web-based sharing instruments to drive improvement.”

**Step 1b. An internal improvement team is organized and charged with the improvement work.**

Improvement involves understanding the agency’s opportunities for improvement, testing changes to care delivery processes, and learning from those tests of change and using data to drive improvement. A front-line improvement team who will be responsible for performing these tests of change and choosing a segment of patients on whom to test the changes will be necessary.

The composition of the front-line improvement team(s) will vary from agency to agency. These teams are most successful when they include staff who participate in care on a regular basis, as each staff role brings a unique perspective to the work. A typical front-line improvement team for home health care may include some combination of the following:

- A Day-to-Day Leader for the team;
- Home health care nurses;
- Home health care aides;
- Home health care medical director;
Pharmacists – home health care staff or community pharmacists;

Social workers, therapists – physical therapy, occupational therapy, speech therapy;

Palliative care representative or hospice representative;

Patients and family caregivers; and

When possible, a quality improvement professional to facilitate the improvement work.

**Step 2. The team identifies opportunities for improvement.**

All improvement effort begins with the understanding and use of data to help focus the efforts on changes that impact the overall aims. Performing an internal “diagnostic review” for the purposes of the agency leadership and front-line improvement team learning about opportunities for improvement is a key step.

IHI recommends a three-part “deep dive” to understand these opportunities: chart reviews, interviews with readmitted patients and families, and understanding key data. The tools to help organize the information for learning are included below.

Ideally, data for improvement work is directly related to the aims and is reviewed as frequently as possible – at least monthly. However, systems to collect data can be resource intensive and difficult to accomplish. For this reason, this How-to Guide, as much as possible, recommends using home health care data that is already widely collected and reported, such as the Outcome and Assessment Information Set (OASIS) Outcomes and Process reports and the Home Health Consumer Assessment of Healthcare Providers and Systems (HHCAHPS) data. Data for the improvement of home health care processes in the first 24-48 hours can be pulled from the reports listed in the third arrow in Figure 2. The improvement measurement strategy for the process improvements detailed in this How-to Guide can be found on page 57 in the Data Reporting Guidelines.
Figure 2. Sources of Data for Home Health Care

- STAAR Diagnostic Review
  - Diagnostic Chart Reviews
  - Patient Interviews
  - Interviews with community professionals who know the patient

- HHCAHPS Data Relevant to First 24-48 Hours
  - Overall scores for relevant data

- OBIQI Outcomes Data Relevant to First 24-48 Hours
  - Outcome-based Quality Improvement Outcome Report (posted quarterly)
  - Process Quality Measure Report

The following OASIS reports may also provide insight into opportunities:
- Agency Patient-Related Characteristic Reports
- Potentially Avoidable Event Report

Step 2a. Conduct an in-depth review of the last five of the agency’s hospital admissions to identify opportunities for improvement. In addition, home health care agencies may want to review acute care hospitalizations within 30 days of a hospital discharge. Conduct chart reviews of the last five patients receiving home health care services who were hospitalized for an acute condition, ideally a readmission from a recent discharge. Transcribe key information onto Part 1 of the Diagnostic Worksheet (Figure 3).

Figure 3: Diagnostic Worksheet (Part 1) (How-to Guide Resources, page 53)
• Conduct interviews with patients who were recently hospitalized (ideally, a rehospitalization) and their family members. If possible, interview the same patients whose charts were reviewed. These interviews are key to ensuring a well-rounded view of the care delivery processes and will provide valuable information to the improvement team *not available from any other source*.

• Next, conduct interviews with inpatient caregivers, clinicians in the community who also know the admitted patient (e.g., physicians, nurses in the skilled nursing facility, home health nurses, etc.), to identify problem areas from their perspective. These interviews also provide a perspective not available to home health care staff.

• Transcribe information from these interviews onto Part 2 of the *Diagnostic Worksheet* (Figure 5).

• Create a histogram of common themes that emerge from the chart reviews and interviews. Figure 4 below is a histogram from chart reviews of the Visiting Nurse Service of New York. For more guidance on creating a histogram, see page 57.
Emerging Trends from
Cross-Continuum Team Hospitalization Reviews

Figure 4: Histogram of Issues Found in Chart Reviews

Figure 5: Diagnostic Worksheet (Part 2) (How-to Guide Resources, page 55)
Step 3. Develop an aim statement.

Based on the above work of identifying opportunities for improvement, and an understanding of where the improvement team will focus their improvement efforts – internally, co-designing with cross-continuum partners, on a cross-continuum team, or a mixture – the improvement team will develop an aim statement to guide their work.

Aim statements communicate to all stakeholders the magnitude of change and the time by which the change will happen. Aim statements help teams commit to the improvement work.

Effective aim statements include five pieces of information:

- What to improve for patients and families;
- Where (specific nurse or home health care team);
- For which patients;
- By when (date specific deadline); and
- A measurable goal.

Sample aim statements:

1) The Best Home Healthcare Agency will improve transitions home for all patients as measured by a decrease in their acute care hospitalization rate within 30 days of the last day of hospital stay by 30 percent within 24 months. We will start with patients being cared for by Teams A and B and will expect to see a decrease in readmissions for patients being care for by those teams of at least 15 percent within 12 months.

2) The Best Home Health Care Agency will improve the transition between the hospital and their agency by improving the handover and focusing on medication management during the first week of service so that within the next 12 months we will reduce ED visits by 50 percent and acute care hospitalizations within 30 days of discharge by 20 percent. OASIS data will show improvement in medication management and medication stabilization by 15 percent or more.

For more on setting aims, please see:  
http://preview.ihi.org/knowledge/Pages/HowtoImprove/ScienceofImprovementSettingAims.aspx
III. Key Changes

The *How-to Guide: Improving Transitions from the Hospital to Home Health Care to Reduce Avoidable Acute Rehospitalizations* outlines three recommendations for improving the transition home in the first 24-48 hours (Figure 6): 1) meet the patient, family caregiver(s), and inpatient caregiver(s) in the hospital and review the transition home plan; 2) assess the patient, initiate the plan of care, and reinforce patient self-management at the first post-discharge home health care visit; 3) engage, coordinate, and communicate with the full clinical team.\(^{16,17,22,24,25,26}\)

Changes two and three are considered by many to be standard of care; however, there are challenges to staff being able to always carry them out as needed. The intention is to support home health care agencies and their partners to improve care delivery processes so that these changes are delivered reliably, effectively, and efficiently to each patient, every time.

**Figure 6: Key Changes to Create an Ideal Transition Home**

<table>
<thead>
<tr>
<th>1. Meet the patient, family caregiver(s), and inpatient caregiver(s) in the hospital and review transition home plan.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1A. Whenever possible, home health care nurse or liaison meets the patient, family caregiver(s), and at least one inpatient caregiver (e.g., nurse, hospitalist, social worker, discharge case manager) in the hospital and reviews the transition home plan. It is important to identify and collaborate with the appropriate responsible caregiver whenever possible.</td>
</tr>
<tr>
<td>1B. Reinforce to patient, family caregiver(s), and inpatient caregiver(s) that a follow-up appointment should be made before discharge to ensure timely follow-up after hospitalization with primary care or managing clinician.</td>
</tr>
<tr>
<td>2. Assess the patient, initiate plan of care and reinforce patient self-management.</td>
</tr>
<tr>
<td>2A. Evaluate the patient’s clinical status since leaving the hospital.</td>
</tr>
<tr>
<td>2B. Reconcile all medications, including all medications in the home.</td>
</tr>
<tr>
<td>2C. Assess, reinforce, and improve patient and family caregiver’s understanding and ability to manage medications and clinical procedures required for self-care with Teach Back.</td>
</tr>
</tbody>
</table>
3. Engage, coordinate, and communicate with the full clinical team.

   A. Ensure early, consistent, real-time consultation with primary care provider or other managing clinicians.

   B. Use a patient-centered health record to communicate to all caregivers.

   C. Advocate as necessary to ensure referrals are completed and needed services are received to assist the patient in being maintained in the community.

Note: Detailed discussion of each of these changes follows. This How-to Guide highlights specific tools and resources for the focus of the changes recommended. The following websites have many home health care related tools, resources, case studies, and more, all based on previous, robust quality improvement work for home health care. Many of the resources and tools in the How-to Guide are pulled from these websites:


Center for Home care Policy & Research (CHAMP) Visiting Nurse Service of New York: http://champ-program.org/
1. Meet the patient, family caregiver(s), and inpatient caregiver(s) in the hospital and review transition home plan.

Recommended Changes:

1A. Whenever possible, home health care nurse or liaison meets the patient, family caregiver(s), and at least one inpatient caregiver (e.g., nurse, hospitalist, social worker, discharge case manager) in the hospital and reviews the transition home plan. It is important to identify and collaborate with the appropriate responsible caregiver whenever possible.

1B. Reinforce to patient, family caregiver(s), and inpatient caregiver(s) that a follow-up appointment should be made before discharge to ensure timely follow-up after hospitalization with primary care or managing clinician.

A proactive approach to receiving patients into home health care has been identified as a key strategy to improve transitions in care. There may be staffing constraints to this approach; however, many home health care agencies are finding ways to partner with hospitals to make this possible by working with their cross-continuum teams. Use of liaisons in the hospital to bridge the gap or telephone contact between home health care staff, patient, and/or caregiver prior to discharge are strategies some agencies have adopted.

Typical failures in the transition to home health care include the following:

- Inadequate communication with physicians and other caregivers;
- Inadequate problem detection before or on admission to home health care;
- Inadequate assessment of functional and cognitive abilities and ability to self-manage;
- Inadequate care plan development;
- Not addressing palliative care needs;
- Referral to home health care made too late to be proactive in the transition; and
Lack of implemented standards and specific care delivery processes within agencies and between hospitals, primary care providers, specialists, and others post-discharge.

**What are your typical failures and opportunities for improvement?**

- Review the findings from Step 2: The team identifies opportunities for improvement. Periodically repeat Step 2 to continually learn about opportunities for improvement.
- Observe your current process for assisting in the transition from hospital to home and completing the admission assessment.
- What did you learn?

1A. **Whenever possible, home health care nurse or liaison meets the patient, family caregiver(s), and at least one inpatient caregiver (e.g., nurse, hospitalist, social worker, discharge case manager) in the hospital and reviews the transition home plan. It is important to identify and collaborate with the appropriate responsible caregiver whenever possible.**

- Using principles of coaching and motivational interviewing, ask what the patient’s/caregiver’s primary concern is about going home.
- Identify the primary caregiver(s).
- Review clinical information, including diagnosis, medications, depression screening results from PHQ2 or PHQ-9, and home treatments needed.
- Identify potential barriers to a successful transition home. Elicit potential problems by describing typical problems patients and caregivers encounter when going home; work to uncover and discover undetected or unarticulated problems, and engage the patient and family caregiver in problem solving.
- Identify status of patient and family caregiver’s ability to teach back key medication information.
- Create a list of personalized “red flags” indicative of a deteriorating condition in terms understood by patient and care partners, including whom to contact when red flag occurs.
- Review the transition home plan with the patient, family, and inpatient caregivers.
Identify and include the patient and family caregiver goals for care, and identify challenges, such as unsuccessful Teach Back, resource constraints, or cognitive issues.

For more information on proactive activities for patients, family, and inpatient caregivers to enhance handovers to home health care, please see the following resources:


- **Resident/Patient Continuum of Care Transfer Form.** Colorado Foundation for Medical Care. Available at [www.cfmc.org/caretransitions/files/toolkit/intervention/QIO%20Developed%20Tools/GA_Continuum%20of%20Care%20Transfer%20Form.pdf](http://www.cfmc.org/caretransitions/files/toolkit/intervention/QIO%20Developed%20Tools/GA_Continuum%20of%20Care%20Transfer%20Form.pdf).

1B. **Reinforce to patient, family caregiver(s), and inpatient caregiver(s) that a follow-up appointment is made before discharge to ensure timely follow-up after hospitalization with primary care or managing clinician.**

- Ensure follow-up visit with primary care physician or managing clinician is scheduled according to risk. Many readmissions occur in the first seven days after discharge from the hospital. Although home health care staff have little control over whether patients get an appointment when they need it, home health care staff can work with hospital and office practice partners to improve access to appointments and they can advocate for high-risk patients to get a timely appointment.

- To date, although there are many risk readmission tools, there is no generally accepted tool that predicts the risk for readmission. IHI recommends the use of the simple but powerful rubric in Figure 7 below for a guide as to when patients need to see their managing clinician.

- See Figure 8 below for recommended follow-up schedule with primary care provider or managing clinician post-discharge from the hospital.
Consider front-loading home health care visits with two visits in the first 48 hours and phone calls.

**Figure 7: Categories of a Patient's Risk of Acute Care Hospitalization**

<table>
<thead>
<tr>
<th>High-Risk Patients</th>
<th>Moderate-Risk Patients</th>
<th>Low-Risk Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Patient has been admitted two or more times in the past year.</td>
<td>• Patient has been admitted once in the past year.</td>
<td>• Patient has had no other hospital admissions in the past year</td>
</tr>
<tr>
<td>• Patient is unable to teach back or the patient or family caregiver has a low degree of confidence to carry out self-care at home.</td>
<td>• Based on Teach Back results, patient or family caregiver has moderate degree of confidence to carry out care at home.</td>
<td>• Patient or family caregiver has high degree of confidence and can teach back how to carry out self-care at home.</td>
</tr>
</tbody>
</table>
Figure 8: Follow-Up Schedule after Discharge

<table>
<thead>
<tr>
<th>High-Risk Patients</th>
<th>Moderate-Risk Patients</th>
<th>Low-Risk Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior to discharge:</td>
<td>Prior to discharge:</td>
<td>Prior to discharge:</td>
</tr>
<tr>
<td>• Schedule a face-to-face follow-up visit within 48 hours of discharge. Care teams should assess whether an office visit or home health care is the best option for the patient.</td>
<td>• Schedule a follow-up phone call within 48 hours of discharge and schedule a physician office within 5-7 days. Consult with the patient's physician to identify whether home health care is needed.</td>
<td>• Schedule a physician office visit as ordered by the attending physician. Ensure the patient and family have the phone number for questions and concerns.</td>
</tr>
<tr>
<td>• If a home health care visit is scheduled in the first 48 hours, an office visit must also be scheduled within the first 3-5 days.</td>
<td>• Initiate a referral to social services and community resources as needed.</td>
<td>• Initiate a referral to social services and community resources as needed.</td>
</tr>
<tr>
<td>• Initiate intensive care management programs as indicated.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Initiate a referral to social services and community resources as needed.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

For more information on timely follow-up after discharge, please see the following resources:

*Top 10 Reasons You Need a Physician Follow-up within 7 Days*. Colorado Foundation for Medical Care. Available at:  

IPRO Discharge Criteria Flyer-with criteria for referral to Home Health Care. Available at:  
[http://champprogram.org/static/IPROFlyer1.pdf](http://champprogram.org/static/IPROFlyer1.pdf)

Patient PASS from Project BOOST. Available at: [http://champ-program.org/static/PASS.pdf](http://champ-program.org/static/PASS.pdf)
Recommended Measures for This Change

(Data Reporting Guidelines, How-to Guide Resources, page 57)

Use these process measures when you are focusing on improving the care processes to ensure timely connection with managing clinician and to ensure that families and patients are included in home needs prior to home health care admission.

| Patients and family included in home needs prior to hospital discharge. | Percent of home health care admissions where patients and family caregivers were included in assessing home needs prior to hospital discharge or “vital information is obtained by hospital discharge planner” and conveyed to home health care provider in the first 24 hours. |

**Recommended Changes:**

2A. Evaluate the patient’s clinical status since leaving the hospital.

2B. Reconcile all medications, including all medications in the home.

2C. Assess, reinforce and improve patient and family caregiver’s understanding and ability to manage medications and clinical procedures required for self-care with Teach Back.

Many patients who are readmitted to the hospital are readmitted in the first seven days. Home health care executives and clinicians state that the acuity of patients being discharged from the hospital and transferred to home health care has increased over the past few years. Most patients discharged to home health care have complex chronic conditions with several co-morbidities and complex medication regimes increasing the need for self-management. Home health care agencies are in an ideal position to assist patients and their family caregivers in this transition as they are able to assess the patient in their home environment, see the barriers and challenges while caring for patients in the community setting, and work directly with the patient and family caregivers in preventing or problem solving issues that may occur.

Proactive intervention by home health care staff at the point of a transition for a patient into home health care is a significant strategy to reduce avoidable rehospitalizations. It is at this point that new problems and undetected issues for patients and family caregivers may arise. The hand-off from the hospitals to the managing clinicians may cause problems. Patients and caregivers receive direct problem solving and patient-centered support to address issues, barriers and challenges related to their chronic disease management as they move along the care continuum.
Typical failures found in assessing, initiating the plan of care, and reinforcing patient self-management at the first post-discharge home health care visit include the following:

- Inadequate completion of comprehensive assessment, problem identification, and care plan development;
- Lack of timely and thorough medication reconciliation and proactive medication management;
- Patient and family caregiver unable to overcome challenges of self-managing medications. This may include knowledge deficits, cognitive and functional challenges, financial constraints, conflicting care goals between patient and clinicians, lack of communication with managing clinician, or ineffective problem solving.
- Focus on completing the OASIS assessment and documentation may be a barrier to focusing on the immediate needs of the patient and their caregivers. A more important focus must be the on the immediate clinical and personal goals of the patient to achieve and/or maintain clinical stability.

What are your agency’s typical failures and opportunities for improvement?

- Review the findings from Step 2: The team identifies opportunities for improvement. Periodically repeat Step 2 to continually learn about opportunities for improvement.
- Collect data on common medication reconciliation errors for patients in the first 24-48 hours. The Care Transitions Program ® has developed a Medication Discrepancy Tool that is quite helpful in understanding medication reconciliation issues: http://www.caretransitions.org/downloadmdt.asp.
- Use the Observation or Self Audit Guide: Current Processes for an Admission Assessment. Observe your current process for assessing and initiating the plan of care at home health care visits within first 48 hours. What did you learn?
Recommended Changes

The following changes are based on 4 Pillars of the Coleman Care Transition Model. The pillars identified to prevent rehospitalization from occurring include (a) assistance with medication self-management; (b) use of a patient-centered health record; (c) early, consistent communication or follow-up with primary care providers and/or the medical specialist; and (d) a list of personalized “red flags” indicative of a deteriorating condition. 17

2A. Re-evaluate the patient’s clinical status since leaving the hospital.

- Obtain and review the hospital discharge summary and instructions;
- Front-load visits for high-risk patients with two visits or a visit and a phone call in the first 48 hours;
- Perform a comprehensive physical, functional, and cognitive assessment of the patient – identify any conditions that risk de-stabilizing the patient’s condition and coordinate with managing clinician;
- Follow up on outstanding test results or orders from the hospital that are critical in this first 24-48 hours, e.g., O2 saturation, INR levels, hematocrit, and potassium;
- Identify and report possible medication-related complications; and
- Assess patient self-care goals, abilities, strengths, and barriers, with use of motivational interviewing.
2B. Reconcile all medications, including all medications in the home.\textsuperscript{16,22,25,27}

- Within 24 hours of hospital discharge, reconcile medications with discharge instructions with patients and caregivers.
  - Verify that the patient has the needed medications and family caregivers are able to reliably obtain the medications.
  - Check all medications and include herbal remedies, trial medications, over-the-counter medications, medications taken prior to hospitalization, and physician-administered medications such as injections. Determine which are on the current medication list and which the patient should not take.
  - Verify that the patient is taking medications correctly, assess adverse side effects, medication effectiveness, drug/drug interactions, therapeutic duplication, and non-adherence. Use free or relatively inexpensive downloadable tools for drug/drug interactions using smart phones or PDAs that are available. An example of the use of a drug interaction tool would be the entry of the following commonly prescribed drug into the program: Coumadin, Flexeril, Glucophage, Keflex, lisinopril, omeprazole, and Motrin. The results identified the following interactions: Coumadin plus Motrin may cause increase in INR; Coumadin plus omeprazole may also increase INR; lisinopril plus Motrin may decrease antihypertensive efficacy, plus increase risk of nephrotoxicity.
  - Use a patient-friendly and easily updatable medication list. Write in pencil so the list can be easily updated. Educate patient and caregiver on how to keep the list updated and share it at the time of each medical encounter.

- Look for ways to simplify the medication regime.
  - Check for potentially inappropriate medications.
  - Identify medication schedules that are unrealistic in a home setting and propose a more realistic schedule. For example, if the insulin prescribed is sliding scale insulin, consider recommending a combination insulin; or identify an easier schedule for medications prescribed every 6 hours.
  - Provide Personal Health Record for patient to keep and maintain medication list.
Help patients link their med times to routine activities – i.e., meals or TV shows or regular activity.

For resources and more information on managing medications, please refer to the following resources:

**Medication Management resources for professionals:**

*Improving the Management of Oral Medications, HHQI, BPIP:*
www.homehealthquality.org/hh/campaign/mmbpip/default.aspx

*Medication QUICK GUIDE: Tips for accurate M2020 assessment.* Home Health Quality Improvement National Campaign. Available under Associated Resources at this link:
www.homehealthquality.org/shared/content/Campaign_Tracked_Files/1_M2020%20Quick%20Guide%20FINAL%20042110.pdf

Medication Management Tips for Staff and Medication Management Care Planning Tool, pages 30 and 31, *Improving the Management of Oral Medications, HHQI, BPIP:*
www.homehealthquality.org/hh/campaign/mmbpip/default.aspx


Scripts: Adherence Counseling and Medication Reconciliation: http://champ-program.org/app


*Medication Reconciliation Toolkit.* American Society of Hospital Pharmacists. Available at www.ashp.org/Import/PRACTICEANDPOLICY/PracticeResourceCenters/PatientSafety/ASHPMedicationReconciliationToolkit_1.aspx. This online resource center provides tools,
references, recommendations, innovative ideas, and examples of success stories and lessons learned.

*My Medicine List™* - *Information for Health Professionals.* American Society of Health-System Pharmacists. Available at [www.ashpfoundation.org/MainMenuCategories/PracticeTools/MyMedicineList/InformationforHealthProfessionals.aspx](http://www.ashpfoundation.org/MainMenuCategories/PracticeTools/MyMedicineList/InformationforHealthProfessionals.aspx)


**Medication Management Resources for patients and caregivers:**

Medication Action Plan. Available at [www.medactionplan.com](http://www.medactionplan.com)


**2C. Assess, reinforce, and improve patient and family caregiver’s understanding and ability to manage medications and clinical procedures required for self-care with Teach Back.**

- Identify key learners and caregivers and discuss their goals for the transition and first 48 hours at home.
- Identify preferred mode of learning for patients and caregivers (i.e., written, verbal, demonstration, etc.).
- Engage patients and family caregivers in early identification of red flags indicating a deterioration in condition and actions to take if needed.
- Verify through Teach Back the patient and family caregiver’s understanding of the current medication list, what medication has been stopped, adverse drug side effects to report, what
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happens when new medications are prescribed/changed, when medications need to be taken and by what route.

- Use motivational interviewing to assess patient and family caregiver confidence and commitment to their medication regimen. Assist the patient and family caregivers in problem solving any barriers to obtaining and taking the medications as prescribed.

- Through coaching, elicit patient self-management goals for the transition home and incorporate clinician care plan into patient goals. Provide supplemental education as needed to the patient and caregiver to enable them to deliver the plan of care.

- Prepare patent and family for their first medical appointment by helping them identify their questions and ensuring that their updatable medication list is current.

Resources such as Ask Me 3™ (available at www.npsf.org/askme3) are useful in helping to structure the conversations. For resources and more information on supporting self-care and the use of Teach Back, please refer to the following resources.

**Resources for professionals to support patient self-management:**

*Patient Activation Assessment.* The Care Transitions Program™. Available at www.caretransitions.org/documents/Activation_Assessment.pdf.

Clinician education on motivational interviewing:

www.motivationalinterview.org/quick_links/about_mi.html

Best Practice: Evidence-based Health Coaching: A Lever for Better Home Health Outcomes. HHQI, BPIP Cross Settings 1, pages 24-29:

www.homehealthquality.org/hh/campaign/cross1/default.aspx

**Principles of Motivational Interviewing** - An excerpt from MassPro’s "Planned Care: Self-Management Support in Home Healthcare HHQI, BPIP Cross Settings 1:

www.homehealthquality.org/hh/campaign/cross1/tools.aspx

**Resources for patients and caregivers to support self-management:**


Taking Care of Myself: A Guide for When I Leave the Hospital. Agency for Healthcare
AHRQ Toolkit - Taking Care of Myself: A Guide for When I Leave the Hospital

Zone Tools in English and Spanish:
CHF:
http://champprogram.org/app?component=listPage.pager.%24DirectLink_0&page=main%2FTools&service=direct&session=T&sp=5
COPD:
http://champprogram.org/app?component=listPage.pager.%24DirectLink_0&page=main%2FTools&service=direct&session=T&sp=6
Depression:
http://champprogram.org/app?component=listPage.pager.%24DirectLink_0&page=main%2FTools&service=direct&session=T&sp=7
Diabetes:
http://champprogram.org/app?component=listPage.pager.%24DirectLink_0&page=main%2FTools&service=direct&session=T&sp=8

Resources for Teach Back

“Teach Back” Nurse Practice Exercise (focus on medications): Home Health Quality Improvement National Campaign http://champ-program.org/

Teach Back Medication Cards: Home Health Quality Improvement National Campaign http://champ-program.org/


Resources for health literacy:


AHRQ Health Literacy Universal Precautions Toolkit: www.ahrq.gov/qual/literacy/
Recommended Measures for This Change
(Data Reporting Guidelines, How-to Guide Resources, page 57)

Use these process measures when focusing on improving the care processes to determine whether patients and the family are prepared to engage in self-care or whether they require additional support.

<table>
<thead>
<tr>
<th>HHCAHPS Question 5</th>
<th>When you started getting home health care from this agency, did someone from the agency ask to see all the prescription and over-the-counter medicines you were taking?</th>
</tr>
</thead>
<tbody>
<tr>
<td>HHCAHPS Question 4</td>
<td>When you started getting home health care from this agency, did someone from the agency talk with you about all the prescription and over-the-counter medicines you were taking?</td>
</tr>
<tr>
<td>1 self-care goal documented in the first 24-48 hours.</td>
<td>Percent of patients or family caregivers with at least 1 self-care goal documented in the first 24-48 hours.</td>
</tr>
<tr>
<td>OASIS M2010: Patient or caregiver high-risk drug education.</td>
<td>Percentage of home health episodes of care in which patients or caregivers were educated about high-risk medications at the start/resumption of care including instructions on how to monitor the effectiveness of drug therapy; how to recognize potential adverse side effects, and how and when to report problems.</td>
</tr>
<tr>
<td>Teach Back on managing medications.</td>
<td>Percent of patients who can teach back 75% or more of what they are taught to manage their medications.</td>
</tr>
<tr>
<td>Teach Back of content vital for a successful transition home.</td>
<td>Define three or four “vital few” elements for transition instructions, medications, and/or self-care needs, e.g., when to call the physician, dietary needs or when a follow-up appointment is scheduled. Then track these vital elements: Percent of patients who can teach back 75% or more of what they are taught when content is broken into easy-to-learn segments.</td>
</tr>
</tbody>
</table>
3. Engage, coordinate, and communicate with the full clinical team.

<table>
<thead>
<tr>
<th>3. Engage, coordinate, and communicate with the full clinical team, including patient and caregivers.</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Ensure early, consistent, real-time consultation with primary care provider or other managing clinicians.</td>
</tr>
<tr>
<td>B. Use a patient-centered health record to communicate to all caregivers.</td>
</tr>
<tr>
<td>C. Advocate as necessary to ensure referrals are completed and needed services being received to assist the patient in being maintained in the community.</td>
</tr>
</tbody>
</table>

The challenges for home health care agencies in collaborating with the numerous and geographically spaced primary care and specialty physicians, and the many community agencies that might be involved in a patient’s home health care, are daunting. However, the function of communicating and coordinating care in real time is one of the most important care processes that can be made to improve the process of patients successfully transitioning home.\textsuperscript{16,22,24,27} Home health care agencies can seek to partner with hospitals, office practices, and others in the community and work together to design communication and coordination processes that are efficient and effective. When possible, participation on a robust cross-continuum team, with good representation from office practices, hospitals, and community agencies is invaluable to testing the co-design of care processes across sites and learning efficient ways to accomplish this. As in all good improvement work, we recommend that home health care agencies start small and work with partners who are willing to work at improving communication and coordination. As processes are successfully redesigned, the more efficient processes can be spread to other practices and agencies. Criteria to use in choosing partners to work with include either physicians and agencies that do a high volume of work with the home health care agency or an enthusiastic partner, willing to test changes.

**Typical failures** in coordinating care with primary care and other providers in the community include the following:

- Lack of a shared understanding of the patient’s current status, situation, and comprehensive care plan;
- Lack of a clear, designated clinician to coordinate needed care and care decisions;
When primary care physician is designated as the lead clinician, often they are not current on hospitalization, discharge instructions, and current status;

Financial and other patient constraints are a barrier to receiving needed services;

Inadequate care plan development and implementation due to incomplete understanding of the whole patient context;

Too many “care managers” calling post-discharge, which can be confusing and/or overwhelming to the patient and family caregivers;

Confusion for patient when given different approaches and or instructions; and

Lack of “health literacy” regarding navigating the health care system to have self-care goals met.

What are your typical failures and opportunities for improvement?

Review the findings from Step 2: The team identifies opportunities for improvement.

What are you learning?

Recommended Changes

3A. Ensure early, consistent, real-time consultation with primary care provider or other managing clinician(s).

Within 24 hours, contact managing clinician with any significant clinical findings or medication issues and obtain physician parameters for managing symptoms in the home.

As soon as available, send assessment of the clinical status and plan of care, patient’s ability to manage self-care, cognitive, functional, and other barriers, to managing clinician and others as appropriate.

Coordinate other needed therapies through the home health agency – for example, wound care, diabetes management, rehabilitation services, and social services. Ensure that key information for self-management, barriers to self-care, and other contextual information is relayed as soon as possible.
• Use evidenced-based guidelines when providing care and managing symptoms of home health care patients such as the American Cardiology Association, American Diabetic Association, and Global Obstructive Lung Disease.

For more information on evidence-based guidelines, visit the National Guideline Clearinghouse, AHRQ: www.guideline.gov.

3B. Use a patient-centered health record to communicate to all caregivers.

• Assist patient and family to create a clear, concise, and customized Patient Health Record, with an initial focus on a clear, patient-friendly, and updatable medication list.

• Help the patient and family caregivers understand the importance of keeping an updated medication list and the importance of taking their list to all appointments and ensuring it is updated in real time.

Include a list of patient-centered goals for care through use of motivational interviewing, e.g., asking what is important to patient and/or their concerns and if they are confident they can manage. For more information on patient-centered health records, please refer to the following resources:


For more information on patient-centered health records, please refer to the following resources:

Patient-centered health record: www.caretransitions.org/documents/phr.pdf

3C. Advocate for and teach patients and care partners to advocate for themselves to ensure referrals are completed and needed services in place.29

- Establish relationships with other care team members in the community and hospital to facilitate communication.26

- Use SBAR communication model (situation, background, assessment, and recommendation) as an efficient and effective communication strategy around patient issues. Provide patient and care partners with tools to aid in communication with other managing clinicians.

- Work with community partners to establish efficient and effective means to communicate, and especially to trigger when a critical situation occurs. An example would be a back line to a primary care physician’s nurse.

For more information on SBAR communications, please refer to the following resources:


*On Demand Presentation: Effective Teamwork as a Care Strategy: SBAR and other tools for improving communication between caregivers.* Institute for Healthcare Improvement. Available at: [http://preview.ihi.org/offerings/VirtualPrograms/Individuals/Teamwork/Pages/default.aspx](http://preview.ihi.org/offerings/VirtualPrograms/Individuals/Teamwork/Pages/default.aspx).

*SBAR Assessment and Competency Assessment.* Institute for Healthcare Improvement. [www.ihi.org/IHI/Topics/MedicalSurgicalCare/MedicalSurgicalCareGeneral/Tools/SBARTrainingScenariosandCompetencyAssessment.htm](http://www.ihi.org/IHI/Topics/MedicalSurgicalCare/MedicalSurgicalCareGeneral/Tools/SBARTrainingScenariosandCompetencyAssessment.htm).

Effective Teamwork as a Care Strategy: SBAR and other tools for improving communication between caregivers. A no cost On Demand audio resource: [www.ihi.org/IHI/Programs/AudioAndWebPrograms/Effective+Teamwork+as+a+Care+Strategy+SBAR+and+Other+Tools+for+Improving+Communication+Between+Careg.htm](http://www.ihi.org/IHI/Programs/AudioAndWebPrograms/Effective+Teamwork+as+a+Care+Strategy+SBAR+and+Other+Tools+for+Improving+Communication+Between+Careg.htm)

*SBAR Assessment and Training Scenario Tools:* [www.ihi.org/IHI/Topics/MedicalSurgicalCare/MedicalSurgicalCareGeneral/Tools/SBARTrainingScenariosandCompetencyAssessment.htm](http://www.ihi.org/IHI/Topics/MedicalSurgicalCare/MedicalSurgicalCareGeneral/Tools/SBARTrainingScenariosandCompetencyAssessment.htm)

Recommended Measures for This Change  
*(Data Reporting Guidelines, How-to Guide Resources, page 57)*

Use these process measures when focusing on improving care processes to determine adequate communication between home health professional in the home and the managing community clinician.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>OASIS M2002 Potential Medication Issues Identified and Timely Physician Contact at Start of Episode</td>
<td>Percentage of home health episodes of care in which the patient’s drug regimen at start/resumption of home health care was assessed to pose a risk of clinically significant adverse effects or drug reactions and whose physician was contacted within one calendar day</td>
</tr>
<tr>
<td>Follow-Up Appointment</td>
<td>Percentage of patients who can tell the home health care staff, in the first 48 hours of care, the date &amp; time of their follow-up appointment with their managing clinician</td>
</tr>
<tr>
<td>Managing Clinician Identified</td>
<td>Percent of patients who can identify their primary doctor or provider</td>
</tr>
</tbody>
</table>
IV. Testing, Implementing, and Spreading Changes

Step 1. Based on your learning from the Getting Started activities (in Section II), select a place to start and identify the opportunities or failures in your current processes.

All three key changes (outlined in Section III) are strongly recommended for improving a patient’s transition home in the first 48 hours after discharge from the hospital. These three changes are depicted in the flow chart below (Figure 9). Many teams start with improving the enhanced transition to home health care or medication reconciliation, but there are merits to allowing the front-line team’s interests to determine where to start improvement. If there are two pilot care teams, the teams may want to begin testing different process improvements and share what they are learning to accelerate overall progress.

![Flowchart of Key Changes to Create an Ideal Transition to Home Health Care](image)

**Key Change 1:** Meet the patient, family caregiver(s), and inpatient caregiver(s) in the hospital and review transition home plan.

**Key Change 2:** Assess the patient, initiate plan of care and reinforce patient self-management at first post-discharge home health care visit.

**Key Change 3:** Engage, coordinate, and communicate with the full clinical team.

Each key change to improve transitions contains several processes. Choose the processes you want to investigate and use observation or self-audit to gain a deeper understanding of the current processes and to assess your own local opportunities for improvement. Many quality improvement and innovation strategies include observation as an essential foundation to inform process improvements.30-33

Tips for Fixing Problems from *The High Velocity Edge*, by Steve Spear

- “Start small. Find a process or system that is reasonably tightly bounded so that the number of people learning together is relatively small. That way the chance for shared reflection will be relatively high.”
- “Solve a problem that really matters...When you start to score gains, you want people to sit up and take notice.”
- “Don’t think too much but do a lot. That’s where the real learning takes place. Start with a small footprint but a long leg. Although you should start with a fairly small group and a fairly well-defined problem...make sure that every layer of management is involved. After all, what you are trying to master is a fundamentally different set of roles and relationships.”
- “Don’t wait.”
For example, processes related to Key Change 2 (Assess the patient, initiate plan of care and reinforce patient self-management at first post-discharge home health care visit) include an observation or self-audit of how staff engage patients in self-management.

- 2A. Re-evaluate the patient’s clinical status since discharge leaving the hospital.
- 2B. Assess and improve the patient’s and family caregiver’s understanding and ability to manage self-care with Teach Back.

**Step 2. Use the Model for Improvement; test changes.**

Developed by Associates in Process Improvement, the Model for Improvement is a simple yet powerful tool for accelerating improvement that has been used successfully by hundreds of health care organizations to improve many different health care processes and outcomes.

The model has two parts:

- Three fundamental questions guide improvement teams to 1) set clear aims, 2) establish measures that will tell if changes are leading to improvement, and 3) identify changes that are likely to lead to improvement.

The Plan-Do-Study-Act (PDSA), cycle, developed by W. Edwards Deming, supports testing small-scale change in real work settings — by planning a test, trying it, observing the results, and acting on what is learned. This is a pragmatic version of the scientific method used for action-oriented process improvement.
First Test of Change: A first test of change should involve a very small sample size (typically one nurse or one patient) and should be described ahead of time in a Plan-Do-Study-Act format so that the improvement team can easily predict what they think will happen, observe the results, learn from them, and continue to the next test.

Use iterative PDSA cycles to design and redesign processes to make them effective and reliable.

Figure 11 is a blank PDSA worksheet that outlines guidance for each of the steps: Plan, Do, Study, Act. Figure 12 shows an example of a completed PDSA form for patient education.

Figure 11: PDSA Worksheet (How-to Guide Resources, page 63)
Example: Series of PDSA Cycles

- **Cycle 1:** One nurse, on one day, tests whether using Teach Back with one patient who has heart failure (HF) helps the patient learn the reasons to call the physician for help now that they are at home. The nurse learned that patient teaching materials were confusing to the patient.

- **Cycle 2:** Nurse adapts the materials to better meet the patient’s needs by circling key information. Uses Teach Back for all heart failure patients she is visiting that day. One patient is asked to include her daughter in the teaching. Learned that all the circled information could be taught back by patient’s daughter and patient could teach back two of the three selected items.

- **Cycle 3:** Nurse expands use of Teach Back to all patients and checks with each patient to find out if there is a family caregiver they want included in the teaching.

- **Cycle 4:** Nurse starts to train her colleagues in the method, making time to observe or role-play and give feedback to each trainee.

- **Cycle 5:** Educational module and competency assessment developed and tested on one group.

- **Cycle 6:** Module adapted and rolled out agency-wide, including plan for new staff orientation.
**Suggestions for Conducting PDSA Cycles**

- Remember that one test of change informs and builds upon the next.
- Keep tests small; be specific.
- Refine the next test based on learning from the previous one.
- Expand test conditions to determine whether a change will work under a variety of conditions like different times of day (e.g., day and night shifts, weekends, holidays, when the agency is adequately staffed, in times of staffing challenges) or different types of patients (those with lower health literacy, non-English speaking patients, short- or long-stay patients).
- Collect sufficient data to evaluate whether a test has promise, was successful, or needs adjustment.
- Continue PDSA cycles of learning and testing to improve process reliability.

**Step 3. Increase the reliability of your processes.**

The Plan step (P) of each PDSA cycle should include a high level of detail about the change being tested: who, what, when, where, and the specifics of how. Adapt and build out this detail as you conduct iterative PDSA cycles and learn about what works in your organization. The aim is to end up with a process that can be executed as designed, every time, for every appropriate patient, with the desired results.

*Teach Back example: When redesigning your patient education processes in order to better teach patients about their home care instructions (as described in the example PDSA cycles on p. 36), work with staff who conduct the tests to precisely describe the work, including information regarding:*

- **Who will do it** (be specific – e.g., include the name of the nurse assigned to the patient)?
- **What will they do** (for example, use Ask Me 3 framework to organize teaching for all patients and each patient is asked [in a non-shaming way] to describe in their own words what was learned)? Document learning in the patient’s record so that details about the patient’s ability to teach back the key points can be shared with other caregivers.
• When will they do it (e.g., during beginning of first home visit while patient is not overly tired)?

• Where will they do it?

• How do they do it (include tools that are used, e.g., Teach Back documentation tool kept in patient’s home folder)?

• How often will they do it (e.g., at each visit, by each multi-professional team member)?

• Why should they do it (e.g., to enhance learning and identify patients who are at risk for problems while caring for themselves post-transition)?

Continue to test the process under a variety of conditions (e.g., different nurses, different kinds of patients). Adapt the change until it optimally meets the needs of both patients and staff.

When testing a change, you will learn from your failures as well as from your successes. Understanding common failures (situations when a process is not executed as expected) helps the team to (re)design the new processes to eliminate those failures.

Here is an example of a team learning from a failed test and applying that learning to improve the process:

• The process being tested required nurses to use the Ask Me 3 framework for all patients. During testing, a nurse assigned to a patient with heart failure and chronic depression was unsure about the relevant Ask Me 3 questions to assist her with patient education; nurses and social workers met to delineate the relevant Ask Me 3 questions for commonly seen mental health conditions, and the training was redesigned to cover this information.

After successful testing under varying conditions with desired results, document the process so there is no ambiguity: all involved can articulate the exact same steps in the process.
Step 4. Use data, displayed over time, to assess progress.

The Getting Started activities (in Section II) include collecting baseline data on acute care hospitalizations within 30 days of hospital discharge and patient experience, and displaying those data in time series graphs. This data can be pulled from OASIS and HHCAHPS reports on a monthly basis and put into run charts to look at the data over time.

Continue to collect and display this data in order to see whether your changes result in improvement for your patients. We recommend looking at data both for your pilot population(s) and your agency as a whole. Augment this quantitative data with information you gather from asking readmitted patients about their experience (consider using the Diagnostic Worksheet, How-to Guide Resources, page 53). Annotate run charts to indicate when specific changes were implemented.

In addition to the outcome measures for hospitalizations within 30 days of hospital discharge and patient experience, it is necessary to track whether your new and improved processes are being executed as expected. These “process” measures tell us whether the specific changes we make are working as planned and they provide information on the relationship between our theory (the changes we are making) and the outcomes for our patients. Plotting process data over time uncovers signals of improvement (increased reliability of the process) or opportunities (problems with the execution of the process). These signals show us when to investigate and apply the resulting learning to redesign the process to make it work better.

Figure 13 shows an example of an annotated time series graph for a process measure for Key Change 2 (Assess patient, initiate plan of care and reinforce patient self-management at first post-transition home health care visit), specifically the change to assess and improve patient and family members’ understanding and ability to manage of self-care with Teach Back. The annotations show when specific changes were tested or implemented.
Example: When we start to test Teach Back as a new teaching strategy, we need a way to understand if patients are being taught as we want them to be taught. This is difficult to assess without direct observation that is best done during a home visit. It may be done as a self audit by the nurse. We recommend that a sample of teaching opportunities be observed or self-audited each week or month to determine if the intervention (Teach Back) is being executed as planned. Note that this means that a clearly documented set of expectations for what Teach Back should look like is needed to determine if the teaching matches those expectations. Consider using the Observation or Self-Audit Guide: Current Processes for Patient Teaching (Figure 14).

---

Sampling is an important strategy for collecting process measures since this kind of data is often not available through automated systems. In the example above, ten observations were conducted each month (two each week) in order to collect just enough data on the process to inform the team’s understanding of what was happening.
When the data suggest we are not performing a process reliably, we want to go to the people who should be executing the process and ask them what barriers they face. Use the data to identify opportunities to make the new processes easier to execute, not to blame staff. Assume the problem is the design of the process or the system in which it is embedded and work with your team to fix it. For example, if the team observes that nurses or care team members are not using Teach Back, the team should consider how to improve the training process by getting input about what barriers were encountered with the process.

Collecting and reviewing data, over time, through implementation, helps you see when new problems arise with the execution of your desired interventions – note, for example, how the data in the graph in Figure 13, page 43, enables the team to see when performance declined so they could test new interventions to improve reliability. Share data with agency staff, physicians, community partners, and senior leaders. Reflect on lessons learned from both successful and unsuccessful tests of change. Develop the habit of challenging assumptions.

Figure 15 lists examples of process measures that can help evaluate the successful implementation of each of the recommended key changes.
<table>
<thead>
<tr>
<th>Key Change</th>
<th>Process Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Meet the patient, family caregiver(s), and inpatient caregiver(s) in the hospital and review transition home plan.</td>
<td>Percentage of home health admissions where patients and family caregivers were included in assessing home needs prior to hospital discharge or “vital information is obtained by hospital discharge planner” and conveyed to home health care provider in the first 24 hours</td>
</tr>
</tbody>
</table>
| 2. Assess the patient, initiate plan of care, and reinforce patient self-management at first post-discharge home health care visit. | * When you started getting home health care from this agency, did someone from the agency ask to see all the prescription and over-the-counter medicines you were taking?  
* Percentage of patients or family caregivers with at least 1 self-care goal documented in the first 24-48 hours  
* Percentage of home health episodes of care in which patients/caregivers were educated about high-risk medications at the start/resumption of care including instructions on how to monitor the effectiveness of drug therapy; how to recognize potential adverse side effects, and how and when to report problems  
* Define three or four “vital few” elements for transition instructions, medications, and/or self-care needs, e.g., when to call the physician, dietary needs or when a follow-up appointment is scheduled. Then track: Percentage of patients who can teach back 75% or more of what they are taught when content is broken into easy-to-learn segments.  
* Percentage of patients who can teach back 75% or more of what they are taught to manage their medications |
| 3. Engage, coordinate, and communicate with the full clinical team.         | * Percentage of home health episodes of care in which the patient’s drug regimen at start/resumption of home health care was assessed to pose a risk of clinically significant adverse effects or drug reactions and whose physician was contacted within one calendar day  
* Percentage of patients who can tell the home health care staff in the first 48 hours of care when their follow-up appointment with their managing clinician is  
* Percentage of patients who can identify their primary doctor or provider |
Step 5. Implement and spread successful practices.

Implementation

After testing a change on a small scale, learning from each test, and refining the change through several PDSA cycles, the team can implement the change on a broader scale — for example, for an entire pilot population like patients with heart failure. Implementation is the process of making an improvement a part of the day-to-day operation of the system in your pilot population or for all patients assigned to a nurse or care team. Unlike the testing that you’ve done to develop your new processes, implementation is a permanent change to the way work is done and, as such, involves building the change into the organization. It may affect written policies, hiring, training, compensation, equipment, and other aspects of the organization’s infrastructure that are not heavily engaged in the testing phase. Attention should be paid to communication (i.e., publicizing the benefits of the change), documenting improvement, as well as keeping in contact with the pilot team so that they are supported during the implementation phase. PDSA cycles can and should be used to enhance learning and accelerate the process of hard-wiring the changes so they become an integral part of the system.

Example: During the testing process, a few nurses may be trained in the redesigned patient education processes that use Teach Back with the identified learners. Once the processes and support materials have been adapted so that these nurses are able to teach the identified learner effectively over 90 percent of the time, those processes should be implemented. Making these processes the default system (i.e., the way the work is done rather than the way a few nurses do the work from time to time) requires a training system for all current nurses and changes to orientation programs for new nurses; it might also require changes to an IT system where information about education is documented and shared. Communication to all staff about the revised expectations for teaching and learning might be developed to start to generate interest in implementing the redesigned process in other service lines or with all disciplines in preparation for spread.

During implementation, attend to the social aspects of the change as well as the technical infrastructure. Leaders need to communicate the why as well as the how of the change, and to address questions and concerns. It is common for processes that seem to be working well (i.e., being executed reliably) during testing to get less reliable, temporarily, when you move to implementation. During implementation, a larger group, some unfamiliar or unsympathetic with
the purpose, are now expected to make the change – and there may be resistance, or simply confusion. It may take some cycles of testing to put in place an effective infrastructure to support the change(s). Continue to monitor whether your processes are being executed as planned and to act on that information to adapt the processes and the related infrastructure to support the change. **Make it easy to do the right thing, and hard to do the wrong thing.**

**Tips for Sustaining Improvements**

- Communicate aims and successful changes that achieved the desired results (e.g., newsletters, storyboards, patient stories, etc.).
- “Hard-wire” processes so that the new processes are difficult to reverse (e.g., IT template, yearly competencies, role descriptions, policies and procedures).
- Assign ownership for oversight and ongoing quality control to “hold the gains.”
- Assign responsibility for ongoing measurement of processes and outcomes.

**Spreading Changes**

Leaders should begin making plans for spreading the improvement developed in the pilot population or pilot team during the early stages of the initiative. After successful implementation of a change or package of changes for a pilot population or for all patients under your care, leaders will be prepared to lead the spread of the changes to other parts of the agency or to other agencies. Even though the changes have been tested and implemented, spread efforts will benefit from testing and adaptation (using PDSA cycles) in the new patient populations or with additional care teams. Those adopting the change may need to adapt it to their own setting and to build confidence that the change will result in the predicted improvement.

Some considerations for leaders as they plan for spread of the changes to improve transitions include the following:

- If the initial population of focus was a specific patient population (e.g., patients with a particular disease type like heart failure), consider adaptations to the process that may be necessary for spread to all patients. For example, if you developed a teaching strategy and materials for heart failure patients, what tools and strategies will your nurses need to apply to teaching all patients?
- If the initial population of focus was a particular nurse or care team, what do you need to do to spread to others? What adaptations might be needed? Who are the stakeholders
who need to be engaged in the process? How might you involve them early on to build will and excitement in the staff who will be spread to?

Successful spread of reliable processes requires that leadership take responsibility for spread and commit sufficient resources to support spread. Pilot staff also play an important role in spread activities by 1) making the case that the changes contribute to better transitions for patients and reduced acute care hospitalizations, and 2) generating information and materials that leaders can package to make it easier for others to adapt the changes they made. They may also be involved in teaching and mentoring others although the responsibility for developing the overall training and support system lies with leadership.

An important consideration for leaders in preparing for spread is whether staff outside of the pilot group or those caring for the pilot population will have the time and resources to make the same changes that have been made at the pilot level. In other words, are the changes developed at the pilot level scalable to the rest of the organization? For example, completing an enhanced transition to home health care services; using Teach Back for all patients; or ensuring that follow-up appointments for patients have been made may mean that nurses and other staff will need to rethink and redesign their activities and responsibilities to free up time to reliably carry out these as well as the other steps needed for an ideal transition.

One way that leaders together with the nurses in the home health care agency can begin the redesign effort is to use structured observation or self audit methods to evaluate their current workflows and processes, identify areas of waste (i.e., time spent looking for supplies, information, etc.), and then to test new ways of carrying out work more efficiently so they have more time to spend with patients, providing care as well as supporting the patient and family caregivers in their transition into the home. Information about how to engage front-line staff in the redesign of patient care can be found in the IHI materials on Transforming Care at the Bedside (see the web resources list below).

A key responsibility of leaders is to develop a plan and timetable for spread and then to measure and monitor progress as the spread unfolds. This oversight process involves two parts: 1) measuring and monitoring the rate of spread of the changes, and 2) tracking improvement in outcomes (e.g., reductions in acute care hospitalization rates). Figure 16 is an example of a tool with hospital changes that leaders can use to monitor the spread of a package of changes (the changes are listed in rows, and the areas designated for spread are listed in columns). This tool allows a leader to understand the progress of the spread of each change and the spread of...
changes across the locations designated for spread (in this example, among nurses and other disciplines in the home health agency, but it could also be service lines or multiple agencies within a larger system). Use Figure 17 as a template to monitor spread.

**Figure 16: Tool to Monitor Spread**

![Spread Plan](image)

**Figure 17: Spread Tracker Template** (How-to Guide Resources, page 68)

![Spread Tracker Template](image)
Data about acute care hospitalization rates or other outcome measures as identified by the leaders can be used in conjunction with information about the rate of adoption of the changes. For example, if a care team sees no reduction in acute care hospitalizations then a leader could check their progress in implementing each of the recommended changes. Leaders would want to determine if further guidance and support is needed to accelerate progress and the achievement of results. It is recommended that outcome measures be reported and tracked at the home health care agency or system level as well as at the care team level in order to provide leaders, care team managers, and front-line staff with regular feedback on their progress.

**Recommended Resources on Quality Improvement**

Books and articles:


Web tools and resources:

*Spreading Changes.* Institute for Healthcare Improvement. Available at [http://preview.ihi.org/knowledge/Pages/HowtoImprove/ScienceofImprovementSpreadingChanges.aspx](http://preview.ihi.org/knowledge/Pages/HowtoImprove/ScienceofImprovementSpreadingChanges.aspx).


*On Demand Presentation: An Introduction to the Model for Improvement.* Institute for Healthcare Improvement. Available at [http://preview.ihi.org/offerings/VirtualPrograms/Individuals/ImprovementModelIntro/Pages/default.aspx](http://preview.ihi.org/offerings/VirtualPrograms/Individuals/ImprovementModelIntro/Pages/default.aspx).

*Transforming Care at the Bedside (TCAB).* Institute for Healthcare Improvement. Available at [http://preview.ihi.org/offerings/Initiatives/PastStrategicInitiatives/TCAB/Pages/default.aspx](http://preview.ihi.org/offerings/Initiatives/PastStrategicInitiatives/TCAB/Pages/default.aspx).


*How to Improve.* Institute for Healthcare Improvement. Available at [http://preview.ihi.org/knowledge/Pages/HowtoImprove/default.aspx](http://preview.ihi.org/knowledge/Pages/HowtoImprove/default.aspx).

*Quality Improvement 101-106.* IHI Open School for Health Professions. Available at [http://preview.ihi.org/offerings/Pages/openschool.aspx](http://preview.ihi.org/offerings/Pages/openschool.aspx). The Institute for Healthcare Improvement offers online courses, through the IHI Open School for Health Professions, that are available free to medical students and residents and for a subscription fee for health care professionals.

## VI. How-to Guide Resources

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Diagnostic Worksheet: In-depth Review of Patients Who Had an Acute Care Hospitalization within 30 days of a Hospital Discharge

Part 1: Chart Review

Conduct chart reviews of the last five patients with an acute care hospitalization within 30 days of a hospital discharge. Reviewers should be nurses experienced in the clinical setting and in chart review for quality and safety. Reviewers should not look to assign blame, but rather to discover opportunities to improve the care of patients. The intent is to learn how to prevent failures once thought impossible to prevent.

<table>
<thead>
<tr>
<th>Question</th>
<th>Patient #1</th>
<th>Patient #2</th>
<th>Patient #3</th>
<th>Patient #4</th>
<th>Patient #5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of days between the last discharge and this acute care hospitalization date?</td>
<td>_____ days</td>
<td>_____ days</td>
<td>_____ days</td>
<td>_____ days</td>
<td>_____ days</td>
</tr>
<tr>
<td>Was the follow-up physician visit scheduled prior to discharge based on risk assessment of patient?</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>If yes, was the patient able to attend the office visit?</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Were there any urgent clinic/ED visits before this acute care hospitalization?</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Functional status of the patient on admission?</td>
<td>Comments:</td>
<td>Comments:</td>
<td>Comments:</td>
<td>Comments:</td>
<td>Comments:</td>
</tr>
<tr>
<td>Was a clear discharge plan documented?</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Was evidence of “Teach Back” documented?</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>List any documented reason/s for acute care hospitalization.</td>
<td>Comments:</td>
<td>Comments:</td>
<td>Comments:</td>
<td>Comments:</td>
<td>Comments:</td>
</tr>
<tr>
<td>Did any social conditions (transportation, lack of money for medication, lack of housing) contribute to the readmission?</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Diagnostic Worksheet: In-depth Review of Patients Who Were Readmitted
Part 1: Reflective Summary of Chart Review Findings

What did you learn?

What themes emerged?

What, if anything, surprised you?

What new questions do you have?

What are you curious about?

What do you think you should do next?

What assumptions about readmissions that you held previously are now challenged?
Diagnostic Interview Worksheet: In-depth Review of Patients Who had an Acute Hospitalization within 30 days of Hospital Discharge

Part 2: Interviews with Patients, Family Members, and Care Team Members in the Community

If possible, conduct the interviews on the same patients from the chart review. Use a separate worksheet for each interview.

**Ask Patients and Family Members:**

How do you think you became sick enough to go back to the hospital?

Did you see your doctor or the doctor’s nurse in the office before you came back to the hospital?

- Yes
- No

If yes, which doctor (PCP or specialist) did you see?

If no, why not?

Describe any difficulties you had to get an appointment or getting to that office visit.

Has anything gotten in the way of your taking your medicines?

How do you take your medicines and set up your pills each day?

Describe your typical meals since you got home.

**Ask Care Team Members in the Community:**

What do you think caused this patient to be readmitted?

*After talking to the care team members about why they think the patient was readmitted, write a brief story about the patient’s circumstances that contributed to the readmission.*
### Diagnostic Worksheet: In-depth Review of Patients

**Part 2: Summary of Interview Findings**

**What did you learn?**

**What themes emerged?**

**What, if anything, surprised you?**

**What new questions do you have?**

**What are you curious about?**

**What do you think you should do next?**

**What assumptions about readmissions that you held previously are now challenged?**
Data Reporting Guidelines

The following measures are recommended for use when actively working to improve transitions in care in the first 24-48 hours into home health care. It is recommended that the following outcome measures and the process measures pulled from OASIS and HHCAHPS data be used as a monthly dashboard to track and drive the improvement work. Process measures that need manual data collection can be used when focusing on those specific care processes to ensure effective and reliable new processes are developed and implemented.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Description</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Data Collection Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Care Hospitalizations (ACH) within 30 days of admission to home health care</td>
<td>Percent of acute care hospitalizations within 30 days of admission to home health care.</td>
<td>Number of home health episodes of care that indicate the patient had unscheduled admission to a hospital.</td>
<td>Number of home health episodes of care ending with a home health care agency discharge or a transfer to hospital during the reporting period.</td>
<td></td>
</tr>
</tbody>
</table>

*Exceptions include other than those covered by generic or measure-specific exclusions. Generic exclusions include those patients not evaluated with the OASIS-C document: 1) pediatric home health patients, 2) home health patients receiving maternity care only, 3) home health clients receiving non-skilled care only or 4) home health patients for whom the payment source is neither Medicare nor Medicaid. Measure Specific Exclusions include: Home health episodes of care that end in patient death (Medicare 1a, 2011).


Option 1: Pull your agencies’ OASIS data on ACHs as often as the data is reported by CMS and put into a run chart. This data is annualized (includes the last 12 months of data) and case mix adjusted. This makes this data less sensitive to showing improvement from the change efforts.

Option 2: Track the number of ACHs at the agency level and track monthly. For the improvement work, there is no need to annualize or case mix adjust. This is the recommended option as it will be more sensitive to showing changes due to the improvement work. It is therefore more useful to the improvement team.
<table>
<thead>
<tr>
<th>Optional Measure for when the improvement work focuses on a sub-population, e.g. heart failure: Acute Care Hospitalizations within 30 days of admission to home health care for a Specific Clinical Condition</th>
<th>Percent of acute care hospitalizations within 30 days of admission for home health care for Specific Clinical Condition.</th>
<th>Count of acute care hospitalizations within 30 days of hospital discharge with a specific clinical condition who were hospitalized for any cause within 30 days of discharge.</th>
<th>Number of home health episodes of care with a specific clinical condition ending with a home health care agency discharge or a transfer to hospital during the reporting period.</th>
<th>Track the number of ACHs with specific clinical conditions and patients with the specific clinical condition who had ACH at the agency level and track monthly.</th>
</tr>
</thead>
<tbody>
<tr>
<td>HHCAHPS Question 17 Home health care providers explained things in a way that was easy to understand.</td>
<td>In the last 2 months of care, how often did home health providers from this agency explain things in a way that was easy to understand?</td>
<td>Number of patients surveyed in the month who answered, “Always”</td>
<td>Number of surveys completed in the month with an answer for this question</td>
<td>Every month, pull your agencies HHCAHPS data for this question.</td>
</tr>
<tr>
<td>HHCAHPS Question 18 The home health care providers listened carefully to me.</td>
<td>In the last 2 months of care, how often did home health providers from this agency listen carefully to you?</td>
<td>Number of patients surveyed in the month who answered, “Always”</td>
<td>Number of surveys completed in the month with an answer for this question</td>
<td>Every month, pull your agencies HHCAHPS data for this question.</td>
</tr>
</tbody>
</table>
### Process Measures

<table>
<thead>
<tr>
<th>Measure</th>
<th>Description</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Data Collection Strategy</th>
</tr>
</thead>
</table>
| **Change 1. Meet the patient, family caregiver(s), and inpatient caregiver(s) in the hospital and review transition home plan.**

Patients and family included in home needs prior to hospital discharge.  
Percent of home health admissions where patients and family caregivers were included in assessing home needs prior to hospital discharge or "vital information is obtained by hospital discharge planner" and conveyed to home health care provider in the first 24 hours.  
"Family" is defined by the patient and includes any individual(s) who provide support. "Family caregivers" is the phrase used to represent those family members who are directly involved in care of the patient outside hospital or other community institutions.

| | | Number of patients admitted to home health care for whom the patient and family caregivers were included prior to hospital discharge or vital information is obtained and conveyed to the home health care provider in the first 24 hours post-discharge. | Number of admissions in the sample | • Option 1: Review charts of 10-20 patients discharged from the pilot team: 2-5 per week for 4 weeks a month.  
• Option 2: Build data collection into discharge process – i.e., at discharge, review record to determine if patients had a follow-up office visit scheduled in accordance with their risk assessment. Enter data monthly. |
|---|---|---|---|---|

| **Change 2: Assess the patient, initiate plan of care and reinforce patient self-management at first post-discharge home health care visit.**

Medication Management

| HHCAHPS Question 5  
Did home health care staff ask to see all prescriptions and over-the-counter medicines? | When you started getting home health care from this agency, did someone from the agency ask to see all the prescription and over-the-counter medicines you were taking? | Number of patients in the survey for the month who answered “Always”. | Number of surveys in the month with an answer to this question. |
|---|---|---|---|

| HHCAHPS Question 4  
Did home health care staff talk with you about all the | When you started getting home health care from this agency, did someone from the agency talk | Number of patients in the survey for the month who answered “Always”. | Number of surveys in the month with an answer to this question. |
<table>
<thead>
<tr>
<th>Measure</th>
<th>Description</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Data Collection Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>prescription and over-the-counter medicines you were taking?</td>
<td>with you about all the prescription and over-the-counter medicines you were taking?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Engaging Patients and Family Caregivers in Self-Care</td>
<td>1 self-care goal documented in the first 24-48 hours.</td>
<td>Number of times at least one self-care goal is documented in the first 24 hours.</td>
<td>Number of patients or caregivers in the population of focus. The population of focus is the group of patients for whom tests of change are being run, or the change is being implemented or spread.</td>
<td>Review charts of 10-20 patients from the pilot team: 2-5 per week for 4 weeks a month. Enter data monthly.</td>
</tr>
</tbody>
</table>
| OASIS M2010: Patient/caregiver high-risk drug education.               | Percentage of home health episodes of care in which patients/caregivers were educated about high-risk medications at the start/resumption of care including instructions on how to monitor the effectiveness of drug therapy, how to recognize potential adverse side effects, and how and when to report problems. | Number of home health episodes of care during which patient/caregiver was instructed on how to monitor the effectiveness of drug therapy, how to recognize potential adverse effects, and how and when to report problems. | Number of home health episodes of care ending with a discharge or transfer to inpatient facility during the reporting period, other than those covered by generic or measure-specific exclusions.  
Exclusions

Home health episodes for which the patient was not taking any drugs between start/resumption of care and discharge/transfer, OR an assessment for recertification or other follow-up was conducted between start/resumption of care and transfer or discharge, OR the patient died.

[www.medicare.gov/HomeHealthCompare/Data/Measures/RateCalculation.aspx](http://www.medicare.gov/HomeHealthCompare/Data/Measures/RateCalculation.aspx) |
<table>
<thead>
<tr>
<th>Measure</th>
<th>Description</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Data Collection Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teach Back on managing medications.</td>
<td>Percent of patients who can teach back 75% or more of what they are taught to manage their medications.</td>
<td>Number of documented sessions of nurses where the patient or family caregiver can teach back how to manage their medications.</td>
<td>Number of documented sessions where nurse is teaching about medication management</td>
<td>Option 1: Observe 5 teaching opportunities per week from the pilot care team for 4 weeks a month. Option 2: Nurse documents Teach Back response rate with every teaching session. Enter data monthly</td>
</tr>
<tr>
<td>Teach Back of content vital for a successful transition home.</td>
<td>Define three or four “vital few” elements for transition instructions, medications, and/or self-care needs, e.g., when to call the physician, dietary needs or when a follow-up appointment is scheduled. Then track: Percent of patients who can teach back 75% or more of what they are taught when content is broken into easy-to-learn segments.</td>
<td>Number of patients in your sample who were able to teach back 3 out of 3 or 3 out of 4 content elements by the time of transition</td>
<td>Number of patients in the sample where Teach Back is used</td>
<td>At last teaching opportunity (preferably at transition) document which of the 3 or 4 key elements of the transition instructions the patient is able to Teach Back</td>
</tr>
</tbody>
</table>

**Change 3: Engage, coordinate, and communicate with the full clinical team.**

<p>| OASIS M2002 Potential Medication Issues Identified and Timely Physician Contact at Start of Episode. | Percentage of home health episodes of care in which the patient’s drug regimen at start/resumption of home health care was assessed to pose a risk of clinically significant adverse effects or drug reactions and whose physician was contacted within one calendar day. | Number of times the managing physician or clinician is contacted within 24 hours of start/resumption of episodes due to significant clinical finding or medication issue. | Number of episodes in which there was an assessment of clinically significant risk. | Sample 20 charts a month Consider segmenting patients based on a chronic condition like heart failure. |
| Follow-Up Appointment | Percentage of patients who can tell the home health staff in the | Number of patients or family caregivers who were | Number of new home health care admissions. | Sample 20 charts a month Consider segmenting patients |</p>
<table>
<thead>
<tr>
<th>Measure</th>
<th>Description</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Data Collection Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>first 48 hours of care, when their follow-up appointment with their managing clinician is.</td>
<td>able to tell the home health staff when their follow-up appointment with their managing clinician is, in the first 48 hours.</td>
<td></td>
<td></td>
<td>based on a chronic condition like heart failure.</td>
</tr>
<tr>
<td>Managing Clinician Identified</td>
<td>Percent of patients who can identify their managing clinician.</td>
<td>Number of patients or family caregivers who were able to tell the home health staff who their managing clinician is.</td>
<td>Number of new home health care admissions.</td>
<td>Sample 20 charts a month Consider segmenting patients based on a chronic condition like heart failure.</td>
</tr>
</tbody>
</table>
PDSA Worksheet  

**DATE**

Change or idea evaluated: ________________________________

Objective for this PDSA Cycle: ________________________________

_________________________________________________________________________

What question(s) do we want to answer on this PDSA cycle?

_________________________________________________________________________

**Plan:**

*Plan to answer questions (test the change or evaluate the idea):* Who, What, When, Where

*Plan for collection of data needed to answer questions: Who, What, When, Where*

Predictions (For each question listed, what will happen if plan is carried out? Discuss theories.)

**Do:**

*Carry out the Plan; document problems and unexpected observations; collect data and begin analysis.*

**Study:**

*Complete analysis of data: What were the answers to the questions in the plan (compare to predictions)? Summarize what was learned.*

**Act:**

*What changes are to be made? Plan for the next cycle.*
Sample PDSA Worksheet  

DATE __8/10/2010__

Change or idea evaluated: Use Heart Failure Zone handout to improve patient learning

Objective for this PDSA Cycle: Improve patient understanding of HF self-care by using the zone worksheet, improve nurse teaching skills.

What question(s) do we want to answer on this PDSA cycle?

If we use health literacy principles and Teach Back, will (1) our nurses be comfortable using the Teach Back technique, and (2) our patients have a better understanding of their care?

Plan:

Plan to answer questions (test the change or evaluate the idea): Who, What, When, Where

Emily will talk to Jane (a nurse we know is interested in this project) and ask her to try the change
An HF patient with sufficient cognitive ability (Jane will decide) will be identified on Aug 10.
Jane will use HF zone handout example from St. Luke’s as teaching tool.
Jane will ask four St. Luke’s sample questions:
  • What is the name of your water pill?
  • What weight gain should you report to your doctor?
  • What foods should you avoid?
  • Do you know what symptoms to report to your doctor?

Plan for collection of data needed to answer questions: Who, What, When, Where

Jane will write down which answers patients were able to Teach Back successfully and which they had trouble with and come to the next team meeting on the 11th and report on her experience.

Predictions (for each question listed, what will happen if plan is carried out? Discuss theories)

1) Nurse may have trouble remembering not to say “do you understand”
   But will like the change, be able to use the technique, and
2) The patient will be able to Teach Back (will choose someone with sufficient cognitive Ability for the test).

Do:

Carry out the Plan; document problems and unexpected observations; collect data and begin analysis.

There wasn’t an appropriate patient on the 10th, but there was on the 11, Jane reported to the team the next day that the patient was able to Teach Back three of the four questions – had trouble remembering weight gain to report to doctor. Jane reported that she really liked the new teaching style and wanted to practice it with other patients.

Study:

Complete analysis of data: What were the answers to the questions in the plan (compare to predictions)? Summarize what was learned.
Jane reported that she did say “do you understand” a couple of times and then would catch herself, but she had explained the test in advance to the patient and they liked the idea, too.

**Act:**

*What changes are to be made? Plan for the next cycle*

Find one or more patients willing to work with Jane on redesigning patient materials and continue to test the Teach Back technique – Jane will try on more patients and try to recruit another nurse to test with her. Will report back at next meeting. Jane will create a paper tool that will help her keep track of which items the patients Teach Back so that she can continue to collect the data.
Observe or conduct self audit of patient teaching as it exists today. Observe or self audit three teaching sessions (done in the usual way) conducted by nurses. Reflect upon what you discovered went well and where there are opportunities for improvement.

What do you predict you will observe?

<table>
<thead>
<tr>
<th>Did you or the care team member(s)…</th>
<th>Patient # 1</th>
<th>Patient # 2</th>
<th>Patient # 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use simple language and terminology?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Use patient-friendly teaching materials?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Request the patient teach back what was understood in patient’s own words?</td>
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<td></td>
</tr>
<tr>
<td>Use non-shaming language in the Teach Back request?</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Display a warm attitude?</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Use a friendly tone of voice?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Display comfortable body language?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ask “Do you understand?” or “Do you have any questions? (THEY or YOU SHOULD NOT)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Use teaching materials in patient’s language of choice?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Reflections after findings are completed (to be shared with the entire team):

What did you learn?
Observation or Self Audit Guide: Current Processes for Patient Teaching

How did your findings compare to the predictions?

What, if anything, surprised you?

What new questions do you have? What are you curious about?

What assumptions about patient education that you held previously are now challenged?

As a result of the findings from these observations, what do you plan to test?

1.

2.

3.

4.

5.
## Spread Tracker Template

A=Planning  B=Start  C=In Progress  D=Fully Implemented

<table>
<thead>
<tr>
<th></th>
<th>Pilot Team 1</th>
<th>Pilot Team 2</th>
<th>Spread Team 1</th>
<th>Spread Team 2</th>
<th>Spread Team 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Change 1</td>
<td>D</td>
<td>C</td>
<td>A</td>
<td>B</td>
<td>C</td>
</tr>
<tr>
<td>Change 2</td>
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<td>B</td>
<td>B</td>
<td>C</td>
</tr>
<tr>
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<td>C</td>
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<tr>
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<td>A</td>
<td>B</td>
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<tr>
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<td>C</td>
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<td>A</td>
</tr>
<tr>
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<td>Change 7</td>
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<td>Change 8</td>
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</tbody>
</table>
VII. References


