



# Best Practice: Hospitalization Risk Assessment

# Home Health Aide Track





## Home Health Aide Track

This best practice package is designed to introduce the home health aide to the hospitalization risk assessment to assist in reducing avoidable acute care hospitalizations.

### Objectives

After completing the activities in the Home Health Aide track of this Best Practice Intervention Package – Hospitalization Risk Assessment, the learner will be able to:

1. State at least one reason why reducing avoidable acute care hospitalizations is a national focus.
2. Define what a hospitalization risk assessment is and how it can be used by a home health agency.
3. Identify two home health aide applications of the hospitalization risk assessment.

Complete the following:

|                          | <b>Activity</b>   | <b>Location</b> | <b>Estimated Time</b> |
|--------------------------|---|-----------------|-----------------------|
| <input type="checkbox"/> | Read the risk assessment description and review the sample risk assessment tool   | Pages 73, 75    | 10 minutes            |
| <input type="checkbox"/> | Listen to the audio recording: ACH – Audio Recording for Home Health Aides – History & National Priority  | Page 74         | 10 minutes            |
| <input type="checkbox"/> | Listen to the audio recording: Hospitalization Risk Assessments for Home Health Aides   | Page 74         | 15 minutes            |
| <input type="checkbox"/> | Read the Hospitalization Risk Assessment – Home Health Aide’s Guide to Practical Application  | Page 76         | 5 minutes             |
| <input type="checkbox"/> | Read the success story  | Page 77         | 5minutes              |
| <input type="checkbox"/> | Access and explore the supporting resources for reducing acute care hospitalizations on <a href="http://www.medqic.org">www.medqic.org</a> (optional – will need computer access) | Page 78         | 15 minutes            |
| <input type="checkbox"/> | Complete the home health aide post-test and give it to your manager   | Page 79         | 15 minutes            |
|                          | <b>Total Time</b>   |                 | <b>75 minutes</b>     |



## Hospitalization Risk Assessment

A hospitalization risk assessment is a tool that is used by nurses and/or therapists to identify patients that are high risk for being admitted to the hospital. Some of the high risk factors can be:

- history of falls
- previous hospitalizations
- lives alone
- confusion
- needs help with activities of daily living (ADLs)
- needs help with medications
- medication non-adherence
- financial issues
- chronic skin ulcers
- certain diseases – CHF, Diabetes, COPD

A structured communication process must be established to communicate the high-risk patients to appropriate staff, including home health aides and those on-call after business hours.

It is the responsibility of the **home health aide** to be aware of their patients' risk for hospitalization. The home care nurse and/or therapist are responsible for completing a hospitalization risk assessment at start of care and resumption of care (post-hospitalization) and for selecting appropriate interventions (actions) to assist in reducing avoidable acute care hospitalizations. Discussion of a patient's risk for being admitted to the hospital and actions to minimize that risk should be communicated to the home health aide as part of all routine reporting and possibly incorporated into the aide's care plan. The home health aide is responsible for reporting any potential risk factors or changes in condition immediately, and to help with the interventions (actions) that are being used with the patient.

Examples of interventions that an agency may offer include:

- Patient emergency planning
- Medication management
- Front-loading visits
- Phone monitoring
- Telemonitoring
- Triage
- Fall prevention
- Immunization
- Patient self-management
- Disease/case management



## Audio Recordings

Listen to the two audio recordings to learn more about reducing avoidable acute care hospitalizations and the use of the hospitalization risk assessment. A sample hospitalization risk assessment form is on the next page.

| <b>Title</b>   | <b>Description</b>  | <b>Link</b>   |
|--|---|---|
| ACH – History & National Priority– for Home Health Aides | A 10-minute audio recording related to ACH, the national priority outcome, QIOs & home care agencies working collectively as a team to reduce ACH rates.      | The audio link is located at <a href="http://www.homehealthquality.org/hh/ha/interventionpackages/hra.aspx">www.homehealthquality.org/hh/ha/interventionpackages/hra.aspx</a> |
| Hospitalization Risk Assessment for Home Health Aides    | A 15-minute audio recording that can be used by home health aides in staff/team meetings or while traveling in the car. A few discussion points are included. | The audio link is located at <a href="http://www.homehealthquality.org/hh/ha/interventionpackages/hra.aspx">www.homehealthquality.org/hh/ha/interventionpackages/hra.aspx</a> |

There are several ways you can listen to these audio recordings. You can visit the link above and listen directly through the Web site. You can also download the audio recording by right-clicking on the audio file and selecting “Save Target As...”. This will save the file to your hard drive. Once you have saved the file, you can listen to it on your computer or you can burn the audio file to a CD to listen to in your car or stereo.

### Discussion Questions

You may complete these discussion questions together in a group setting (team meeting) or just think about them if you are doing this as a self-study.

- What is an avoidable acute care hospitalization? Can you give an example?
- How does using a hospitalization risk assessment tool help reduce avoidable acute care hospitalizations?
- Can you describe some of the risk factors for at-risk patients for hospitalization?
- How could you work differently with your patients if you knew they were at-risk for hospitalization?
- Can you think of some situations where you as the home health aide discovered high risk factors that were not previously known about the patient and reported them to the nurse, therapist or manager?
- Do you find that patients and families tend to open up and tell some details that could be very important in their care to you and not to the nurse or therapist? Can you see how valuable your eyes and ears are at each and every visit?
- Give some examples of how a home health aide can work with the nurses, therapists, and/or social workers in reducing acute care hospitalization.
- How does your patient benefit?

# Hospitalization Risk Assessment

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

Patient Name: \_\_\_\_\_ Record # \_\_\_\_\_

Date: \_\_\_\_\_

|   |   |   |  |
|---|---|---|--|
| <b>Prior pattern: Check all that apply</b>  |   |   |  |
| <input type="checkbox"/> > 1 Hospitalizations or ER visits in the past 12 months  | <input type="checkbox"/> History of falls * ( <i>Complete Falls Risk Assessment</i> )   |   |  |
| <b>Chronic conditions: Check all that apply (M0230/M0240)</b>   |   |   |  |
| <input type="checkbox"/> CHF  | <input type="checkbox"/> Chronic skin ulcers ( <i>Wound consult if indicated for any wounds</i> )   |   |  |
| <input type="checkbox"/> Diabetes   |   |   |  |
| <input type="checkbox"/> COPD   | <input type="checkbox"/> HIV/AIDS   |   |  |
| <b>Risk Factors: Check all that apply</b>   |   |   |  |
| <input type="checkbox"/> Discharged from hospital or skilled nursing facility (M0175)   | <input type="checkbox"/> Help with managing medications needed (M0780) ▶ ★  |   |  |
| <input type="checkbox"/> More than 2 secondary diagnoses (M0240)  | <input type="checkbox"/> Non-compliance with medication regimen ◆ ★   |   |  |
| <input type="checkbox"/> Low socioeconomic status or financial concerns ◆   | <input type="checkbox"/> Confusion (M0570) ◆ ★  |   |  |
| <input type="checkbox"/> Lives alone (M0340) ▶ ◆  | <input type="checkbox"/> Pressure ulcer (M0445) ★   |   |  |
| <input type="checkbox"/> Inadequate support network ◆   | <input type="checkbox"/> Stasis ulcer (M0468) ★   |   |  |
| <input type="checkbox"/> ADL assistance needed ▶  | <input type="checkbox"/> Short life expectancy (M0280) ■  |   |  |
| <input type="checkbox"/> Home safety risks ▶ ◆  | <input type="checkbox"/> Poor prognosis (M0260) ■   |   |  |
| <input type="checkbox"/> Dyspnea (M0490) ▶ ★  | <input type="checkbox"/> Low literacy level ◆   |   |  |
| ▶ Consider Therapy referral (PT, OT, ST)  | ◆ Consider MSW referral   | ■ Consider Hospice referral   | ★ Consider RN referral, if not ordered |
| Total # of checked boxes is _____. <b>Your agency may want to select a threshold score to target patients at high risk.</b><br>(For example: 5 or greater risk factors may indicate that the patient is at risk for hospitalization. Note: This number is for convenience only and has not been tested or validated. The agency may modify the score based upon the needs of their patient population.) |   |   |  |
| <b>Consider implementing any of the following interventions, if patient is at risk for hospitalization:</b>   |   |   |  |
| Referrals:<br><input type="checkbox"/> SN <input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> ST<br><input type="checkbox"/> MSW <input type="checkbox"/> HHA <input type="checkbox"/> Dietary Consultant<br><input type="checkbox"/> Other _____  | <input type="checkbox"/> Medication Management Reconciliation<br>• Assess patient's: knowledge, ability, resources and adherence<br>• Education | <input type="checkbox"/> Patient/family education<br><input type="checkbox"/> Enrollment into a disease management program (specify): _____ |  |
| <input type="checkbox"/> Hospice/Palliative Referral  | <input type="checkbox"/> Phone Monitoring   | Immunizations<br><input type="checkbox"/> Influenza <input type="checkbox"/><br><input type="checkbox"/> Pneumonia                          |  |
| <input type="checkbox"/> Individualized Patient Emergency Care Plan   | <input type="checkbox"/> Front-loading Visits   | <input type="checkbox"/> Care Coordination (Physicians, hospitals, nursing homes...)  |  |
| <input type="checkbox"/> Fall Prevention Program  | <input type="checkbox"/> Telemonitoring   | <input type="checkbox"/> Other: _____   |  |

Consider notification of any/all of the following if patient is at risk for hospitalization:

|   |   |  |   |
|---|---|--|---|
| <input type="checkbox"/> Patient/family/caregiver | <input type="checkbox"/> Interdisciplinary Team | <input type="checkbox"/> On Call Staff       | <input type="checkbox"/> Payer: (e.g. Managed Care Organizations) |
| <input type="checkbox"/> Physician                | _____   | <input type="checkbox"/> Agency Case Manager | <input type="checkbox"/> Other: _____                             |

Clinician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Adapted from Personal Touch Home Care, VA 6/25/04 Professional Practice Model.

The following articles provide more information on risk assessments:

Rosati, R.J., Liping, H., Navaie-Waliser, M., & Feldman, P.H. (2003) Risk Factors for Repeated Hospitalizations among Home Healthcare Recipients. *Journal for Healthcare Quality, 25*(2).  
 Fortinsky, RH, Madigan, EZ, Sheehan, TJ, Tullai-McGuinness, S. & Fenster, JR. (2006) Risk factors for hospitalization among Medicare home care patients. *West J Nurse Res, 28*(8).





# Hospitalization Risk Assessment

## Home Health Aide's Guide to Practical Application

Purpose: To enable the home health aide to:

- (1) Become increasingly aware of those patients who have been identified as being at high-risk for hospitalization
  - (2) Learn what actions home health aides can take to assist the care team in reducing avoidable hospitalizations
- ❑ Communicate to nurse, therapists or manager any risk factors identified, such as:
    - Patient reports being seen in the emergency room
    - Change in caregiver status – caregiver moves out or new caregiver begins
    - Patient falling in the home
    - Patient having periods of confusion – new for patient or a significant increase in frequency of confusion
    - Patient requiring more assistance with activities of daily living – more unsteady in shower, weaker than usual
    - Trouble getting pill bottles or pill boxes open
    - Not taking medications correctly or at all – finding pills in bed or on the floor or patient refusing to take medications
    - Financial difficulties – patient or family commenting on difficulty in getting medications refilled
    - Lack of food related to financial or other issues
    - Increased shortness of breath or weight gain
    - Wound looking worse or having an odor
  - ❑ Assist nurse and/or therapists with planned interventions (actions):
    - Participate in interdisciplinary case conferences when appropriate, discussing high risk factors and offering insight and suggestions for plan of care, sharing your knowledge of the patient and family.
    - Review the patient emergency care plan (when to call the agency) on each home health aide visit.
    - If patient is at risk for falls, encourage use of walker or cane (if applicable) or walk with patient.
    - If patient is at risk for falls, instruct patient on the need to use the walker, cane or the assistance of another person when walking.
    - If patient has been ordered telemonitoring, determine if patient/caregiver is using the equipment each day, as instructed.
    - If patient has been ordered to obtain daily weights, determine if the patient is being weighed daily. May assist patient with use of daily weight chart and/or assist patient with weighing during visit also.
    - Report increase in weight above the patient's physician targeted range.
    - If self blood glucose monitoring has been ordered, determine if blood sugars are being checked as ordered.



## Success Story

### Washington State Home Health Agency Reduces Acute Care Hospitalizations through Team Approach

Assured Home Health has been praised for best practice achievement in the ReACH collaborative for its weekly team conferencing for patients at high risk. ReACH—Reducing Acute Care Hospitalization (ACH)—was launched in 2006 as a collaborative demonstration project aimed at reducing the number of avoidable hospitalizations for home health patients.

Most home health agencies already hold weekly team conferences to discuss patients, including those at high risk for hospitalization, so what does Assured Home Health do that makes the agency stand out? Quality Improvement Manager JoAnna McGeoghegan said the agency, for starters, brings together an interdisciplinary team for weekly conferences (including nurses, therapists, medical social workers, and **home health aides**).

“When starting ReACH, the supervisor who runs the team conferences would get a copy of the risk assessment for all at risk patients,” she said. “In the process of discussing the ‘usual’ things, we would discuss a patient and their risk factors, and what really emerged as a benefit was that it wasn’t just the nurse dealing with risks. It would be social workers, physical therapists, and the **home health aides** that would be aware there were issues in the household.” According to McGeoghegan, many times, team members had additional information to share that would help with setting up a better plan for patients—as well as providing improved care.

In addition to some of the individual processes, McGeoghegan said one of the overwhelming improvements is increased staff awareness of the role home health plays in reducing hospitalization. In the past, agency leaders did not necessarily talk with staff about the way in which **everyone** plays a role in helping to reduce the risk of ACH. The focus instead in previous years was specifically on the nursing practice.

With the new system-wide, interdisciplinary approach to reducing hospitalizations, the agency benefited from the increased sharing and participation among staff in the development of care plans for at-risk patients. “A lot of times patients would bare themselves or reveal secrets to one team member, when they wouldn’t tell anybody else,” McGeoghegan said.

This “secret” example illustrates how each team member has something different - and important - to offer in addressing patients’ risk factors. That’s why McGeoghegan heralds the interdisciplinary approach in quality improvement to reduce ACH. The agency’s rates indicate that the outcomes are heading in the right direction, too. In January 2006, the baseline ACH rate was 25.4 percent. The rate dropped to 23.7 percent as of December 2006, McGeoghegan said. The agency’s immediate target goal is 23 percent. “We’ve given all staff tools, ideas, and ways to communicate better and they realize that they can make a difference in reducing avoidable ACH,” she reported.

*Data in this article was provided by JoAnna McGeoghegan, Assured Home Health.*



## Investigating Resources



### Home Health Compare








Since fall 2003, Centers for Medicare and Medicaid Services (CMS) has posted many of the quality outcomes that come from the OASIS assessments the nurses and therapist complete. They are posted on [www.medicare.gov](http://www.medicare.gov) and are updated every three months.

The measures currently on Home Health Compare are:

#### Patients who:

- Get better at walking or moving around
- Get better at getting in and out of bed
- Have less pain when moving around
- Improve bladder control
- Get better at bathing
- Get better at taking their medicines correctly (by mouth)
- Experience shortness of breath less often
- Stay at home after an episode of home health care ends
- Had to be admitted to the hospital
- Need urgent, unplanned medical care

### Home Health Compare Investigation Activities

|   |   |
|---|---|
|  | Go online to <a href="http://www.medicare.gov">www.medicare.gov</a> (ask someone in your agency help you, if needed)  |
|  | Scroll down page to Search Tools section, then click on “Compare Home Health Agencies in Your Area”   |
|  | Under “How would you like to find a Home Health Agency”, click on either “By Geography” or “By Name”  |
|  | Step 1 of 4 – Enter the required field(s) – click “next step”<br>Step 2 of 4 – Select all services your HHA provides – click “next step”<br>Step 3 of 4 – Select your HHA – click “next step”<br>Step 4 of 4 – Select all – click “next step” |
|  | You can review the other outcomes on this page and see how your HHA is doing compared to your state and the national averages   |
|  | Go to the bottom of the page to “Percentage of patients who had to be admitted to the hospital”   |
|  | <b>Fill in the blank:</b> My agency’s percentage of patients who had to be admitted to the hospital is _____.   |



## Home Health Aide Post-Test

1. Reducing acute care hospitalizations is only for nurses, therapists and social workers to work on.
  - a. True
  - b. False
2. The focus of trying to reduce avoidable acute care hospitalizations is to select appropriate interventions (actions) to help reduce the risk of the patient being hospitalized.
  - a. True
  - b. False
3. A hospitalization risk assessment tool helps the nurse and/or therapist to identify those patients who are high-risk for hospitalization. Which of the following risk factors is/are included?
  - a. Confusion
  - b. Financial issues
  - c. Needing assistance with activities of daily living (ADLs)
  - d. History of falls
  - e. All of the above
4. During your home health aide visit there are many actions that you could do to assist in reducing the risk for acute care hospitalizations. Examples include:
  - Remind patient to call the home health agency if they are not feeling well
  - Report falls to the nurse or therapist
  - Remind patients to use a walker or cane, if ordered

Is this statement true or false?

  - a. True
  - b. False
5. The home health aide has an important role in reducing avoidable acute care hospitalizations. Your eyes and ears may pick up on risk factors or situations of which the nurse or therapist are not aware. Which of the following risk factors is/are included?
  - a. Patient reports falling last night
  - b. Notice increased confusion
  - c. Finding pills in patients bed or on the floor
  - d. Very little food in the home
  - e. All of the above