

Acknowledgements

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Home Health Quality Improvement National Campaign

The **Centers for Medicare & Medicaid Services (CMS)**, an agency of the U.S. Department of Health and Human Services, in conjunction with the Home Health Quality Improvement Organization Support Center (HHQIOSC), has launched the Home Health Quality Improvement (HHQI) National Campaign.

The HHQI National Campaign seeks to unite the home care community under the shared vision of reducing avoidable hospitalizations to improve patient quality of care. Being hospitalized can unnecessarily create financial and emotional burdens for patients and their families, and can negatively impact the health care delivery system. Currently, more than one in four home health patient episodes will result in a hospitalization (according to the Home Health Compare national outcome rate of 28% - December 2006).

This campaign targets avoidable hospitalizations. Its goal is to reduce the acute care hospitalization (ACH) rate nationally. Home health agencies' support for achieving this goal will be provided through the monthly distribution of tools, resources, practice guidelines, clinical information and best practice education, such as this Best Practice Intervention Package. This is an interdisciplinary campaign. All disciplines need to work collaborative toward the goal of reducing avoidable hospitalizations.

The monthly intervention packages have been designed for ease of use by leadership and individual disciplines as they strive to reduce avoidable ACH. Monthly intervention package will be released the beginning of each month starting in March 2007. You will work through the package within the four weeks, selecting the sections you want to utilize at your agency.

The packages were designed for use with the Medicare population (age 65 or older), but can be adapted by an individual agency to meet their specific patient needs. The best practice intervention packages can be used to supplement an agency's quality improvement efforts or can be used to orient all agency new hires. The various approaches to the use of the information in these packages will promote ongoing quality improvement and assure that all staff are informed of current best practice interventions for reducing avoidable hospitalizations.

“This campaign represents an opportunity for home health agencies to come together in the name of quality.”

Leslie Norwalk,
CMS Acting
Administrator

Nationally, 28% of home health episodes of care result in a hospitalization.

Home Health Compare
Web site at
www.medicare.gov

Best Practice Intervention Package Introduction

Welcome to the Home Health
Quality Improvement National Campaign!!!

Introduction to the Best Practice Intervention Package

There will be a new “best practice” theme for each month of the 12-month campaign.

The theme for this month is the **hospitalization risk assessment**.

This best practice intervention package was designed to educate and create awareness of current strategies or “**best practices interventions**” to reduce avoidable hospitalizations.

Home health agencies can be flexible in their use of these packages. **Agencies may choose to use all, some or none of the components of the monthly packages.** There is no requirement to utilize the entire package.

The Best Practice Intervention Packages have **something for all home health agencies:**

- Agencies experienced with the best practice of the month or
- Agencies that have no experience with this best practice

Package Contents

Each package contains the following sections for agency personnel:

- Leadership (administration, managers, quality improvement leads)
- Care Providers (direct care provider staff)

Leadership

The Leadership section is for agency administration, managers, and those leading the campaign.

As home health agencies vary in their knowledge and use of the best practice strategies used in this campaign, each Best Practice Intervention Package will offer information to leadership in two formats; information that is geared toward the novice and information appropriate for the expert.

Leadership information will be made available through two distinctly different leadership tracks:

- The **“Leadership Path”** for the leader that has limited or no experience with this best practice of the month.
- The **“Leadership Highway”** for those leaders that have implemented this best practice and have a comfortable level of knowledge.

Throughout this campaign, **it is expected that an agency leader will need to “alter their route” each month** depending upon their level of knowledge and experience with the monthly best practice theme. While a leader may take the Leadership Path one month, the Leadership Highway may be more appropriate for the next month.

Leadership Track #1 – “Leadership Path”



Home health agency leaders that have **no previous experience** with the best practice intervention of the month should select this track. The “Leadership Path” will offer simple, easy to understand leadership strategies needed to succeed with this best practice. These agencies will be directed to use the content as an introduction to the best practice interventions in the package.

Leadership Track #2 – “Leadership Highway”



Home health agency leaders that have **experience** with the best practice intervention of the month should select this track. The “Leadership Highway” will offer content to assess the current effectiveness of the intervention(s) and improve their agency’s performance by modifying their approach to the best practice.

Care Providers

The Care Providers section is for agency staff that care directly for patients. It is recommended that each of these tracks be distributed to the appropriate agency staff monthly. Further suggestions for use of the Best Practice Intervention Packages are available in the Leadership sections of each package.

There are four Care Provider Tracks:



Nursing Track

Nurse



Therapy Track

Therapist



Medical Social Worker Track

MSW



Home Health Aide Track

HHA

How to Use the Best Practice Intervention Packages

1. **Begin each month by having the leadership in your agency review the leadership section.** Minimally, this should include your agency lead for the campaign.
2. Since there will be 12 different intervention packages (one for each month of the campaign, March 2007-February 2008), you may want to **develop a small team to monthly review all the sections of the package** and determine what portions will implemented.

Team membership may include any of the following:

- a. Organizational Leadership (administration or management team member)
 - b. QI lead or QI team member
 - c. A representative from each of the Care Providers (nursing, therapy, home health aide, and medical social work)
 - d. Staff who have a good understanding of implementing or modifying processes and interventions
3. **Schedule time each month to review and then discuss the Best Practice Intervention Package.** As the package will be available on the first day of each month, this review and planning period should occur within the first week of each month.
 4. Plan on breaking down this package and **distributing portions of the package (“tracks”) to staff members within your agency monthly.**
 5. **Encourage your staff to actively participate** by visiting the campaign Web site at www.homehealthquality.org and becoming a campaign supporter.
 6. **Share your monthly data reports with all staff monthly.** Promote quality improvement and data transparency at each case conference or staff meeting.
 7. **Develop your vision for the “optimal home care experience” for all of your patients. Move one step further toward achieving this vision with each passing month of the campaign.**

Good luck in transforming the quality of care in your agency!



Best Practice: Hospitalization Risk Assessment

Leadership Section





Leadership Section Objectives & Contents

Objectives

After completing the activities included in the Leadership Section of this Best Practice Intervention Package – Hospitalization Risk Assessment, the leader 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. Describe two leadership applications of the hospitalization risk assessment.

Section Contents and Instructions for Use

Leadership Self-Assessment	Use this assessment to analyze current assessment practices and explore opportunities to: <ul style="list-style-type: none"> ○ improve the identification of patients at risk for hospitalization ○ implement specific intervention(s) to avoid an unnecessary hospitalization
Leadership Action Items	Review the list of potential action items and select those that might assist in supporting your quality improvement efforts to reduce avoidable acute care hospitalizations.
Leadership Action Plan	Using the Administration Action Items document, develop your administrative action plan by selecting and prioritizing four to six of these activities that you want to implement or modify at your agency.
Discipline Sections <div style="display: flex; justify-content: space-around; align-items: center;"> <div style="text-align: center;">  Nurse </div> <div style="text-align: center;">  Therapist </div> </div> <div style="display: flex; justify-content: space-around; align-items: center; margin-top: 20px;"> <div style="text-align: center;">  HHA </div> <div style="text-align: center;">  MSW </div> </div>	Review and determine what portions of this Best Practice Intervention Package – Hospitalization Risk Assessment you want to use at your agency and how you choose to utilize them. Utilize the discipline sections for agency continuing education and/or for competencies. The home health aide section can be used for required monthly educational sessions.

Hospitalization Risk Assessment: Role of Leadership

Home health agencies are in a position to respond to patient and health care system needs by implementing strategies targeted at reducing avoidable hospitalizations. Agencies can identify patients who are at higher risk of hospitalization. Clinicians can partner with these patients to implement strategies, which reduce risk. Patients partnering with clinicians can learn to manage their own health. Experience shows that when agencies partner with patients and physicians, acute care hospitalizations can be reduced.

Completing a hospitalization risk assessment at targeted intervals is an intervention used to determine the risk of patient hospitalization. Specific interventions are implemented for those patients rated as high risk to reduce the potential of an unplanned hospitalization. (©2006 Briggs® National Quality Improvement/Hospitalization Reduction Study Sponsored by: Briggs® Corporation, NAHC and Fazzi Associates, Inc.)

The completion of the hospitalization risk assessment should be part of a comprehensive assessment to identify those patients who are at risk for hospitalization, especially older adults. Successful outcomes begin with a dialogue with the patient and family as the unit of care to determine their wishes, goals and desires, to be met by the interdisciplinary team.

Risk assessment forms can be paper-based or integrated into point-of-care systems. A structured communication process must be established to communicate which patients have been identified as high-risk for hospitalization to appropriate staff, including staff on-call after business hours. The risk assessment findings become the basis for the selection of interventions that should be included in the patient's care plan to reduce avoidable hospitalizations and emergent care episodes.



An organization's quality improvement culture is shaped by its leadership commitment to initiate change and sustain improvement efforts. Endorsement of clinical interventions by agency administration is essential for effective implementation and the sustaining of positive results. It is extremely important that agency leaders realize the importance of the hospitalization risk assessment tool and partner with management and staff to identify how recognizing high-risk patients can positively impact their caseload and assist the agency in providing the highest quality of care to their patients.

Home Health Administrators

It is your responsibility to oversee and/or direct the process for implementation of the hospitalization risk assessment and then to support its ongoing use and monitoring of its impact. The identification of patients as high-risk for hospitalization may be unfamiliar to staff and perceived as 'just something else to do.' Leadership commitment to implementing a method for the identification of patients at high risk for hospitalization sets the tone of the environment for organizational change.

Clinical Managers

Structured risk assessments can assist in the identification of high-risk patients and can provide for more effective management of resources necessary to meet patients' needs and reduce the potential for patients to return to the hospital. It is the responsibility of clinical managers to actively support and endorse those clinical interventions selected for implementation, such as a hospitalization risk assessment. When coordinating patient care, clinical interventions' effectiveness will be enhanced when management monitors and rewards staff compliance with the application of the interventions. It is extremely important that agency managers recognize the importance of the acute care hospitalization risk assessment tool and target interventions accordingly. It is also the role of management to educate and coach staff to recognize that the identification of patients at risk for hospitalization can positively impact their caseload and clinical outcomes while assisting the agency in providing the highest quality of care to their patients.

“Good plans shape good decisions. That's why good planning helps to make elusive dreams come true.”

Lester R. Bittel, *The Nine Master Keys of Management*

Hospitalization Risk Assessment Leadership Self Assessment

Does your agency use a hospitalization risk assessment?
Choose one track below based upon your answer:



If NO (Leadership Path)		
	Y	N
Do you have a process in place to identify which patients are at risk for hospitalization?		
Does your computer system or vendor service provide a timely report of high-risk patients?		
If you use a paper system, do you have a process in place to generate a timely report of high-risk patients?		
Do you have a process in place to notify on-call staff, therapists, medical social workers, home health aides and contracted staff of high-risk patients?		
Does the agency have a process in place to notify primary care physician of high-risk patients?		
Do you have a structured process for implementing interventions consistently in a timely fashion when high-risk patients are identified?		
Are there triggers to queue staff to make appropriate therapy or medical social worker referrals?		
Can you integrate a risk assessment into your point-of-care system (if applicable)?		

If YES (Leadership Highway)		
	Y	N
Are your clinicians consistently utilizing the risk assessment?		
Are your clinicians adhering to the process to inform on-call staff, therapists, medical social workers, home health aides, and contracted staff of high-risk patients?		
Does your on-call staff have a listing/report and/or a mechanism in place to identify high-risk patients?		
Does the agency have a process in place to notify primary care physician of high-risk patients? Share hospitalization risk assessment form findings?		
Does your agency have a process to prompt staff for potential interventions (i.e. telehealth, front-loading visits) for high-risk patients?		
Are your risk assessment form triggers effective in ensuring that staff makes appropriate therapy or medical social worker referrals?		
Is your risk assessment integrated into your point-of-care system (if applicable)?		



Hospitalization Risk Assessment

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

Patient Name: _____ Record # _____

Date: _____

Prior pattern: Check all that apply			
<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>)		
Chronic conditions: Check all that apply (M0230/M0240)			
<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		
Risk Factors: Check all that apply			
<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 _____. Your agency may want to select a threshold score to target patients at high risk. (For example: 5 or greater risk factors may indicate that the patient is at risk for hospitalization. Note: This number is for convenience only and has not been tested or validated. The agency may modify the score based upon the needs of their patient population.)			
Consider implementing any of the following interventions, if patient is at risk for hospitalization:			
Referrals: <input type="checkbox"/> SN <input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> ST <input type="checkbox"/> MSW <input type="checkbox"/> HHA <input type="checkbox"/> Dietary Consultant <input type="checkbox"/> Other _____	<input type="checkbox"/> Medication Management Reconciliation • Assess patient's: knowledge, ability, resources and adherence • Education	<input type="checkbox"/> Patient/family education <input type="checkbox"/> Enrollment into a disease management program (specify): _____	
<input type="checkbox"/> Hospice/Palliative Referral	<input type="checkbox"/> Phone Monitoring	Immunizations <input type="checkbox"/> Influenza <input type="checkbox"/> <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

Leadership Action Items

Does your agency use a hospitalization risk assessment?

Choose one track below based upon your answer. Check all the action items you **may** want to execute at your agency.



If NO (Leadership Path)
<input type="checkbox"/> Determine who will review the intervention packages and determine the use of each month's packages.
<input type="checkbox"/> Use your Case Mix Report and other reports to identify your high-risk patient population. Modify the attached risk assessment form (Word file available at www.homehealthquality.org/hh/hha/interventionpackages/hra.aspx). Determine a threshold score, if desired (see sample hospitalization risk assessment form).
<input type="checkbox"/> Integrate the risk assessment into your OASIS assessments, rather than create an extra form. Incorporate the risk assessment into your point-of-care system (if applicable).
<input type="checkbox"/> Complete the risk assessment with OASIS assessments: Start of Care (SOC) and Resumption of Care (ROC).
<input type="checkbox"/> Evaluate need to complete during Recertification and Significant Changes in Condition (SCIC).
<input type="checkbox"/> Pilot the risk assessment with a specific high-risk population (i.e. CHF), specific team, or branch to promote a smooth process. Success stories and lessons learned will create an agency-wide successful implementation.
<input type="checkbox"/> Select one or two clinicians to pilot the tool. Select clinicians that are open to change and quality improvement. Fine-tune the tool with them and then utilize these clinicians as champions for successful implementation.
<input type="checkbox"/> Include triggers on your new assessment to make appropriate referrals to therapies and social worker(s).
<input type="checkbox"/> Develop a communication process to notify appropriate managers and disciplines of the identified high-risk patients.
<input type="checkbox"/> Integrate the risk assessment results into care planning meetings.
<input type="checkbox"/> Monitor the compliance of staff using the hospitalization risk assessment tool. (Must use tool consistently to be effective.)
<input type="checkbox"/> Share your risk assessment tool with discharge planners, hospital case managers or nursing home providers to provide awareness of your endeavor to improve patient care, and to potentially screen and identify high-risk patients before discharge from hospital.
<input type="checkbox"/> Notify primary care physicians of high-risk score/factors and what interventions are needed to assist with reducing avoidable hospitalizations. Utilize SBAR technique to facilitate effective & efficient communication (see page 20).
<input type="checkbox"/> Include therapists in staff education regarding the identification of risk factors and the selection of interventions. Therapist can add expertise in areas such as falls assessment & prevention, identifying risk factors related to mobility, transfers, ADLs/IADLs.
<input type="checkbox"/> Develop a process to daily update your on-call staff of high-risk patients and potential interventions.
<input type="checkbox"/> Therapy-only cases need to have a process in place to have a nurse review the patient's medications for potential medication complications, interactions, etc.
<input type="checkbox"/> Utilize the Best Practice Intervention Package discipline sections for continuing staff education, orientation, and competency evaluation.
<input type="checkbox"/> The home health aide section could be utilized for the one hour/month educational program requirement. Use the post-test as a method to track completion and create an agency certificate, if required by your state. Download the audio recording onto a CD for your home health aides.



If YES (Leadership Highway)

- Determine who will review the intervention packages and determine the use of each month's packages.
- Modify your risk assessment to identify your high-risk population. Determine if risk assessment's threshold is appropriately sensitive to capture your high-risk patients. Modify the form as necessary.
- Use your Case Mix Report, other data reports and clinical observations to determine if high-risk population is being captured with current tool. Modify the form as necessary.
- Determine percentage of risk assessments completed at SOC/ROC (compliance) and identify those at high risk to target interventions.
- Incorporate the risk assessment into your point-of-care system (if applicable).
- Ensure that the hospitalization risk assessment appears on the patient's paper or electronic record for every interdisciplinary visit.
- Investigate your computer system programs or ask your vendor service to run a daily report of at-risk patients. Develop a process to daily update on-call staff of high-risk patients and potential interventions.
- Review and modify your communication process as needed to notify appropriate managers and disciplines of the identified high-risk patients.
- If you are using the risk assessment for a specific high-risk population (i.e. CHF) or team successfully, expand the process to additional high-risk populations or teams, until standard risk assessment practices have become agency and patient population-wide.
- Determine if the triggers that were added to your risk assessment for making appropriate referrals to therapies and social worker(s) are effective.
- Educate staff regarding interventions to utilize for the at-risk patients, such as: front-loading visits, phone monitoring, telemonitoring, emphasizing a patient emergent care plan, and possibly disease management.
- Continue monitoring the compliance of staff using the risk assessment tool, looking for root cause for non-adherence, and implement corrective actions as indicated. (Must use tool consistently to be effective).
- Share your risk assessment tool with discharge planners, hospital case managers or nursing home providers to provide awareness of your endeavor to improve patient care, and to potentially screen and identify high-risk patients before discharge from the hospital.
- Notify primary care physicians of high-risk score/factors and what interventions are needed to assist with reducing avoidable hospitalizations. Utilize SBAR technique to facilitate effective & efficient communication (see page 20).
- Include therapists in staff education regarding the identification of risk factors and the selection of interventions. Therapists can add expertise in areas such as falls assessment & prevention, identifying risk factors related to mobility, transfers, ADLs/IADLs, etc.
- Use interdisciplinary case conferences for discussion of the at-risk patients to ensure the communication of high-risk issues and for brainstorming to determine targeted interventions to reduce avoidable hospitalizations.
- Therapy-only cases need to have a process in place to have a nurse review the patient's medications for potential medication complications, interactions, etc.
- Utilize the Best Practice Intervention Package discipline sections for continuing staff education, orientation, and competency evaluation.
- The home health aide section could be utilized for the one hour/month educational program requirement. Use the post-test as a method to track completion and create an agency certificate, if required by your state. Download the audio recording onto a CD for your home health aides.

Hospitalization Risk Assessment Leadership Action Plan

Using the Leadership Action Items (previous two pages), have your leadership team select and prioritize **four to six items** that they want to implement or modify initially. Remember, you will have four weeks to review, plan and implement some key action items. Another important best practice intervention will be released at the beginning of the following month.

You can add more action items after accomplishing your priority action items.

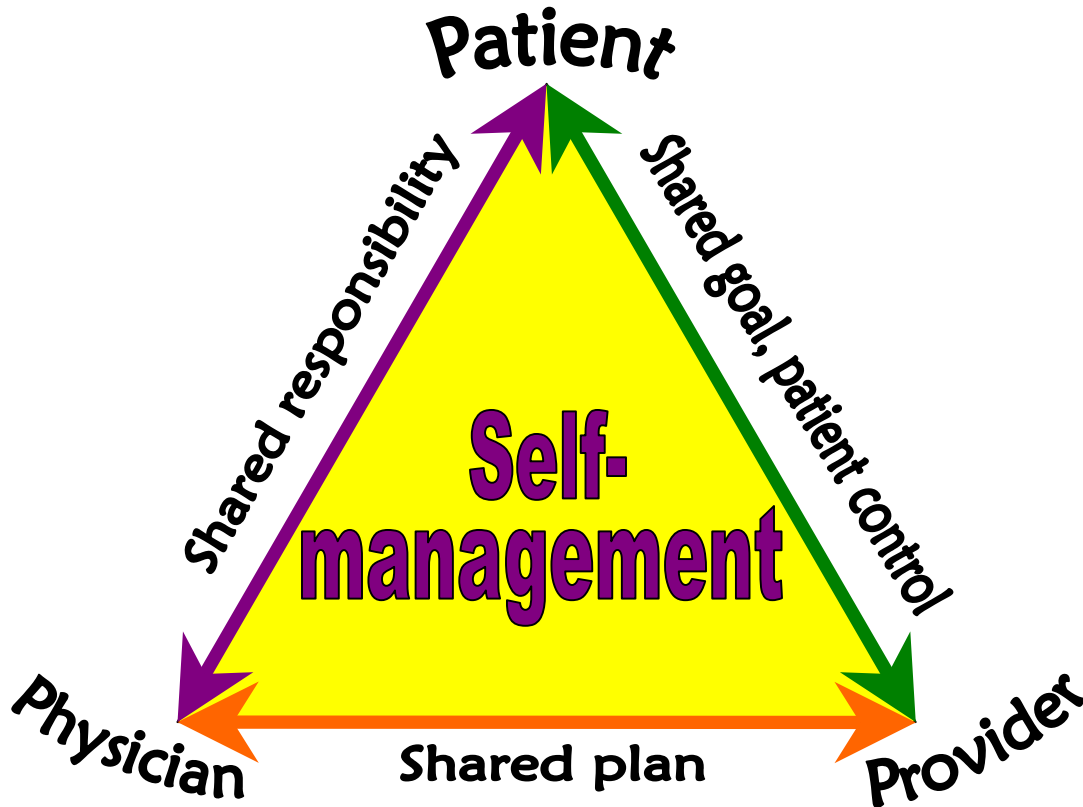


Date	Action	By Whom	Status
	Review nurse, therapy and supporting service sections to determine what portions of this Best Practice Package – Hospitalization Risk Assessment you want to use and how you want to utilize them. Include with the package any other agency-specific risk standards and/or requirements.		
	Select leadership and staff to implement your best practice interventions.		

Patient & Family Connection (Self-Care Management)

What is patient self management?

Patients and families make decisions and perform activities every day that affect the patient's condition. Self-management support is the process of assisting patients and families in understanding their central role in managing their condition, making informed decisions, and engaging in healthy behaviors. Effective patient self management is possessing the knowledge, skills and confidence to assume the central role in managing the patient's health.



How does patient self management apply to home care?

- ✧ Plan is collaboratively developed by clinician with patient/family
- ✧ Patient/family control in the home is respected and supported when developing the plan
- ✧ Plan is shared between the home care provider and physician in support of the patient's self-management
- ✧ Support transfers management of the patient's health from provider to patient/family

Why is patient self management essential to success in reducing ACH?

- ✧ Provider and patient share the goal of avoiding hospitalizations
- ✧ There is increasing evidence that self management reduces hospitalizations

Source: ©2006 Briggs® National Quality Improvement/Hospitalization Reduction Study Sponsored by: Briggs® Corporation, NAHC and Fazzi Associates, Inc. California Health Care Foundation - www.chcf.org/documents/chronicdisease/HelpingPatientsManageTheirChronicConditions.pdf

Physician Connection

Home health agencies actively work with several types of physicians. Improving our physician relationships through awareness and education can improve the care coordination for the patients and assist in reducing avoidable ACH.



Can you select one or two areas to work on with improving physician relationships?

ADMINISTRATIVE

- Home health medical directors & physician liaisons
- **Purpose** for home health includes:
 - Promote education to other physicians on admission criteria
 - Provide expertise on medical coverage issues
 - Act as a physician liaison
- **Interventions** related to ACH
 - Involve Medical Director in QI projects, like HHQI National Campaign
 - Encourage Medical Director input with modifications to Hospitalization Risk Assessment form & Physician Notification SBAR (see next page).

Key Point:
Need **active participation** by medical directors in **marketing and education** about home health, especially relating to reducing ACH, to other physicians.



HOME HEALTH PHYSICIANS

- Frequent referrals for home care
- **Purpose** for home health includes:
 - Making appropriate referrals
 - Coordinating patient care
- **Interventions** related to ACH
 - Integrate the use of the Physician Notification SBAR (see next page) into your communication processes.
 - Communicate high-risk patients' risk assessment scores and factors and collaborate on appropriate interventions
 - Utilize the SBAR method for improving communication skills & asking for appropriate interventions.

Key Point:
Communicate high-risk patients and proactively plan interventions to decrease risk of hospitalization.



OTHER CLINICIANS

- Physicians who infrequently order or consult home care
- **Purpose** for home health includes:
 - Making appropriate referrals
 - Coordinating patient care
- **Interventions** related to ACH
 - Provide Seven Key Points for Physicians Related to ACH sheet to physicians with 485s or verbal orders, or on face-to-face visits (see www.homehealthquality.org/hh/physicians/seven_keys.aspx).

Key Point:
Increase awareness of what home care services can and cannot provide.



Physician Notification SBAR

High-Risk Patient for Acute Care Hospitalization

Your patient has been identified as being at high risk for acute care hospitalization

We need your help in trying to keep your patient out of the hospital. Below, you will see a brief synopsis of our findings with requests/recommendations for achieving this goal.



S SITUATION

I am contacting you about: _____ (patient's name)
who was admitted to our services on _____. According to our standards, your patient has been identified at **high** risk for hospitalization.

B BACKGROUND

State the **primary diagnosis & reason patient is being seen** for home care: _____

State the pertinent **medical history**: _____

*The following **risk factors** identified for hospitalization were:

- | | | |
|--|---|---|
| <input type="checkbox"/> Hospitalizations or ER visits in the past 12 months | <input type="checkbox"/> Lives alone | <input type="checkbox"/> Medication management assistance |
| <input type="checkbox"/> History of falls | <input type="checkbox"/> Socioeconomic issues | <input type="checkbox"/> Non-compliance with medication regimen |
| <input type="checkbox"/> CHF | <input type="checkbox"/> Inadequate support network | <input type="checkbox"/> Confusion |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> ADL assistance needed and/or home safety risk identified | <input type="checkbox"/> Dyspnea |
| <input type="checkbox"/> COPD | | <input type="checkbox"/> Pressure or stasis ulcers |
| <input type="checkbox"/> HIV/AIDS | | |
| <input type="checkbox"/> Other _____ | | |

A ASSESSMENT

Our treatment team is concerned that your patient is at risk for an acute care hospitalization and want to collaborate with you to create a plan of care to that may keep your patient at home.

R RECOMMENDATION

Based upon our findings, we request the following referral(s):

Referral: Nurse PT ST OT ST HH Aide MSW Dietician

Hospice/Palliative, Purpose: _____

Please provide patient specific parameters for the items selected below with possible interventions for findings outside the ranges you have defined.

BP pulse weight blood glucose Pulse oximetry other [identify] _____

Medication recommendations (including standing orders) _____

Phone Monitoring (scheduled calls to patient)

Front-loading visits (accelerated visit frequency early in episode)

Telemonitoring Influenza Immunization Pneumococcal Immunization

Adaptive equipment to assist fall prevention _____

Wound care changes _____

Disease Management Program _____

Schedule for a physician office visit

Physician, Nurse Practitioner or Physician Assistant home visit

Other _____

Hospice & Palliative Connection

Hospice and Palliative Care manages complex and chronic care patients successfully. The mutual goal for their patients is to keep them home and comfortable, which are the same goals we strive for in home care.

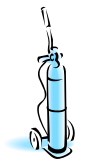
Frequent hospitalizations occur with patients diagnosed with neutropenia, COPD, CHF and uncontrolled pain. A first step to prevent avoidable admissions is to identify the patient's goals through open dialogue with the patient and family. Understanding the wishes of the patient and then committing to achieve these wishes provides the framework for effective management. Included is some information and guidance for managing these complex patients.

NEUTROPENIA:



- An afebrile neutropenic patient is safest in the home setting.
- Neutropenia is best managed by administering CSFs (colony stimulating factors).
- High risk for nosocomial infections from hospital admissions.
- Seek support from the physician to manage this patient in the home setting unless the patient is febrile.
- Low grade fevers can be symptomatic of life threatening infections when neutropenic. Watch for temperatures two degrees over baseline and report immediately. (References: Oncology Nursing Society and the Oxford Textbook of Palliative Medicine)

COPD:



- Palliative management of end stage COPD includes managing dyspnea to prevent avoidable admissions.
- Using low dose morphine to manage acute bouts of dyspnea can prevent many unnecessary hospitalizations. (References: Leading the Way in Provider Communication, Compendium of Treatment of End Stage Non-Cancer Diagnoses: Pulmonary, Managing Shortness of Breath Teaching Sheet are all available through www.hpna.org)

CHF:



- Palliative management of end stage CHF includes frequent weight checks and administration of diuretics according to physician instructions. (References: Compendium of Treatment of End Stage Non-Cancer Diagnoses: Cardiac, Leading the Way in Provider Communication are available through www.hpna.org)

UNCONTROLLED PAIN:



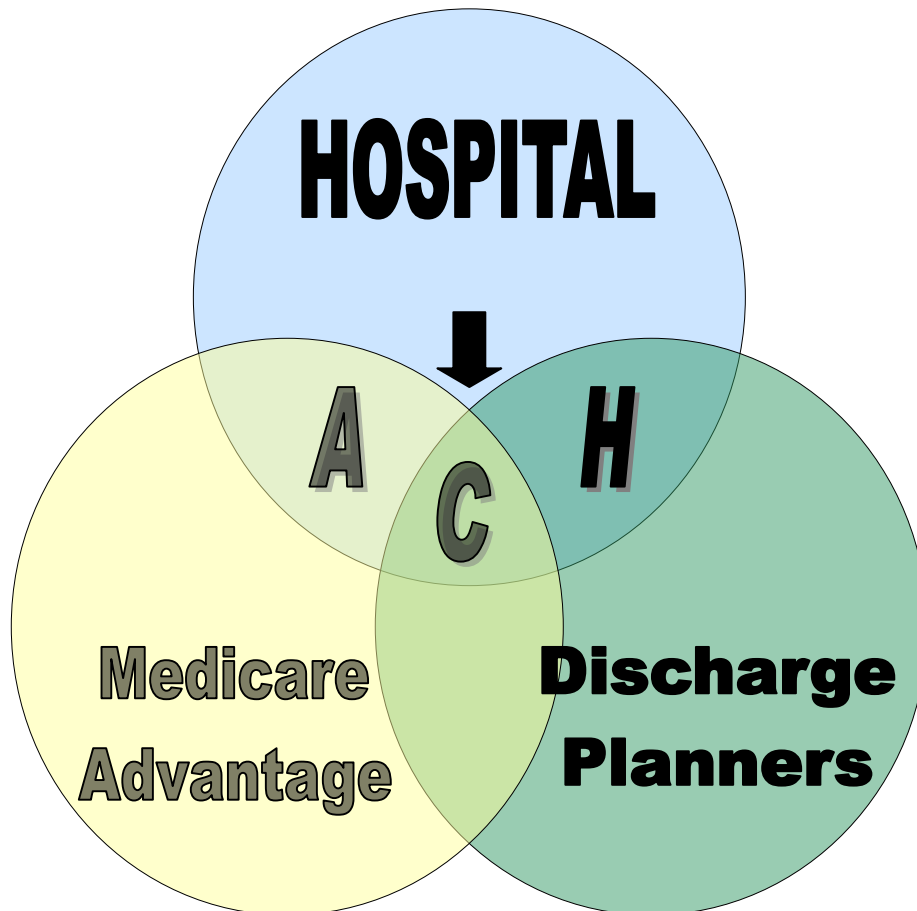
- Management begins with a detailed pain assessment, knowledge of the patient's acceptable level of pain on the pain scale being utilized as compared to the current stated scaled level of pain, compliance with the medication administration record, history of pain over past 24 hours and medication availability.
- At times, aggressive pain management is needed to get the pain in control - maintenance thereafter is the best way to prevent a reoccurrence of poorly controlled pain.
- Most patients do not want to go to a hospital for control of pain. Knowing the patient's goals is extremely important.
- Many resources are available to manage pain. (References: Symptom Management Algorithm, Textbook of Palliative Nursing by Ferrell and Coyle, Managing Pain Teaching Sheet, and Managing Constipation Teaching Sheet are all available through www.hpna.org.)

Hospital & Managed Care Connection

Reducing ACH is complex and multifaceted. Successful interventions cross the continuum to other facilities such as hospitals or nursing homes. In addition, as leaders we need to look at the connection to our managed care systems.

Communicate high-risk patients to the **Hospital**

- Contact ER when high-risk patients are making an emergency encounter to the facility.
- Fax current medication record to ER.
- Offer appropriate home care interventions to ER, if applicable, such as telemonitoring or phone monitoring.



Share Risk Assessment score & factors with **Medicare Advantage**

- Assist with getting more visits authorized (including front-loading visits)
- Educate Medicare Advantage on the benefits of telemonitoring

Share your Hospitalization Risk Assessment with **discharge planners**

- Improve planning for high-risk patients at referral
- Offer risk assessment tool to be used as a screening tool for high risk patients

Hospitalization Risk Assessment



Do you know which of your patients are at risk for hospitalization?

Are all disciplines aware of high risk patients?

Is the on-call staff able to identify which patients are at high risk?

The Hospitalization Risk Assessment identifies high risk patients and provides suggested intervention strategies.

Sample risk factors:

- Previous hospitalization in last 12 months
- History of falls
- Lives alone
- Confusion
- Diagnosis of: CHF, COPD, DM, & Neoplasm



Success Story

Pennsylvania Agency Examines Processes, Reduces Acute Care Hospitalizations

Sun Home Health Services, a visiting nurse association serving central Pennsylvania had an acute care hospitalization (ACH) rate of 26.81 in July 2005. At the time, the national rate was 28 percent. Agency officials were determined to remain below the national average while continuing to improve quality by further reducing this number.

Sun Home Health set a target ACH rate of 25 percent as defined in their plan of action, developed by an interdisciplinary team to roll out from September 2005 to August 2006. The improvement journey began with a process of care investigation to determine agency weaknesses and strengths. A review of patients readmitted to the hospital indicated that 84.6 percent were admitted for emergent reasons, with the two most prevalent diagnoses being respiratory complications and congestive heart failure. There were also a high number of hospitalizations as a result of falls.

The interdisciplinary team identified areas for improvement, including absence of a hospitalization risk assessment, inadequate instruction on specific disease processes - including reporting signs and symptoms - and use of available telemonitoring units for patients who were at high risk for hospitalization. Sun Home Health's telemonitoring program at the time focused only on patients with a chronic heart failure (CHF) diagnosis, therefore missing many patients that were at high risk for hospitalization.

The greatest strengths identified by the agency included a 24-hour Information and Referral Center staffed by RNs (around the clock, seven days a week), and a lower hospital readmission rate within the first three weeks of service than the national average. The first three weeks after discharge is the most vulnerable period for readmissions to the hospital.

Sun Home Health Services developed a plan of action in December 2005 and four registered nurses from the Quality Improvement Department, Information and Referral Center and an outlying office were represented on the team. The team developed a list of best practices and subsequently implemented the following:

- Risk assessment form to assess patients at start of care and resumption of care
- Emergency care plan to be used as a teaching tool for patient and caregivers
- Front-loading visits and telehealth to provide additional patient contacts during the first three weeks of service. The patient contacts included nursing visits, installation of a telehomecare unit (telemonitoring) and/or scheduled telephone calls (phone monitoring) to the patient and/or caregiver.

Education of the staff was an important element of the plan. Information was shared via e-mail, and during ongoing staff meetings. Agency leaders also subsequently followed up with careful monitoring of staff. Communication improvement plans crossed all disciplines including home health aides, therapists and social workers. Leaders reported the intensive, ongoing communication proved critical to the success of the plan of action.

Sun Home Health did make revisions to the initial risk assessment during implementation of the plan. “Seventy-nine percent of the readmissions were not identified as being at high risk during the early stages of the program,” stated Director of Quality Improvement Margaret Nace, who is also a registered nurse. “We found that all areas could not be weighted the same and revisions were made, for example. We increased the weight of patients with diagnosis of CHF and for patients with a history of falls.”

In addition, the agency found that some 49 percent of patients admitted to the hospital did not call the agency first. Patients must know what to look for, such as signs of infection or other indications of changes in their health status, said Nace. “Our goal is to keep the patient at home and safe,” she added.

Educating patients on when and how to call the agency prior to going to the hospital (known as a patient emergency care plan) was also a strong focus of the improvement plan. On each visit, clinicians now remind patients about contacting the agency and review the emergency care plan to increase patient understanding of what to look for and when to call the agency.

In November 2006, Sun Home Health developed an online risk assessment with the help of a local computer company. With the new computer program, every patient is assessed at start of care and resumption of care (which is in line with recommendations mentioned previously in this article). Areas in the system worth mentioning include:

- Indication of low, medium or high risk for hospital readmission (not just indicating “at risk” or “not at risk”)
- Requirement for emergency care plan to be assessed and reviewed with patient/caregiver at every nursing visit and documented on the clinical notes
- Assessment for flu and pneumonia vaccine (including “received” and “wish to receive”)

The planning and implementation described above has resulted in an ACH rate of 25.04 percent, based on November 2006 rates. Building on their current activities, Sun Home Health Agency will continue its efforts to sustain and reduce ACH by implementing additional best practice interventions such as fall risk assessment and management of oral medications.

Data in this article was provided by Margaret Nace, Sun Home Health.

Post-Test Answer Keys

Use the answer keys below to score the post-tests included in the Best Practice Intervention Package – Hospitalization Risk Assessment.

Nursing Post Test Answers:

1. B
2. C
3. C
4. A
5. F

Therapy Test Answers:

1. B
2. C
3. C
4. A
5. F

Medical Social Worker Test Answers:

1. B
2. C
3. D
4. A
5. D

Home Health Aide Test Answers:

1. B
2. A
3. E
4. A
5. E



Best Practice: Hospitalization Risk Assessment

Nurse Track





Nurse Track

This best practice intervention package is designed to introduce all nurses to the hospitalization risk assessment to assist in reducing avoidable acute care hospitalizations.

Objectives

After completing the activities included in the Nurse 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 suitable nursing applications of the hospitalization risk assessment.

Complete the following activities:

	Activity	Location	Estimated Time
<input type="checkbox"/>	Read the risk assessment description and review the sample risk assessment tool	Pages 29, 31	10 minutes
<input type="checkbox"/>	Listen to the audio recording: ACH - Audio Recording for Clinicians - History & National Priority	Page 30	10 minutes
<input type="checkbox"/>	Listen to the audio recording: Hospitalization Risk Assessment for Clinicians	Page 30	15 minutes
<input type="checkbox"/>	Read the Nurse's Guide to Practical Application	Page 32	5 minutes
<input type="checkbox"/>	Read the success stories	Page 34	15 minutes
<input type="checkbox"/>	Access and explore the supporting resources for reducing acute care hospitalizations on www.medqic.org	Page 38	15 minutes
<input type="checkbox"/>	Complete the Nursing post-test	Page 40	10 minutes
	Total time for completion		80 minutes



Hospitalization Risk Assessment

Home health agencies are in a position to respond to patient and health care system needs by implementing strategies targeted to reduce avoidable hospitalizations. Agencies can identify patients who are at higher risk of hospitalization. Clinicians can partner with these patients to implement strategies, which reduce risk. Patients partnering with clinicians can learn to manage their own health. Experience shows that when agencies partner with patients and physicians, acute care hospitalizations can be reduced.

Completing a hospitalization risk assessment at targeted intervals is an intervention used to determine the risk level for patient hospitalization. Specific interventions are implemented for those patients rated as high-risk to reduce the potential of unplanned hospitalization. (©2006 Briggs® National Quality Improvement/Hospitalization Reduction Study Sponsored by: Briggs® Corporation, NAHC and Fazzi Associates, Inc.)

The completion of the hospitalization risk assessment should be part of a comprehensive assessment to identify those patients who are at risk for hospitalization, especially older adults. A dialogue with the patient and family is necessary to determine their wishes, goals and desires to be met by the interdisciplinary team. The team's responsibility is to commit to achieving the patient's stated goals.

Risk assessments can be paper-based or integrated into point-of-care systems. A structured communication process must be established to ensure that appropriate staff, including those on-call after business hours, are aware of patients identified as being "at-risk" for hospitalization. The risk assessment findings serve as the basis for the selection of interventions to be included in the patient's plan of care to reduce avoidable hospitalizations and emergent care.

It is the responsibility of the **home care nurse** to accurately complete the hospitalization risk assessment in a timely manner and to then communicate the high-risk status of patients to appropriate managers, other disciplines, and on-call staff. The home care nurse is also responsible for the selection of appropriate individualized interventions that may be used to assist in reducing avoidable acute care hospitalizations. Examples of interventions that an agency may offer include:

- | | |
|---|--|
| <input type="checkbox"/> Patient emergency planning | <input type="checkbox"/> Triage |
| <input type="checkbox"/> Medication management | <input type="checkbox"/> Fall prevention |
| <input type="checkbox"/> Front-loading visits | <input type="checkbox"/> Immunization |
| <input type="checkbox"/> Phone monitoring | <input type="checkbox"/> Patient self-management |
| <input type="checkbox"/> Telemonitoring | <input type="checkbox"/> Disease/case management |

The nurse must be able to correctly, effectively, and efficiently communicate his/her risk assessment findings to physicians to obtain necessary orders.



Audio Recordings

Instructions:

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 acute care hospitalization risk assessment form is on the next page.

Title	Description	Link
ACH – History & National Priority – for Clinicians	A 10-minute audio recording related to ACH – the national priority outcome.	The audio link is located at www.homehealthquality.org/hh/ha/interventionpackages/hra.aspx
Hospitalization Risk Assessment for Clinicians	A 15-minute audio recording that can be used by clinicians in staff/team meetings or while traveling in the car. A few discussion points are included.	The audio link is located at www.homehealthquality.org/hh/ha/interventionpackages/hra.aspx

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.

Hospitalization Risk Assessment

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

Patient Name: _____ Record # _____

Date: _____

Prior pattern: Check all that apply			
<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>)		
Chronic conditions: Check all that apply (M0230/M0240)			
<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		
Risk Factors: Check all that apply			
<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 _____. Your agency may want to select a threshold score to target patients at high risk. (For example: 5 or greater risk factors may indicate that the patient is at risk for hospitalization. Note: This number is for convenience only and has not been tested or validated. The agency may modify the score based upon the needs of their patient population.)			
Consider implementing any of the following interventions, if patient is at risk for hospitalization:			
Referrals: <input type="checkbox"/> SN <input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> ST <input type="checkbox"/> MSW <input type="checkbox"/> HHA <input type="checkbox"/> Dietary Consultant <input type="checkbox"/> Other _____	<input type="checkbox"/> Medication Management Reconciliation • Assess patient's: knowledge, ability, resources and adherence • Education	<input type="checkbox"/> Patient/family education <input type="checkbox"/> Enrollment into a disease management program (specify): _____	
<input type="checkbox"/> Hospice/Palliative Referral	<input type="checkbox"/> Phone Monitoring	Immunizations <input type="checkbox"/> Influenza <input type="checkbox"/> <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

Nurse's Guide to Practical Application

Purpose: To assist the nurse in becoming more effective and efficient at completing a hospitalization risk assessment or if the home health agency is not using a risk assessment, to learn to recognize high-risk factors. Also, to identify the need for selecting and implementing targeted interventions to reduce avoidable hospitalizations.

- Discuss hospitalization risks with referral source upon referral.
- Complete a hospitalization risk assessment at SOC/ROC, Recertification or Significant Change in Condition (SCIC).
- Initiate a discussion with patient/family regarding patient's hospitalization risk factors that include patient-specific interventions to achieve the goal to stay home while avoiding emergent care and hospitalization.
- Utilize the findings of the risk assessment to trigger referrals to other disciplines to minimize risks of hospitalization. Therapy referrals when ADL/IADL status impaired, cognitive dysfunction, swallowing difficulty, etc. MSW referrals with safety issues, medication non-adherence, financial difficulties, etc. Home health aides as a temporary intervention until strength/balance regained, endurance or shortness of breath improved, etc.
- Participate in interdisciplinary case conferences to assist with the development of patients' plans of care, utilizing interventions to assist in reducing hospitalization.
- Therapy-only cases need to have a process for a nurse to review patient's medications for potential medication complications, interactions, etc.
- Recommend interventions to minimize hospitalization risks such as front-loading visits or telehealth (electronic and/or phone).
- Proactively, notify physician when patient is identified as high-risk for hospitalization and obtain orders to enable early interventions when signs and symptoms of deterioration in health status have been identified.
- Include patient's hospitalization risk level when reporting SOC/ROC information to manager, other disciplines, on-call staff and scheduler.



- ❑ Include hospitalization risk factors in patient report when obtaining visit authorizations from Medicare Advantage organizations.
- ❑ Encourage patient/caregiver self-care activities and establish parameters to call the agency [provide patient-specific self-care management tools as appropriate].
- ❑ Consider the hospitalization risk assessment factors and re-assess risk throughout episode of care as patient condition changes, possibly increasing risk of hospitalization and need for additional changes.
- ❑ Update the hospitalization risk assessment if the patient's condition changes throughout the episodes of care. The patient may be potentially at increased risk for hospitalization and may need changes in care interventions.



“As home care becomes more involved in the prevention of acute care hospitalization, the risk assessment tool provides a standard mechanism to identify clients that need more intense preventative measures. When staff is also provided with agency specific algorithms to guide clinician interventions, then this risk assessment tool becomes doubly useful. We have also found this tool useful for new clinicians who may not have strong home care backgrounds.”

Bobbie Warner, RN, BSN
Performance Improvement Manager
Home Health Care Management



Success Stories

Home Health Agency Uses Case-Mix Analysis to Decrease Hospitalizations

A.T. Home Care, Inc. was one of 17 home health agencies to participate in the March 2005 pilot program sponsored by the Centers for Medicare & Medicaid Service (CMS). The target outcome for the pilot was to reduce acute care hospitalization in the home health setting, and A.T. Home Care, Inc. worked with the Delmarva Foundation, the Medicare Quality Improvement Organization (QIO) for Maryland and the District of Columbia, during the project.

Quality Improvement Manager Carol Elrod said that obtaining the Case Mix Analysis Summary in the pilot project in March 2005—along with an explanation on how to use the reports to lower ACH rates from the QIO—was highly beneficial. The Case Mix Analysis Summary Report compares the differences in an agency's case mix factors (including demographic, payment sources, caregivers, ADLs/IADLs, home care diagnosis groups, length of stay, etc.) among patients that were hospitalized and those that were not hospitalized. Case-mix reports are available to HHAs through the CASPER system. (Contact your state Quality Improvement Organization to learn more about the Case-Mix Analysis Summary Report.)

A.T. Home Care implemented a plan of action to reduce ACH, which included the following interventions:

- Emergency care plan
- High-risk screening tool
- Disease-specific teaching maps
- Front-loading visits and employing evidence-based practices.

In analyzing the case-mix reports to determine which patients were being hospitalized, Elrod said the agency learned those most at risk were dependent on personal care. She also learned by comparing notes with others in the pilot program that every agency had a different patient base that was most at risk for being hospitalized. "Nobody else had the same top five or the top two patients," she said. "This really is a 'drill down' into your specific case mix analysis," Elrod added.

Thanks, in part, to the use of the case-mix reports, A.T. Home Care's ACH rates went from 25.8 in 2003 to 20.5 in 2005, and 20.2 as of June 2006. As part of the ongoing analysis, Elrod also continuously adjusts for those at high risk, based on report findings. "Dependence on personal care," for example, has dropped out of the top five patient profiles for those at risk. In addition, she is taking a closer look at admissions, trying to figure out if one hospital is better or worse than another in terms of re-admitting patients. "If more of our patients from hospital 'X' go back into the hospital than those from hospital 'Y,' then we may have to conduct research to see what disease condition from this hospital is causing patients to be readmitted," Elrod said.



A.T. Home Care adjusted the high-risk screen during flu season when respiratory patients started showing up as high-risk patients (with disease management as a secondary condition). The agency subsequently added chronic diseases as a risk factor, and expanded disease management teaching maps to cover the scope of this disease process.

Elrod said the agency also expanded its diabetic care map, after agency officials noted that many of A.T. Home Care's patients admitted for treatment in a hospital have diabetes as a secondary diagnosis and, due to poor control and compliance, are readmitted for related complications.

Staff now assess all areas of diabetic management, use standardized care delivery and also use the hemoglobin A1c to assess diabetes control and compliance. If recent results aren't immediately available (e.g., with referral information), home health staff contact the patient's primary care provider. If a current report does not exist, staff request a physician order to draw an HbA1c level.

What's the key to maintaining improvements while shifting the focus on high risk areas? Elrod said the agency employs rapid cycle improvement, which is also known as Plan-Do-Study-Act (PDSA) cycles. A.T. Home Care learned about the use of PDSA while participating in the pilot program mentioned above. "Now we have the tools to run rapid cycles, and from month to month, I'll be able to see a difference," she said. "Using small groups and isolated groups study ... we will [implement] small best practices, and see if they work. In my opinion, with rapid cycling or PDSA, if you have the information and if something's not working, you have to either add or look further."

Data in this article was provided by Carol Elrod, A.T. Home Care.

Virginia Home Health Agency Employs Various Strategies to Reduce Avoidable Hospitalizations

Twin County Regional Home Health (TCRHH) is a service of Twin County Regional Hospital, a rural hospital serving a large Medicare population within a total population of approximately 60,000. The hospital is located in Galax, Virginia, and offers hospice and home health care services to as many as 195 patients each week.

The staff at TCRHH has found it beneficial to work with the state's Medicare Quality Improvement Organization (QIO), the Virginia Health Quality Center (VHQC), to improve the care provided to their patients. The agency actively participated in both the OASIS demonstration project and with OBQI projects.

Twin County's decision to participate in a reduction of Acute Care Hospitalization (ACH) project with VHQC was based more on the desire for ongoing reinforcement. Their ACH rate for November 2005 (reported January 2006) was 27.7. The agency's goal was to decrease their ACH rate by one percent. Based upon their September 2006 data (reported December 2006) Twin County's rate



was 25.1 has decreased their ACH rate by 2.6percent. which is three percent below the national average and one percent below the state average.

How did they accomplish this goal? Twin County first used the Outcome Based Quality Improvement process. A team was selected and chart audits completed. Meta Smith, agency director, said that she knew that improving any outcome, including ACH, takes a team effort. The team developed a risk assessment using QIO-provided materials which they adapted for the agency.

Staff used the case mix analysis summary report and other reports, and found that their internal audit findings mirrored the report. Patients with diagnoses of chronic obstructive pulmonary disease (COPD) and congestive heart failure (CHF) and/or requiring oxygen therapy were more likely to be hospitalized. The majority of the agency's patients returning to the hospital also did so within the first 30 days of care. Findings further revealed issues with consistent assignments of staff and a wide variation on the frequency of visits by staff.

The agency developed an organizational plan of action, identifying best practices and key strategies. The plan included:

- Risk assessment
- Front-loading visits
- Phone monitoring
- Consistent staff assignments
- Extensive staff education
- Patient education
- Emergency contact plan

A **risk assessment** is conducted at admission and resumption of care post hospitalization. If the patient is determined to be at risk, he/she is seen two to three times a week during the first three weeks (**front-loading visits**). Because telemonitoring is not available (due to financial constraints), the staff use a structured telephone assessment form to make frequent targeted follow-up calls to high-risk patients between home visits (**phone monitoring**). Staff indicate that it is not a burden to conduct additional monitoring of patients, and said that sometimes a simple phone call can make a big difference for the patient and their families.

Consistent staff assignments (sometimes called primary or permanent assignment) are defined as having the same caregivers (whether that is a registered nurse, licensed practical nurse, certified nursing assistant or therapist) consistently caring for the same patients every time they are on duty. This is an important part of the plan for patients that are identified as high-risk. High-risk patients are "flagged," which indicates the need for a consistent caregiver.

Extensive staff education was initiated and remains ongoing. Written processes and instructions were developed and each member of the team was assigned staff to review and provide feedback on the processes.



Patient education, including an **emergency contact plan**, was initiated. The plan identifies concerns for patients such as when to call the home health agency, when to go to the hospital, and symptoms of problems related to the patient diagnosis. Because of the high, recognized use of the hospital emergency room in this community, physicians are willing to call on the home health staff to visit patients who call the physician for care and/or advice. “Although we use many QIO tools, the emergency contact plan for patients is the best tool the QIO provided,” said Smith.

In addition, the agency continues its work on telephone triage, also known as teletriage. Teletriage occurs when the patient or family calls the agency with a concern or question. Because teletriage is a patient contact for which agencies can be held legally liable, certain documentation must be included in the patient record. The agency documented patient calls in the past, but not always consistently, according to Smith. The agency is now using a telephone triage documentation form to ensure compliance.

Twin County conducts monthly audits and adjusts strategies based on the audits to sustain or improve the ACH outcome. Agency staff adds additional risk areas based on patient population and demographics. More specifically, staff has added:

- Pulmonary diagnosis (improved respiratory assessment included)
- O₂ therapy of two or more liters continuously
- Non-healing wound and indwelling urinary catheter
- Inpatient facility stay or emergent care in past three months
- Dependence in medication administration
- Intractable pain

Continuing staff and patient education has also contributed to the agency’s success in reducing ACH. A fall prevention program and immunization program were instituted as part of the education process, and agency leaders reported these programs have been paramount in decreasing ACH. The agency is developing clinical paths and launching a disease management program, including promotion of patient self-management.

“The whole outcome process is dependent on accurate OASIS assessment,” said Smith. “Outcomes are only as good as the integrity of the assessment.”

Data in this article was provided by Meta Smith, Twin County Regional Home Health.



Investigating Resources



There are many valuable resources to assist you in reducing avoidable acute care hospitalizations. MedQIC (www.medqic.org) is the Web site developed by Centers for Medicare & Medicaid Services (CMS) as a comprehensive online resource of quality improvement information.

ACH Clinical Resource Kit

The Acute Care Hospitalization Clinical Resource Kit was created to organize select tools and resources used by home health agencies to reduce avoidable acute care hospitalizations. It is located on www.medqic.org.

How to Access the ACH Clinical Resource Kit:

After reaching the home page on MedQIC, select the tab for Home Health, then on the left bar, select Acute Care Hospitalizations, and then in the right box select Tools. All available tools related to ACH are listed here. Find the ACH Clinical Resource Kit title and click it.

Below is the direct link to the Kit:

www.medqic.org/dcs/ContentServer?cid=1157485199261&pagename=Medqic%2FMQTools%2FToolTemplate&c=MQTools

On the right box, go to the bottom of the page and select the Toolkit PDF (It will take a few minutes to open a file this large. You may want to right-click and select Save As...). This PDF file is the entire ACH Clinical Resource Kit.

ACH Clinical Resource Kit Investigation Activities

A small magnifying glass icon.	Locate the ACH Clinical Resource Kit (using either the navigation information or the link from above.)
A small magnifying glass icon.	Locate and read the Hospitalization Risk Assessment Tip Sheet, “The ACH Connection: Hospitalization & Emergent Care Risk Factor Assessment.”
A small magnifying glass icon.	Review the table of contents for other resources that may be appropriate for your patients.



Home Health Compare

Since fall 2003, CMS has posted on www.medicare.gov a subset of OASIS-based quality performance information showing how well home health agencies assist their patients in regaining or maintaining their ability to function. Measures of how well people can get along in their homes performing activities of daily living (ADLs) form the core of the measures, and are supplemented with questions about physical status and two use-of-service measures (hospitalization and emergent care). The language on home health compare is written in lay terms for the consumer’s understanding of the measure. Several agencies can be selected and outcome data can be compared to each other, as well as to state and national averages.

Home Health Compare Investigation Activities

	Go online to www.medicare.gov
	Scroll down the page to the Search Tools section, then click on “Compare Home Health Agencies in Your Area”
	Read the information contained on this site from the column entitled “This website has information for:”
	Follow the directions to find your home health agency’s outcomes – begin by following the directions on the left column entitled “How would you like to find a Home Health Agency?” or follow the specific instructions below.
	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” Step 2 of 4 – Select all services your HHA provides – click “next step” Step 3 of 4 – Select your HHA – click “next step” Step 4 of 4 – Select all – “click next step”
	Review and compare all your outcomes to your state and national averages.
	Go to the bottom of the page to “Percentage of patients who had to be admitted to the hospital”
	Fill in the blank: My agency’s percentage of patients who had to be admitted to the hospital is _____.
	You can review the other outcomes on this page and see how your HHA is doing compared to your state and the national averages.

Clinician name: _____

Date: _____



Nursing Post-Test

1. Best practice interventions assist in reducing:
 - a. All hospitalizations
 - b. Avoidable acute care hospitalizations
 - c. Prospective payment costs
 - d. Number of therapy visits

Patient Scenario:

Mr. Smith is a 72-year-old man who lives alone. His son checks on him every other day. Mr. Smith was recently hospitalized with exacerbation of CHF as a result of misunderstanding his medication regimen. Secondary diagnosis includes HTN, anemia and chronic renal failure. He often forgets to take his second daily dose of Lasix. Patient is complaining of shortness of breath on exertion, poor endurance and generalized weakness. Mr. Smith has been hospitalized three times this past year. The physician has made a home care referral for skilled nursing for skilled assessment, medication, dietary and disease management teaching.

2. Using the sample hospitalization risk assessment tool on page 31, how many risk factors are evident in this patient scenario?
 - a. 2
 - b. 4
 - c. 7
 - d. 10
3. Which of the following interventions does **NOT** assist in reducing the risk for acute care hospitalizations?
 - a. Notify physician of high risk
 - b. CHF Disease Management Program
 - c. Declining all referrals for patients with high risk diagnosis
 - d. Front-loading visits including phone monitoring
 - e. Medication Management
4. Hospitalization risk assessment should be completed on Start of Care (SOC)/Resumption of Care (ROC) and may also be performed at recertification or with significant change in condition (SCIC).
 - a. True
 - b. False
5. It is important to not only identify high risk patients, but to also communicate that information. After high-risk patients are identified, who should be notified?
 - a. Patient/family/caregiver
 - b. All ordered disciplines
 - c. Nurse Manager
 - d. On call staff
 - e. Physician
 - f. All of the above



Best Practice: Hospitalization Risk Assessment

Therapy Track





Therapist

Therapy Track

This best practice package is designed to introduce home care physical and occupational therapists and speech language pathologists to the hospitalization risk assessment as an intervention to assist in reducing avoidable acute care hospitalizations.

Objectives

After completing the activities in the Home Care Therapy track of this Best Practice Intervention Package – Hospitalization Risk Assessment, the therapist 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 therapy applications of the hospitalization risk assessment, related to your specialty.

Complete the following activities:

	Activity	Location	Estimated Time
<input type="checkbox"/>	Read the risk assessment description and review the sample risk assessment tool	Pages 43, 45	10 minutes
<input type="checkbox"/>	Listen to the audio recording: ACH – Audio Recording for Clinicians – History & National Priority	Page 44	10 minutes
<input type="checkbox"/>	Listen to the audio recording: Hospitalization Risk Assessment for Clinicians	Page 44	15 minutes
<input type="checkbox"/>	Read the Hospitalization Risk Assessment – Physical, Occupational, or Speech Language Pathologist’s Guide to Practical Application	Page 46	5 minutes
<input type="checkbox"/>	Read the therapy success stories	Page 49	15 minutes
<input type="checkbox"/>	Access and explore the supporting resources for reducing acute care hospitalizations on www.medqic.org	Page 53	15 minutes
<input type="checkbox"/>	Complete the therapy post-test	Page 55	10 minutes
	Total Time		80 minutes



Hospitalization Risk Assessment

Home health agencies are in a position to respond to patient and health care system needs by implementing strategies targeted to reduce avoidable hospitalizations. Agencies can identify patients who are at higher risk of hospitalization. Clinicians can partner with these patients to implement strategies, which reduce risk. Patients partnering with clinicians can learn to manage their own health. Experience shows that when agencies partner with patients and physicians, acute care hospitalizations can be reduced.

Completing a hospitalization risk assessment at targeted intervals is an intervention used to determine the risk level for hospitalization for patients. Specific interventions are implemented for those patients rated as high-risk to reduce the potential of unplanned hospitalizations. (©2006 Briggs® National Quality Improvement/Hospitalization Reduction Study Sponsored by: Briggs® Corporation, NAHC and Fazzi Associates, Inc.)

The completion of the hospitalization risk assessment should be part of a comprehensive assessment to identify those patients who are at risk for hospitalization, especially older adults. A dialogue with the patient and family is necessary to determine their wishes, goals and desires to be met by the interdisciplinary team. The team's responsibility is to commit to achieving the patient's stated goals.

Risk assessment forms can be paper-based or integrated into point-of-care systems. A structured communication process must be established to ensure that appropriate staff, including those on-call after business hours are aware of which patients have been identified to be at risk for hospitalization. The risk assessment findings serve as the basis for the selection of interventions to be included in the patient's care plan to reduce avoidable hospitalizations and emergent care.

If physical therapy is the admitting discipline, it is the responsibility of the **home care therapist** to accurately complete the hospitalization risk assessment, and/or identify hospitalization risk factors in a timely manner. If therapy is an adjunct discipline, it is essential that the therapist communicate any patient high-risk factors to appropriate managers, other disciplines, and on-call staff. If the therapist is supervising an assistant (e.g. PTA or COTA) ensure that the assistant is knowledgeable of high risk factors and when and to whom to report them. The home care therapist is also responsible for providing his/her expertise to assist in determining appropriate interventions to implement that may promote the reduction of avoidable acute care hospitalizations. The therapist must be able to effectively communicate his/her risk assessment findings to physicians to obtain necessary orders. Examples of interventions that an agency may offer include:

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



Audio Recordings

Instructions:

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 acute care hospitalization risk assessment form is on the next page.

Title	Description	Link
ACH – History & National Priority– for Clinicians	A 10-minute audio recording related to ACH – the national priority outcome.	The audio link is located at www.homehealthquality.org/hh/ha/interventionpackages/hra.aspx
Hospitalization Risk Assessment for Clinician	A 15-minute audio recording that can be used by clinicians in staff/team meetings or while traveling in the car. A few discussion points are included.	The audio link is located at www.homehealthquality.org/hh/ha/interventionpackages/hra.aspx

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.

“A quality risk management tool can help to provide focus and priority to physical therapy interventions which will decrease factors which lead to acute hospitalizations. By enhancing the interdisciplinary approach, plan of care and visit patterns become integrated with all staff working on the case. The result is well coordinated care and improved patient outcomes.”

Scott D. Wolovich, MPT
Physical Therapy Team Leader
Celtic Health Care

Hospitalization Risk Assessment

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

Patient Name: _____ Record # _____

Date: _____

Prior pattern: Check all that apply			
<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>)		
Chronic conditions: Check all that apply (M0230/M0240)			
<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		
Risk Factors: Check all that apply			
<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 _____. Your agency may want to select a threshold score to target patients at high risk. (For example: 5 or greater risk factors may indicate that the patient is at risk for hospitalization. Note: This number is for convenience only and has not been tested or validated. The agency may modify the score based upon the needs of their patient population.)			
Consider implementing any of the following interventions, if patient is at risk for hospitalization:			
Referrals: <input type="checkbox"/> SN <input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> ST <input type="checkbox"/> MSW <input type="checkbox"/> HHA <input type="checkbox"/> Dietary Consultant <input type="checkbox"/> Other _____	<input type="checkbox"/> Medication Management Reconciliation • Assess patient's: knowledge, ability, resources and adherence • Education	<input type="checkbox"/> Patient/family education <input type="checkbox"/> Enrollment into a disease management program (specify): _____	
<input type="checkbox"/> Hospice/Palliative Referral	<input type="checkbox"/> Phone Monitoring	Immunizations <input type="checkbox"/> Influenza <input type="checkbox"/> <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 Therapist's Guide to Practical Application

Purpose: To assist the therapist in becoming more effective and efficient with using a hospitalization risk assessment or if the home health agency is not using a risk assessment, to learn to recognize high risk factors. Also, to identify the need for selecting and implementing targeted interventions to reduce avoidable hospitalizations.

- Complete a hospitalization risk assessment at SOC/ROC, when skilled nursing is not ordered or at any other comprehensive assessment points in time in which the agency requires risk assessment completion (e.g. ROC, Recertification, other Follow-Up).
- Identify patient risk factors for hospitalization and communicate to manager and other disciplines.
- Initiate a discussion with patient/family about hospitalization risk factors and patient's goal to stay at home and avoid emergent care and hospitalization.
- Evaluate the patient/caregiver's risk factors, both physically and cognitively, related to the management of their medications. Add interventions to patient's care plan to reduce the risk factors and make appropriate nursing or social worker referrals, if necessary.
- (Therapy-only cases) Conduct the required drug regimen review activities during your comprehensive assessment. Identify risk factors for medication management and have medications reviewed by a nurse for interactions/potential complications. Make referral to nursing if medication problems are identified or if the patient is taking more than eight medications.
- Participate in interdisciplinary case conferences for high-risk patients, discussing high risk factors and offering expertise as indicated in determining patient care intervention needs.
- Discuss possible targeted interventions with manager to minimize hospitalization risks such as fall management programs, front-loading visits or telehealth.
- Initiate a discussion with patient/family regarding patient's hospitalization risk factors that includes patient-specific interventions to achieve the patient's goal to stay home and avoid emergent care and hospitalization.
- Establish intervention plan that incorporates patient's risk management behaviors with patient's daily activities and routines.



- ❑ Utilize risk assessment findings to trigger referrals to other disciplines (SN, therapies, MSW, HH Aide) for targeted care interventions to minimize risks of hospitalization.
- ❑ (Therapy-only cases) Consider nursing referral for acute medical conditions (CHF, COPD, Diabetes, etc.).
- ❑ Collaborate with the agency to proactively notify the physician when patient is identified as high-risk for hospitalization and obtain orders to enable early interventions when signs and symptoms of deterioration in health status have been identified.
- ❑ Instruct on identified or potential home safety risks and home modifications that are appropriate. Make appropriate MSW and HH Aide referrals.
- ❑ Include patient's hospitalization risk level when reporting SOC/ROC information to manager, other disciplines, on-call staff and scheduler.
- ❑ Update the hospitalization risk assessment if the patient's condition changes throughout the episode of care. The patient may be potentially at increased risk for hospitalization and may need changes in care interventions.



“Speech language pathologists can be instrumental in assisting patients and their home care team to reduce avoidable acute care hospitalizations. By using the hospitalization risk assessment tool, the speech language pathologist focuses on specific interventions such as increasing comprehension of patient education, preventing pneumonia through good oral care, dysphagia therapy, and other interventions that will assist in maintaining the patient at home.”

Becky Skrine, CCC-SLP, CHCE, COS-C
Home Health representative
American Speech-Language-Hearing Association



Therapy Tips



Physical Therapy

Participate in agency education programs, sharing rehab expertise related to: falls assessment & prevention, identifying risk factors related to mobility, transfers, ADLs/IADLs, etc.

Speech Therapy

Participate in agency education programs, sharing your expertise related to: the evaluation of potential swallowing difficulties, when to make appropriate speech language pathologist referrals, correct use of thickening agents, alternative medication management strategies related to swallowing difficulties, evaluation of possible cognitive status issues and/or use of appropriate medication compliance aids.



Occupational Therapy

Participate in agency education programs, sharing your expertise related to: falls assessment & prevention, identifying risk factors related to mobility, transfers, ADLs/IADLs, medication management issues related to pill bottles, pill boxes, and other medication compliance aids.



Success Stories

Virginia Home Health Agency Employs Various Strategies to Reduce Avoidable Hospitalizations

Twin County Regional Home Health (TCRHH) is a service of Twin County Regional Hospital, a rural hospital serving a large Medicare population within a total population of approximately 60,000. The hospital is located in Galax, Virginia, and offers hospice and home health care services to as many as 195 patients each week.

The staff at TCRHH has found it beneficial to work with the state's Medicare Quality Improvement Organization (QIO), the Virginia Health Quality Center (VHQC), to improve the care provided to their patients. The agency actively participated in both the OASIS demonstration project and with OBQI projects.

Twin County's decision to participate in a reduction of Acute Care Hospitalization (ACH) project with VHQC was based more on the desire for ongoing reinforcement. Their ACH rate for November 2005 (reported January 2006) was 27.7. The agency's goal was to decrease their ACH rate by one percent. Based upon their September 2006 data (reported December 2006) Twin County's rate was 25.1 has decreased their ACH rate by 2.6percent. which is three percent below the national average and one percent below the state average.

How did they accomplish this goal? Twin County first used the Outcome Based Quality Improvement process. A team was selected and chart audits completed. Meta Smith, agency director, said that she knew that improving any outcome, including ACH, takes a team effort. The team developed a risk assessment using QIO-provided materials which they adapted for the agency.

Staff used the case mix analysis summary report and other reports, and found that their internal audit findings mirrored the report. Patients with diagnoses of chronic obstructive pulmonary disease (COPD) and congestive heart failure (CHF) and/or requiring oxygen therapy were more likely to be hospitalized. The majority of the agency's patients returning to the hospital also did so within the first 30 days of care. Findings further revealed issues with consistent assignments of staff and a wide variation on the frequency of visits by staff.

The agency developed an organizational plan of action, identifying best practices and key strategies. The plan included:

- Risk assessment
- Front-loading visits
- Phone monitoring
- Consistent staff assignments
- Extensive staff education
- Patient education
- Emergency contact plan



A **Risk Assessment** is conducted at admission and resumption of care post hospitalization. If the patient is determined to be at risk, he/she is seen two to three times a week during the first three weeks (**front-loading visits**). Because telemonitoring is not available (due to financial constraints), the staff use a structured telephone assessment form to make frequent targeted follow-up calls to high-risk patients between home visits (**phone monitoring**). Staff indicate that it is not a burden to conduct additional monitoring of patients, and said that sometimes a simple phone call can make a big difference for the patient and their families.

Consistent staff assignments (sometimes called primary or permanent assignment) are defined as having the same caregivers (whether that is a registered nurse, licensed practical nurse, certified nursing assistant or therapist) consistently caring for the same patients every time they are on duty. This is an important part of the plan for patients that are identified as high-risk. High-risk patients are “flagged,” which indicates the need for a consistent caregiver.

Extensive staff education was initiated and remains ongoing. Written processes and instructions were developed and each member of the team was assigned staff to review and provide feedback on the processes.

Patient education, including an **emergency contact plan**, was initiated. The plan identifies concerns for patients such as when to call the home health agency, when to go to the hospital, and symptoms of problems related to the patient diagnosis. Because of the high, recognized use of the hospital emergency room in this community, physicians are willing to call on the home health staff to visit patients who call the physician for care and/or advice. “Although we use many QIO tools, the emergency contact plan for patients is the best tool the QIO provided,” said Smith.

In addition, the agency continues its work on telephone triage, also known as teletriage. Teletriage occurs when the patient or family calls the agency with a concern or question. Because teletriage is a patient contact for which agencies can be held legally liable, certain documentation must be included in the patient record. The agency documented patient calls in the past, but not always consistently, according to Smith. The agency is now using a telephone triage documentation form to ensure compliance.

Twin County conducts monthly audits and adjusts strategies based on the audits to sustain or improve the ACH outcome. Agency staff adds additional risk areas based on patient population and demographics. More specifically, staff has added:

- Pulmonary diagnosis (improved respiratory assessment included)
- O₂ therapy of two or more liters continuously
- Non-healing wound and indwelling urinary catheter
- Inpatient facility stay or emergent care in past three months
- Dependence in medication administration
- Intractable pain



Continuing staff and patient education has also contributed to the agency's success in reducing ACH. A fall prevention program and immunization program were instituted as part of the education process, and agency leaders reported these programs have been paramount in decreasing ACH. The agency is developing clinical paths and launching a disease management program, including promotion of patient self-management.

"The whole outcome process is dependent on accurate OASIS assessment," said Smith. "Outcomes are only as good as the integrity of the assessment."

Data in this article was provided by Meta Smith, Twin County Regional Home Health.

Washington Home Health Agency Puts Twist on Typical Processes, Reduces Acute Care Hospitalizations

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 demonstration collaboration designed to reduce 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, so what does Assured Home Health do that makes the agency stand out? Quality Improvement Manager JoAnna McGeoghegan said the agency, for starters, assembles an interdisciplinary team for weekly conferences (including nurses, therapists, medical social workers, and as needed, home health aides). McGeoghegan reported that, "When starting ReACH, the supervisor who facilitated the team conferences would get a copy of the risk assessment for all at-risk patients." She added that "In the process of discussing the 'usual' things, we would discuss a patient and the 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 whole team 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.

McGeoghegan stated that while conducting initial chart reviews for patients being hospitalized, staff discovered that these patients had poor prognoses or short life expectancies, and that the agency wasn't involving the medical social worker until the very end of the patient's life. As a result of those situations, plans of action were modified to involve the social worker earlier in care, so that hospice might be started sooner or the household would receive more support at the right time. According to McGeoghegan, patients are receiving more appropriate care with risk assessment factors being discussed at case conferences.

During the initial chart review, contrary to what was typically reported as a patient risk characteristic for hospitalization, Assured's hospitalized patients did



not live alone; typically they lived with a family member. Staff then began to dig deeper - was there still a risk because the caregiver is fragile, elderly, burned out or overwhelmed? Sometimes family members get overwhelmed, so they decide to take the patient to the hospital for respite purposes. According to McGeoghegan, recognizing this as a possibility - and being able to raise it as a topic with caregivers - further demonstrated the value of having the medical social worker involved in early discussions.

McGeoghegan indicated that in addition to some of the individual processes, one of the most significant improvements realized through ReACH was 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 role everyone plays in helping to reduce the risk of ACH. In previous years, the focus was specifically on nursing practice.

With the new system-wide, interdisciplinary approach to reducing ACH, 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 stated.

This "secret" example illustrates how each team member has something different - and important - to offer in assessing 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. At the start of ReACH in January 2006, their 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 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.

"Occupational therapy assessments of patients performing necessary skills and activities can better inform agencies of potential hospitalization risks when activities are assessed in the context of a patient's daily routine. Isolated skills that patients successfully 'return demonstrate' to home health staff are often not performed daily by patients whose habits and routines are interrupted by a recent change in their condition. Occupational therapy can prioritize the higher risk areas of performance to improve management of these areas in the home instead of in the hospital."

Karen Vance, OTR
Supervising Consultant



Investigating Resources



There are many valuable resources to assist you in reducing avoidable acute care hospitalizations. MedQIC (www.medqic.org) is the Web site developed by Centers for Medicare & Medicaid Services (CMS) as a comprehensive online resource of quality improvement information.

ACH Clinical Resource Kit

The Acute Care Hospitalization Clinical Resource Kit was created to organize select tools and resources used by home health agencies to reduce avoidable acute care hospitalizations. It is located on www.medqic.org.

How to Access the ACH Clinical Resource Kit:

After reaching the home page on MedQIC, select the tab for Home Health, then on the left bar, select Acute Care Hospitalizations, and then in the right box select Tools. All available tools related to ACH are listed here. Find the ACH Clinical Resource Kit title and click it.

Below is the direct link to the Kit:

www.medqic.org/dcs/ContentServer?cid=1157485199261&pagename=Medqic%2FMQTools%2FToolTemplate&c=MQTools

On the right box, go to the bottom of the page and select the Toolkit PDF (It will take a few minutes to open a file this large. You may want to right-click and select Save As...). This PDF file is the entire ACH Clinical Resource Kit.

ACH Clinical Resource Kit Investigation Activities











A small magnifying glass icon.	Locate the ACH Clinical Resource Kit (using either the navigation information or the link from above).
A small magnifying glass icon.	Locate and read the Hospitalization Risk Assessment Tip Sheet, “The ACH Connection: Hospitalization & Emergent Care Risk Factor Assessment.”
A small magnifying glass icon.	Review the table of contents for other resources that may be appropriate for your patients.



Home Health Compare

Since fall 2003, CMS has posted on www.medicare.gov a subset of OASIS-based quality performance information showing how well home health agencies assist their patients in regaining or maintaining their ability to function. Measures of how well people can manage in their homes performing activities of daily living (ADLs) form the core of the measures, and are supplemented with questions about physical status and two use-of-service measures (hospitalization and emergent care). The language on home health compare is written in lay terms for the consumer's understanding of the measure. Several agencies can be selected and outcome data can be compared to each other, as well as to state and national averages.

Home Health Compare Investigation Activities

	Go online to www.medicare.gov
	Scroll down page to Search Tools section, then click on "Compare Home Health Agencies in Your Area"
	Read the information contained on this site from the column entitled "This website has information for:"
	Follow the directions to find your home health agency's outcomes – begin by following the directions on the left column entitled "How would you like to find a Home Health Agency?" or follow the specific instructions below.
	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" Step 2 of 4 – Select all services your HHA provides – click "next step" Step 3 of 4 – Select your HHA – click "next step" Step 4 of 4 – Select all – click "next step"
	Review and compare all your outcomes to your state and national averages.
	Go to the bottom of the page to "Percentage of patients who had to be admitted to the hospital"
	Fill in the blank: My agency's percentage of patients who had to be admitted to the hospital is _____.
	You can review the other outcomes on this page and see how your HHA is doing compared to your state and the national averages.



Clinician name: _____

Date: _____

Therapy Post-Test

1. Best practice interventions assist in reducing:
 - a. All hospitalizations
 - b. Avoidable acute care hospitalizations
 - c. Prospective payment costs
 - d. Number of therapy visits

Patient Scenario:

Mrs. Adams is a 74-year-old woman, who was hospitalized for five days. Patient was diagnosed with left-sided CVA with mild right-sided residual weakness. Additional diagnoses include hypertension (HTN), congestive heart failure (CHF), and coronary heart disease (CAD). She has been hospitalized three times this past year with exacerbations of CHF. During this hospitalization, she fell two times, secondary to weakness. She is awake, alert and oriented x 3. Mrs. Adams will be staying with her daughter, who will be providing all necessary support, until she is able to safely return to her own home. Her daughter is fearful of the patient falling related to steep steps in her home. Currently the patient is sponge bathing, but has the desire to return to showering. The patient is also experiencing slight difficulty in swallowing her pills and her daughter has been crushing them for her. The patient does not have the dexterity to crush her pills at this time. The referral from the hospital includes nursing and physical therapy.

2. Using the sample hospitalization risk assessment tool on page 45, how many risk factors are evident in this patient scenario?
 - a. 2
 - b. 5
 - c. 8
 - d. 11
3. Which of the following interventions do **NOT** assist in reducing the risk for acute care hospitalizations?
 - a. Notify physician of high risk
 - b. Front-loading visits including phone monitoring
 - c. Declining all referrals for patients with high risk diagnosis
 - d. Occupational therapy & speech language pathologist referrals
 - e. Fall prevention program
4. Hospitalization risk assessment should be completed on Start of Care (SOC)/ Resumption of Care (ROC) and can also be performed at recertification or with significant change in condition (SCIC). If therapy is the primary discipline (no nursing ordered), the hospitalization risk assessment should be completed by the therapist.
 - a. True
 - b. False



5. It is important to not only identify high-risk patients, but to also communicate that information. After high-risk patients are identified, who should be notified?
- a. Patient/family/caregiver
 - b. All ordered disciplines
 - c. Nurse Manager
 - d. On call staff
 - e. Physician
 - f. All of the above



Best Practice: Hospitalization Risk Assessment

Medical Social Worker Track





Medical Social Worker Track

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

Objectives

After completion of the activities in the Medical Social Worker 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 medical social worker applications of the hospitalization risk assessment.

Complete the following activities:

	Activity	Location	Estimated Time
<input type="checkbox"/>	Read the risk assessment description and review the sample risk assessment tool	Pages 59, 61	10 minutes
<input type="checkbox"/>	Listen to the audio recording: ACH – Audio Recording for Clinicians – History & National Priority	Page 60	10 minutes
<input type="checkbox"/>	Listen to the audio recording: Hospitalization Risk Assessment for Clinicians	Page 60	15 minutes
<input type="checkbox"/>	Read the Hospitalization Risk Assessment – Medical Social Worker’s Guide to Practical Application	Page 62	5 minutes
<input type="checkbox"/>	Read the success stories	Page 63	15 minutes
<input type="checkbox"/>	Access and explore the supporting resources for reducing acute care hospitalizations on www.medqic.org	Page 67	15 minutes
<input type="checkbox"/>	Complete the Medical Social Worker post-test and give to your manager	Page 69	10 minutes
	Total Time		80 minutes



Hospitalization Risk Assessment

Home health agencies are in a position to respond to patient and health care system needs by implementing strategies targeted to reduce avoidable hospitalizations. Agencies can identify patients who are at higher risk of hospitalization. Clinicians can partner with these patients to implement strategies, which reduce risk. Patients partnering with clinicians can learn to manage their own health. Experience shows that when agencies partner with patients and physicians, acute care hospitalizations can be reduced.

Completing a hospitalization risk assessment at targeted intervals is an intervention used to determine the risk level for hospitalization for patients. Specific interventions are implemented for those patients rated as high-risk to reduce the potential of unplanned hospitalizations. (©2006 Briggs® National Quality Improvement/Hospitalization Reduction Study Sponsored by: Briggs® Corporation, NAHC and Fazzi Associates, Inc.)

The completion of the hospitalization risk assessment should be part of a comprehensive assessment to identify those patients who are at risk, especially older adults. A dialogue with the patient and family is necessary to determine their wishes, goals and desires to be met by the interdisciplinary team. The team's responsibility is to commit to achieving the patient's state goals.

Risk assessment forms can be paper-based or integrated into point-of-care systems. A structured communication process must be established to ensure that appropriate staff, including those on-call after business hours are aware of which patients have been identified to be at risk for hospitalization. The risk assessment findings serve as the basis for selection of targeted interventions to be included in the patient's care plan to reduce avoidable hospitalizations and emergent care.

It is the responsibility of the **medical social worker** to assist with the identification of hospitalization risk factors and assist other care provider disciplines in minimizing those risks to facilitate keeping the patient in his/her home environment, when possible. Discussions between the social worker and patient/family should include the patient's goals for remaining in the home and barriers to doing so. The social worker will assist with the determination of appropriate interventions, providing alternative solutions, making appropriate referrals to help reduce the risk of hospitalization and to find the additional care support or most appropriate placement for the patient. Examples of interventions that an agency may implement include:

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



Audio Recordings

Instructions:

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 acute care hospitalization risk assessment form is on the next page.

Title	Description	Link
ACH– History & National Priority– for Clinicians	A 10-minute audio recording related to ACH – the national priority outcome.	The audio link is located at www.homehealthquality.org/hh/ha/interventionpackages/hra.aspx
Hospitalization Risk Assessment for Clinicians	A 15-minute audio recording that can be used by clinicians in staff/team meetings or while traveling in the car. A few discussion points are included.	The audio link is located at www.homehealthquality.org/hh/ha/interventionpackages/hra.aspx

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.

Hospitalization Risk Assessment

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

Patient Name: _____ Record # _____

Date: _____

Prior pattern: Check all that apply			
<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>)		
Chronic conditions: Check all that apply (M0230/M0240)			
<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		
Risk Factors: Check all that apply			
<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 _____. Your agency may want to select a threshold score to target patients at high risk. (For example: 5 or greater risk factors may indicate that the patient is at risk for hospitalization. Note: This number is for convenience only and has not been tested or validated. The agency may modify the score based upon the needs of their patient population.)			
Consider implementing any of the following interventions, if patient is at risk for hospitalization:			
Referrals: <input type="checkbox"/> SN <input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> ST <input type="checkbox"/> MSW <input type="checkbox"/> HHA <input type="checkbox"/> Dietary Consultant <input type="checkbox"/> Other _____	<input type="checkbox"/> Medication Management Reconciliation • Assess patient's: knowledge, ability, resources and adherence • Education	<input type="checkbox"/> Patient/family education <input type="checkbox"/> Enrollment into a disease management program (specify): _____	
<input type="checkbox"/> Hospice/Palliative Referral	<input type="checkbox"/> Phone Monitoring	Immunizations <input type="checkbox"/> Influenza <input type="checkbox"/> <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

Medical Social Worker's Guide to Practical Application

Purpose: To assist the medical social worker in becoming more effective and efficient with using hospitalization risk assessment findings or if the home health agency is not using a risk assessment, to learn to recognize high risk factors. Also, to identify the need for selecting and implementing targeted interventions to reduce avoidable hospitalizations.

- Review the completed hospitalization risk assessment and identify areas that need medical social worker intervention.
- Initiate a discussion with patient/caregiver regarding patient's hospitalization risk factors and his/her goal to remain at home and avoid emergent care and hospitalization.
- Utilize risk assessment findings to initiate referrals to community resources to help keep patient safely at home.
- Learn more about your agency's telehealth program (phone monitoring and/or telemonitoring) and become an advocate for use of these interventions with the patient and family, when appropriate.
- Participate in case conferences for high-risk patients, discussing high risk factors and offering expertise.
- Evaluate patient/caregiver cognitive status for potential issues that could impact their ability to remain at home safely.
- Communicate potential issues and possible solutions to staff, managers and physicians.
- Participate in agency education programs, sharing your expertise related to: patient adherence issues, home safety evaluation, the identification of identifying environmental hazards, community resources, cognitive assessments, anxiety/depression, stress reduction, and patient medication resources.





Success Stories

Virginia Home Health Agency Employs Various Strategies to Reduce Avoidable Hospitalizations

Twin County Regional Home Health (TCRHH) is a service of Twin County Regional Hospital, a rural hospital serving a large Medicare population within a total population of approximately 60,000. The hospital is located in Galax, Virginia, and offers hospice and home health care services to as many as 195 patients each week.

The staff at TCRHH has found it beneficial to work with the state's Medicare Quality Improvement Organization (QIO), the Virginia Health Quality Center (VHQC), to improve the care provided to their patients. The agency actively participated in both the OASIS demonstration project and with OBQI projects.

Twin County's decision to participate in a reduction of Acute Care Hospitalization (ACH) project with VHQC was based more on the desire for ongoing reinforcement. Their ACH rate for November 2005 (reported January 2006) was 27.7. The agency's goal was to decrease their ACH rate by one percent. Based upon their September 2006 data (reported December 2006) Twin County's rate was 25.1 has decreased their ACH rate by 2.6percent. which is three percent below the national average and one percent below the state average.

How did they accomplish this goal? Twin County first used the Outcome Based Quality Improvement process. A team was selected and chart audits completed. Meta Smith, agency director, said that she knew that improving any outcome, including ACH, takes a team effort. The team developed a risk assessment using QIO-provided materials which they adapted for the agency.

Staff used the case mix analysis summary report and other reports, and found that their internal audit findings mirrored the report. Patients with diagnoses of chronic obstructive pulmonary disease (COPD) and congestive heart failure (CHF) and/or requiring oxygen therapy were more likely to be hospitalized. The majority of the agency's patients returning to the hospital also did so within the first 30 days of care. Findings further revealed issues with consistent assignments of staff and a wide variation on the frequency of visits by staff.

The agency developed an organizational plan of action, identifying best practices and key strategies. The plan included:

- Risk assessment
- Front-loading visits
- Phone monitoring
- Consistent staff assignments
- Extensive staff education
- Patient education
- Emergency contact plan



A **risk assessment** is conducted at admission and resumption of care post hospitalization. If the patient is determined to be at risk, he/she is seen two to three times a week during the first three weeks (**front-loading visits**). Because telemonitoring is not available (due to financial constraints), the staff use a structured telephone assessment form to make frequent targeted follow-up calls to high-risk patients between home visits (**phone monitoring**). Staff indicate that it is not a burden to conduct additional monitoring of patients, and said that sometimes a simple phone call can make a big difference for the patient and their families.

Consistent staff assignments (sometimes called primary or permanent assignment) are defined as having the same caregivers (whether that is a registered nurse, licensed practical nurse, certified nursing assistant or therapist) consistently caring for the same patients every time they are on duty. This is an important part of the plan for patients that are identified as high-risk. High-risk patients are “flagged,” which indicates the need for a consistent caregiver.

Extensive staff education was initiated and remains ongoing. Written processes and instructions were developed and each member of the team was assigned staff to review and provide feedback on the processes.

Patient education, including an emergency contact plan, was initiated. The plan identifies concerns for patients such as when to call the home health agency, when to go to the hospital, and symptoms of problems related to the patient diagnosis. Because of the high, recognized use of the hospital emergency room in this community, physicians are willing to call on the home health staff to visit patients who call the physician for care and/or advice. “Although we use many QIO tools, the emergency contact plan for patients is the best tool the QIO provided,” said Smith.

In addition, the agency continues its work on telephone triage, also known as teletriage. Teletriage occurs when the patient or family calls the agency with a concern or question. Because teletriage is a patient contact for which agencies can be held legally liable, certain documentation must be included in the patient record. The agency documented patient calls in the past, but not always consistently, according to Smith. The agency is now using a telephone triage documentation form to ensure compliance.

Twin County conducts monthly audits and adjusts strategies based on the audits to sustain or improve the ACH outcome. Agency staff adds additional risk areas based on patient population and demographics. More specifically, staff has added:

- Pulmonary diagnosis (improved respiratory assessment included)
- O₂ therapy of two or more liters continuously
- Non-healing wound and indwelling urinary catheter
- Inpatient facility stay or emergent care in past three months
- Dependence in medication administration
- Intractable pain



Continuing staff and patient education has also contributed to the agency's success in reducing ACH. A fall prevention program and immunization program were instituted as part of the education process, and agency leaders reported these programs have been paramount in decreasing ACH. The agency is developing clinical paths and launching a disease management program, including promotion of patient self-management.

"The whole outcome process is dependent on accurate OASIS assessment," said Smith. "Outcomes are only as good as the integrity of the assessment."

Data in this article was provided by Meta Smith, Twin County Regional Home Health.

Washington Home Health Agency Puts Twist on Typical Processes, Reduces Acute Care Hospitalizations

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 demonstration collaboration designed to reduce 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, so what does Assured Home Health do that makes the agency stand out? Quality Improvement Manager JoAnna McGeoghegan said the agency, for starters, assembles an interdisciplinary team for weekly conferences (including nurses, therapists, medical social workers, and as needed, home health aides). McGeoghegan reported that, "When starting ReACH, the supervisor who facilitated the team conferences would get a copy of the risk assessment for all at-risk patients." She added that "In the process of discussing the 'usual' things, we would discuss a patient and the 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 whole team 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.

McGeoghegan stated that while conducting initial chart reviews for patients being hospitalized, staff discovered that these patients had poor prognoses or short life expectancies, and that the agency wasn't involving the medical social worker until the very end of the patient's life. As a result of those situations, plans of action were modified to involve the social worker earlier in care, so that hospice might be started sooner or the household would receive more support at the right time. According to McGeoghegan, patients are receiving more appropriate care with risk assessment factors being discussed at case conferences.

During the initial chart review, contrary to what was typically reported as a patient risk characteristic for hospitalization, Assured's hospitalized patients did



not live alone; typically they lived with a family member. Staff then began to dig deeper - was there still a risk because the caregiver is fragile, elderly, burned out or overwhelmed? Sometimes family members get overwhelmed, so they decide to take the patient to the hospital for respite purposes. According to McGeoghegan, recognizing this as a possibility - and being able to raise it as a topic with caregivers - further demonstrated the value of having the medical social worker involved in early discussions.

McGeoghegan indicated that in addition to some of the individual processes, one of the most significant improvements realized through ReACH was 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 role everyone plays in helping to reduce the risk of ACH. In previous years, the focus was specifically on nursing practice.

With the new system-wide, interdisciplinary approach to reducing ACH, 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 stated.

This “secret” example illustrates how each team member has something different - and important - to offer in assessing 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. At the start of ReACH in January 2006, their 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 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



There are many valuable resources to assist you in reducing avoidable acute care hospitalizations. MedQIC (www.medqic.org) is the Web site developed by Centers for Medicare & Medicaid Services (CMS) as a comprehensive online resource of quality improvement information.

ACH Clinical Resource Kit

The Acute Care Hospitalization Clinical Resource Kit was created to organize select tools and resources used by home health agencies to reduce avoidable acute care hospitalizations. It is located on www.medqic.org.

How to Access the ACH Clinical Resource Kit:

After reaching the home page on MedQIC, select the tab for Home Health, then on the left bar, select Acute Care Hospitalizations, and then in the right box select Tools. All available tools related to ACH are listed here. Find the ACH Clinical Resource Kit title and click it.

Below is the direct link to the Kit:

www.medqic.org/dcs/ContentServer?cid=1157485199261&pagename=Medqic%2FMQTools%2FToolTemplate&c=MQTools

On the right box, go to the bottom of the page and select the Toolkit PDF (It will take a few minutes to open a file this large. You may want to right-click and select Save As...). This PDF file is the entire ACH Clinical Resource Kit.

ACH Clinical Resource Kit Investigation Activities











	Locate the ACH Clinical Resource Kit (using either the navigation information or the link from above).
	Locate and read the Hospitalization Risk Assessment Tip Sheet, “The ACH Connection: Hospitalization & Emergent Care Risk Factor Assessment.”
	Review the table of contents for other resources that may be appropriate for your patients.



Home Health Compare

Since fall 2003, CMS has posted on www.medicare.gov a subset of OASIS-based quality performance information showing how well home health agencies assist their patients in regaining or maintaining their ability to function. Measures of how well people can get along in their homes performing activities of daily living (ADLs) form the core of the measures, and are supplemented with questions about physical status and two use-of-service measures (hospitalization and emergent care). The language on home health compare is written in lay terms for the consumer’s understanding of the measure. Several agencies can be selected and outcome data can be compared to each other, as well as to state and national averages.

Home Health Compare Investigation Activities

	Go online to www.medicare.gov
	Scroll down page to Search Tools section, then click on “Compare Home Health Agencies in Your Area”
	Read the information contained on this site from the column entitled “This website has information for:”
	Follow the directions to find your home health agency’s outcomes – begin by following the directions on the left column entitled “How would you like to find a Home Health Agency?” or follow the specific instructions below.
	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 Step 2 of 4 – Select all services your HHA provides – click next step Step 3 of 4 – Select your HHA – click next step Step 4 of 4 – Select all – click next step
	Review and compare all your outcomes to your state and national averages.
	Go to the bottom of the page to “Percentage of patients who had to be admitted to the hospital”
	Fill in the blank: My agency’s percentage of patients who had to be admitted to the hospital is _____.
	You can review the other outcomes on this page and see how your HHA is doing compared to your state and the national averages.



Medical Social Worker Post-Test

1. Best practice interventions assist in reducing:
 - a. All hospitalizations
 - b. Avoidable acute care hospitalizations
 - c. Prospective payment costs
 - d. Number of therapy visits

Patient Scenario:

Mrs. White is a 72-year-old woman with CHF, diabetes, HTN and renal insufficiency who lives alone. There are no family members living in the state and no neighbors/friends to assist patient. The physician ordered skilled nursing after observing her blood pressure rising even after making several changes in her medications. Currently she is ordered ten different medications. Patient has also been complaining of lightheadedness and dizziness. Physician is concerned patient is not taking her medications correctly and is at risk for falling or having a stroke.

On the admission visit the nurse feels the patient is non-compliant with her medications and found there is very little food in the home. The patient states that after she pays her rent and utilities, there is not enough money to pay for her medications. Patient finally admitted that she has to skip medications because she cannot afford to get them refilled, and has not gotten two of her new blood pressure medicines filled related to the cost of the medicines.

2. Using the sample hospitalization risk assessment tool on page 61, how many risk factors are evident in this patient scenario?
 - a. 2
 - b. 5
 - c. 7
 - d. 10
3. Which of the following potential actions could the MSW take to assist in reducing the risk for acute care hospitalizations?
 - a. Make appropriate community referrals for (i.e. food assistance) to keep patient independent in her home, if possible
 - b. Coordinate with patient and family a net work of caregivers/friends/family to check on patient everyday (i.e. phone calls, hired care givers)
 - c. Work collaboratively with nurse and physician in obtaining needed medications, reducing those not needed and obtaining any free or discounted medications
 - d. All of the above



4. It is important to discuss with patient/family their goal of remaining at home and avoiding hospitalizations. MSW should always be looking for hospitalization risk factors and for barriers that may prevent the patient from remaining at home. MSW must communicate risk factors and barriers to the interdisciplinary team.
 - a. True
 - b. False

5. A hospitalization risk assessment can **NOT** be used by a MSW to:
 - a. Identify areas that need MSW interventions
 - b. Initiate a discussion with patient/family on their goal to stay at home
 - c. Identify patients who would benefit from a case conference
 - d. Determine which patient referrals NOT to accept for services
 - e. Identify needed community resources



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:

	Activity	Location	Estimated Time
<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 www.medqic.org (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
	Total Time		75 minutes



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.

Title	Description	Link
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 www.homehealthquality.org/hh/ha/interventionpackages/hra.aspx
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 www.homehealthquality.org/hh/ha/interventionpackages/hra.aspx

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: _____

Prior pattern: Check all that apply			
<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>)		
Chronic conditions: Check all that apply (M0230/M0240)			
<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		
Risk Factors: Check all that apply			
<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 _____. Your agency may want to select a threshold score to target patients at high risk. (<i>For example: 5 or greater risk factors may indicate that the patient is at risk for hospitalization.</i> 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.)			
Consider implementing any of the following interventions, if patient is at risk for hospitalization:			
Referrals: <input type="checkbox"/> SN <input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> ST <input type="checkbox"/> MSW <input type="checkbox"/> HHA <input type="checkbox"/> Dietary Consultant <input type="checkbox"/> Other _____	<input type="checkbox"/> Medication Management Reconciliation • Assess patient's: knowledge, ability, resources and adherence • Education	<input type="checkbox"/> Patient/family education <input type="checkbox"/> Enrollment into a disease management program (specify): _____	
<input type="checkbox"/> Hospice/Palliative Referral	<input type="checkbox"/> Phone Monitoring	Immunizations <input type="checkbox"/> Influenza <input type="checkbox"/> <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 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 www.medicare.gov (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” Step 2 of 4 – Select all services your HHA provides – click “next step” Step 3 of 4 – Select your HHA – click “next step” 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”
	Fill in the blank: 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