

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.

“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

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.

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.

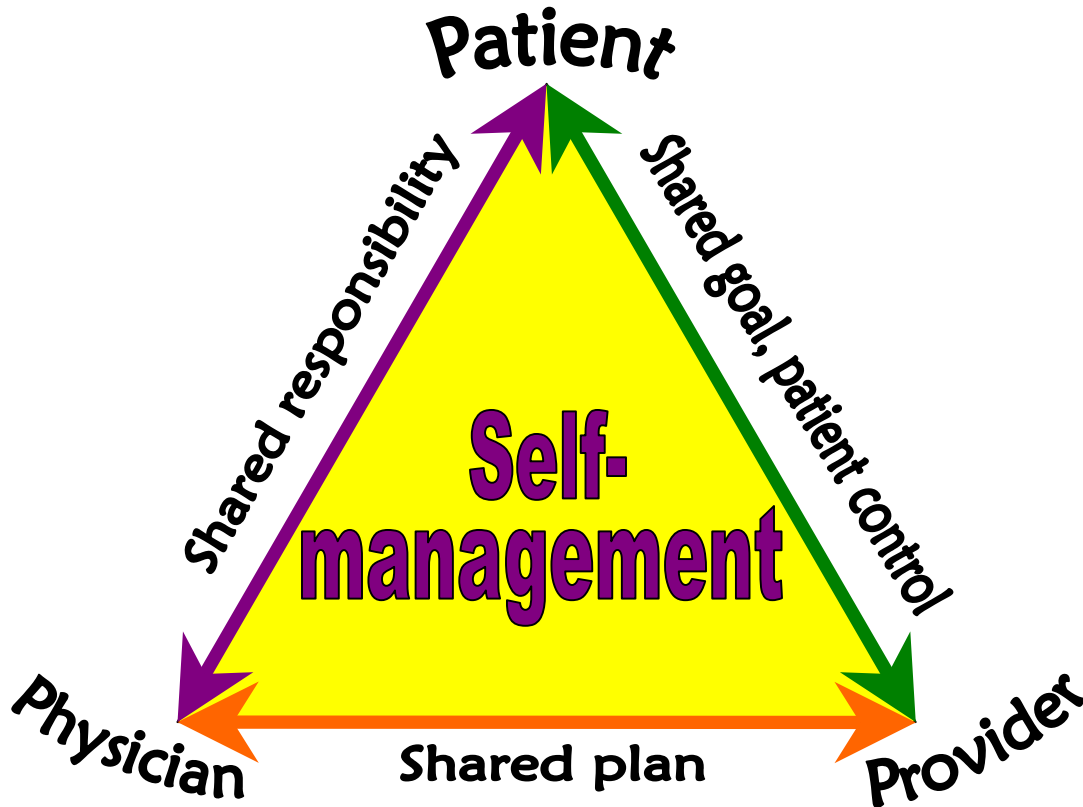


Date	Action	By Whom	Status
	Review nurse, therapy and supporting service sections to determine what portions of this Best Practice Package – Hospitalization Risk Assessment you want to use and how you want to utilize them. Include with the package any other agency-specific risk standards and/or requirements.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

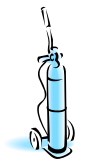
Frequent hospitalizations occur with patients diagnosed with neutropenia, COPD, CHF and uncontrolled pain. A first step to prevent avoidable admissions is to identify the patient's goals through open dialogue with the patient and family. Understanding the wishes of the patient and then committing to 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:



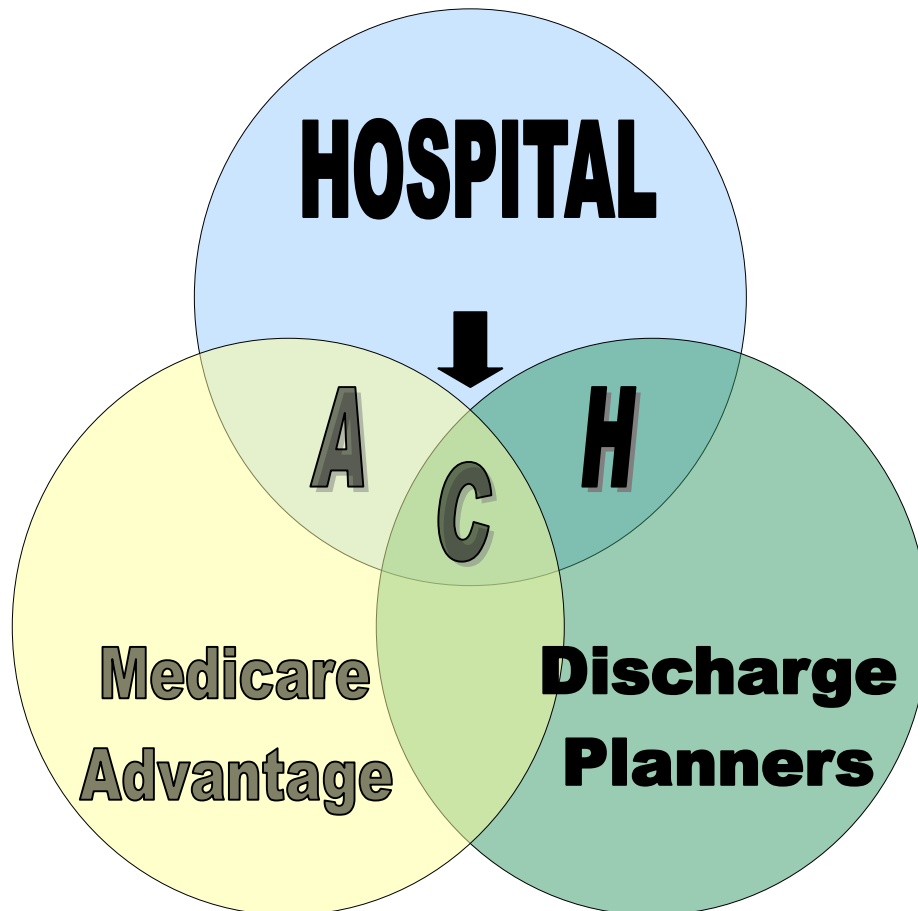
- Management begins with a detailed pain assessment, knowledge of the patient's acceptable level of pain on the pain scale being utilized as compared to the current stated scaled level of pain, compliance with the medication administration record, history of pain over past 24 hours and medication availability.
- 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