



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. (<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

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