VNAA BLUEPRINT FOR EXCELLENCE

BEST PRACTICES TO REDUCE HOSPITAL ADMISSIONS FROM HOME CARE

Training Slides 061015
Why Take Action to Prevent Readmissions?

- Better patient care and patient experience
- Home Health Compare
- Star Ratings
- IMPACT ACT
- Payers want it: value-based purchasing, ACO
- Reimbursement
Thank you
VNAA Quality Council –
Readmission Work Group
VNAA Blueprint for Excellence

Best Practice Information, Case Studies, Resources and more information

Vnaablueprint.org
Condition specific, medication management, care initiation

5-Star Best Practices (Members only)
http://vnaablueprint.org/5-star-best-practices/5-star-best-practices-HH.html

VNAA
Visiting Nurse Associations of America
About the Blueprint

- Expert recommendations from VNAA member Work Groups
- Based on evidence, but evidence not always available
- Work in progress – knowledge continues to evolve
- Identifies multiple options for improvement
- Blueprint is used in conjunction with Clinical Pathways, accreditation, electronic tools, regulatory compliance and other requirements for home health agencies
- Users identify strategies that work in their organization, given size, workforce availability, caseload, customer needs

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• 20% of all patients readmitted
• Top causes: CHF, septicemia, pneumonia; COPD, Cardia dysrhythmias
• CMS Hospital Readmissions Reduction Program
See abstracts in Resources and References section

Review articles: multi-faceted interventions more effective than single element strategies

No magic bullets

Very little of the literature relates to home health and no studies address long term stay in the community after home health (an IMPACT Act measure)

Improved continuum of home health, palliative care and hospice may reduce unwanted emergency and hospital use

Nurse practitioner and physician home visits gaining traction

Telehealth, frontloading have variable results
What should home-based care organizations do?
Early hospital discharge
MD referral direct to Emergency Room
Inconsistent staffing at agency
Lack of reimbursement for nurse practitioner and telehealth interventions
Lack of planning for emergencies so patient and family are comfortable knowing to call 911 and when to call the agency
Lack of clear documentation in record about when to call the VNA and when to call MD
Quality staff resource availability makes it difficult to track readmissions and underlying factors
Challenging to identify high risk patients early in hospital admission process
Unclear evidence on interventions that reduce readmissions
Readmission prevention activities layer-on to an overall quality strategy:

1) Adopt a quality improvement model
2) Collect and use data strategically
3) Educate and train staff to improve reliability
4) Ensure accurate OASIS assessment and documentation
5) Engage multi-disciplinary staff and care across the continuum (including hospice)
• Use EMR or other system to track high risk patients, ED visits, and hospital admissions

• Integrate clinical pathways into the agency EMR

• Create an agency-level Nurse Council to develop pathways and protocols

• Use the ‘Situation-Background-Assessment-Recommendation’ (SBAR) format to communicate with physicians

• Develop capacity to ‘scale up’ services for patients at risk for readmissions.

• Integrate rehab and nursing services to maximize functional status

• Implement social work referral protocols
• Use in-hospital liaison visit to begin assessment process and education about signs and systems of exacerbation
• Implement referral arrangement with palliative care / Advanced Illness Management
• Consider home visits with physician, NP, palliative service
• Adopt protocols for same day contact after discharge and first visit within 24 hours of admission for high risk patients
• Use initiation visit to focus on key care transition interventions and high priority risk assessments
• Use additional assessments of risk: low literacy, lack of caregivers, complex medication regimen, risk for canceling visits
• Adopt standards of care or care pathways for prevalent clinical conditions such as heart failure, infection prevention for surgical care, etc. In the protocol, include the agency’s plans for telehealth and emergency care.

• Develop stand order protocols for certain rescue medications (such as Lasix) under specific criteria.

• Work with hospitals and ACOs on common pathways; bring in other partners for specific expertise e.g. infusion therapy.

• Have a physician contact authorized to intervene quickly as part of the protocol or pathway.
Improve Systems for Care: Data

- Program electronic ‘alerts’ to clinicians reminding them of high priority activities associated with patient risks
- Use predictive alerts to flag patients at risk for ED use or readmission to the clinical managers
- Have management review trends and evaluate use of alerts regularly to identify weaknesses
- Look for patterns in ED and readmission data (such as correlation with staffing, day of the week, or clinical conditions) that can drive performance improvement interventions
- Build the data reports into daily, monthly and quarterly quality monitoring processes
Best practice tip: Make readmissions a quality improvement priority: identify opportunities for improvement. For example, conduct 100% review of tagged high risk patients that are readmitted within 30 days of discharge. Identify factors influencing readmission and determine what could have prevented readmission. Convene weekly manager and team meetings to discuss hospitalized clients.
Schedule regular reviews of the plan of care for high risk patients. Intensify POC as patient risk factors change.

Address functional status in POC and use rehabilitation services assertively.

Align pathways and protocols with payer protocols.

Identify other providers (from hospitals, insurance companies or community-based organizations) visiting the home and educate patient on ‘who is doing what’.
Build trust and relationships with physician practices:

- Collaborate with physician groups on billing and supervision to secure home visiting services by physicians or nurse practitioners.
- Consider assigning dedicated nursing teams to medical groups to facilitate relationship building.
- Use SBAR by fax or email to make suggestions to MD for treatment instead of sending to hospital.
- Develop relationship with and recommend a visiting physician practice to visit patients in their home.
• Consider your partner’s ‘incentives’ and develop initiatives that help your organization and the partner achieve goals – e.g. ACO financial incentives
• Develop hospital / ACO collaborations such as an ‘ED U Turn’ program
• Collaborate with hospitals to develop protocols for managing exacerbations, e.g. Lasix program with local hospital for CHF patients
• Adopt routine and transitional care meetings with hospitals and SNF on reducing readmissions
• Develop direct admit policy to nursing home to bypass ED or acute stays
• Visit local urgent care clinics or retail sites to educate them on referral to home health as an alternative to ED referral
• Meet with insurer, hospital or ACO care management teams to understand and coordinate home visiting program offered by these organizations
Manage Key Risks: Assess

• Improve and standardize the agency’s Risk Assessment process
• Conduct falls risk assessment and depression risk assessment
• Adopt protocol to intensify the care plan for patients at high risk:
  ▪ First visit within 24 hours
  ▪ Week one check in call
  ▪ **Front loading of visits** (See VNAA Blueprint for Excellence)
  ▪ Maximize the number of touch points during the first 2-4 weeks
  ▪ Develop and implement telehealth protocols
  ▪ Offer or arrange nurse practitioner visits for high risk patients or patients with unstable clinical condition
  ▪ Verifying MD appointment
• Improve communication of risk factors at the time of referral.
Manage Key Risks: Medications

• Enhance communication between disciplines regarding Plan of Care for medication teaching
• Use interdisciplinary model of care - all practitioners reinforce medication teaching.
• Train both nurses and therapists on effective teach-back; use scenarios
• Incorporate a geriatric pharmacist on the care team
• Implement an agency-wide policy for med reconciliation every visit
• Always include caregivers in medication teaching,
• Assess patient / caregiver health literacy, and cognitive function
• Use a low literacy medication lists and educational materials
• Post the medication list and agency contact information in patient's residence or facility
• Audit records to assure consistent practices
Manage Key Risks: Functional Status

- Reduced functional status is increasingly correlated with increased risk of readmission.
- Screen all patients for factors that influence functional decline.
- Also screen high risk patients for risks associated with the OASIS M – 2102 (types and sources of assistance) indicator.
- Establish individualized functional status plan of care.
- Increase use of Occupational Therapy (OT) referral for ADL assessment and patient teaching.
- Consider palliative care consultations for patients.
- Educate referral sources (physician groups) on need for therapy, palliative referrals.
- Increase OT, palliative referral initiations within the agency.
Gray Areas

- Telehealth
- Frontloading
- Nurse practitioner visits
**Top Tip:** Make sure patients and caregivers know what to do if they have problems. For example, use Zone Tools to discuss possible clinical issues and ‘call me first’ posters or information to remind the patients to contact the nurse HHA they are having a true emergency.
Patient Engagement

- Elicit patient and family goals to remain at home
- Use motivational interviewing to connect patient actions to goals, and to reinforce positive behaviors
- Consider need for behavioral interventions or behavioral consult
- Implement agency-level multidisciplinary care conferencing
- Develop protocol for hospital or health system-level multidisciplinary case conference.
- Use Social Work referral to link patients with community resources
Patient Education

- Use technology to assist in patient education
- Educate staff to educate patients to call VNA office “Call home care first”
- Teach the patient to identify condition specific red flags
- Personalize patient educational material by documenting patient specific goals
- Have patient teach back goals and post goals in the patient home
- Develop Emergency Plan and self-management strategies
- Use ‘Zone’ or ‘stoplight’ tools
- Post lists and agency contact information in patient's residence or facility

See also the VNAA Blueprint Modules on Patient Engagement and Patient Safety (includes Self-Management Tools to Prevent Exacerbations)
Top Tip: Make it an ‘always event’ to ask about the patient’s personal goal for each specific visit: “what can I do for you today?”
Measurement

• Follow Star Ratings, Home Health Compare, IMPACT Act measures applicable to readmission
• Understand definitions and time frames used measures: all cause, preventable readmissions, 30 day, 60 day
• Also measure performance on factors related to readmission: pain, function, experience
• Be aware of how your partners are held accountable for readmission: physicians, hospitals, ACOs
Resources

- Agency for Healthcare Quality and Research – Preventing Avoidable Readmissions

- Agency for Healthcare Quality And Research - Interventions to Prevent Readmissions for People with Heart Failure

- CMS Guide to Preventing Readmissions among Racially and Ethnically Diverse Medicare Beneficiaries

- Center for Health Care Quality and Payment Reform – Preventing Readmissions

- http://www.chqpr.org/readmissions.html

- HHQI Fundamentals of Reducing Acute Care Hospitalizations - tools and patient education
Contact

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