



How-to Guide:

Improving Transitions from the Hospital to Home Health Care to Reduce Avoidable Rehospitalizations

Support for the How-to Guide was provided by a grant from The Commonwealth Fund.

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How to cite this document:

Sevin C, Evdokimoff M, Sobolewski S, Taylor J, Rutherford P, Coleman EA. *How-to Guide: Improving Transitions from the Hospital to Home Health Care to Reduce Avoidable Rehospitalizations*. Cambridge, MA: Institute for Healthcare Improvement; June 2013. Available at www.IHI.org.

**Institute for Healthcare Improvement
How-to Guide: Improving Transitions from the Hospital to Home Health Care to Reduce Avoidable
Rehospitalizations**

Acknowledgments

The Commonwealth Fund is a national, private foundation based in New York City that supports independent research on health care issues and makes grants to improve health care practice and policy. The views presented here are those of the author and not necessarily those of The Commonwealth Fund, its directors, officers, or staff.

The Institute for Healthcare Improvement (IHI) is a leading innovator in health and health care improvement worldwide. For more than 25 years, we have partnered with a growing community of visionaries, leaders, and front-line practitioners around the globe to spark bold, inventive ways to improve the health of individuals and populations. Together, we build the will for change, seek out innovative models of care, and spread proven best practices. To advance our mission, IHI is dedicated to optimizing health care delivery systems, driving the Triple Aim for populations, realizing person- and family-centered care, and building improvement capability.

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I. Introduction

Delivering high-quality, patient-centered health care requires crucial contributions from many clinicians and staff across the continuum of health care, including the effective coordination of transitions between providers and care settings. Poor coordination of care across settings too often results in rehospitalizations, many of which are avoidable. Importantly, working to reduce avoidable rehospitalizations is one tangible step toward the dramatic improvement of health care quality and the experience of patients and families over time.

The Institute for Healthcare Improvement (IHI) has a substantial track record of working with clinicians and staff in clinical settings and health care systems to improve transitions in care after patients are discharged from the hospital and to reduce avoidable rehospitalizations. IHI gained much of its initial expertise by leading an ambitious idealized design initiative called [Transforming Care at the Bedside \(TCAB\)](#). Funded by the Robert Wood Johnson Foundation, TCAB enabled IHI to work initially with a few high-performing hospital teams to create, test, and implement changes that dramatically improved teamwork and care processes in medical/surgical units. One of the most promising TCAB innovations was improving discharge processes for patients with heart failure (see the [TCAB How-to Guide: Creating an Ideal Transition Home for Patients with Heart Failure](#) for a summary of the “vital few” promising changes to improve transitions in care after discharge from the hospital and additional guidance for front-line teams to reliably implement these changes).

In 2009, IHI began a strategic partnership with the American College of Cardiology to launch the [Hospital to Home \(H2H\) initiative](#). The goal is to reduce all-cause readmission rates among patients discharged with heart failure or acute myocardial infarction by 20 percent. H2H aims to create a rapid learning community where people can share their knowledge and best practices to reduce cardiovascular-related hospital readmissions and improve the transition from inpatient to outpatient status for individuals hospitalized with cardiovascular disease.

IHI led a groundbreaking multistate, multistakeholder initiative called [STate Action on Avoidable Rephospitalizations \(STAAR\)](#). The aim was to dramatically reduce rehospitalization rates in states or regions by simultaneously supporting quality improvement efforts at the front lines of care while working in parallel with state leaders to initiate systemic reforms to overcome barriers to improvement. Since 2009, STAAR's work in Massachusetts, Michigan, and Washington has been funded through a generous grant provided by The Commonwealth Fund, a private

foundation supporting independent research on health policy reform and a high-performance health system.

The Case for Creating an Ideal Transition Home and Reducing Avoidable Rehospitalizations

Hospitalizations account for nearly one third of the total \$2 trillion spent on health care in the United States.^{1,2} In the majority of cases, hospitalization is necessary and appropriate. However, experts estimate that 20 percent of US hospitalizations are rehospitalizations within 30 days of discharge.^{1,2} According to an analysis conducted by the Medicare Payment Advisory Committee (MedPAC), up to 76 percent of rehospitalizations occurring within 30 days of discharge in the Medicare population are potentially avoidable.³ Avoidable hospitalizations and rehospitalizations are frequent, potentially harmful and expensive, and represent a significant area of waste and inefficiency in the current delivery system.

Poorly executed care transitions negatively affect patients' health, well-being, and family resources, and unnecessarily increase health care system costs. Continuity in patients' medical care is especially critical following a hospital discharge. For individuals with multiple chronic conditions, this transition takes on even greater importance. Research shows that one quarter to one third of these patients return to the hospital due to complications that could have been prevented.⁴ Unplanned rehospitalizations may signal a failure in hospital discharge processes, in patients' ability to manage self-care, in the quality of care in the next community setting (office practices, home health care, or skilled nursing facility), and lack of appropriate care resources for high-risk patients.

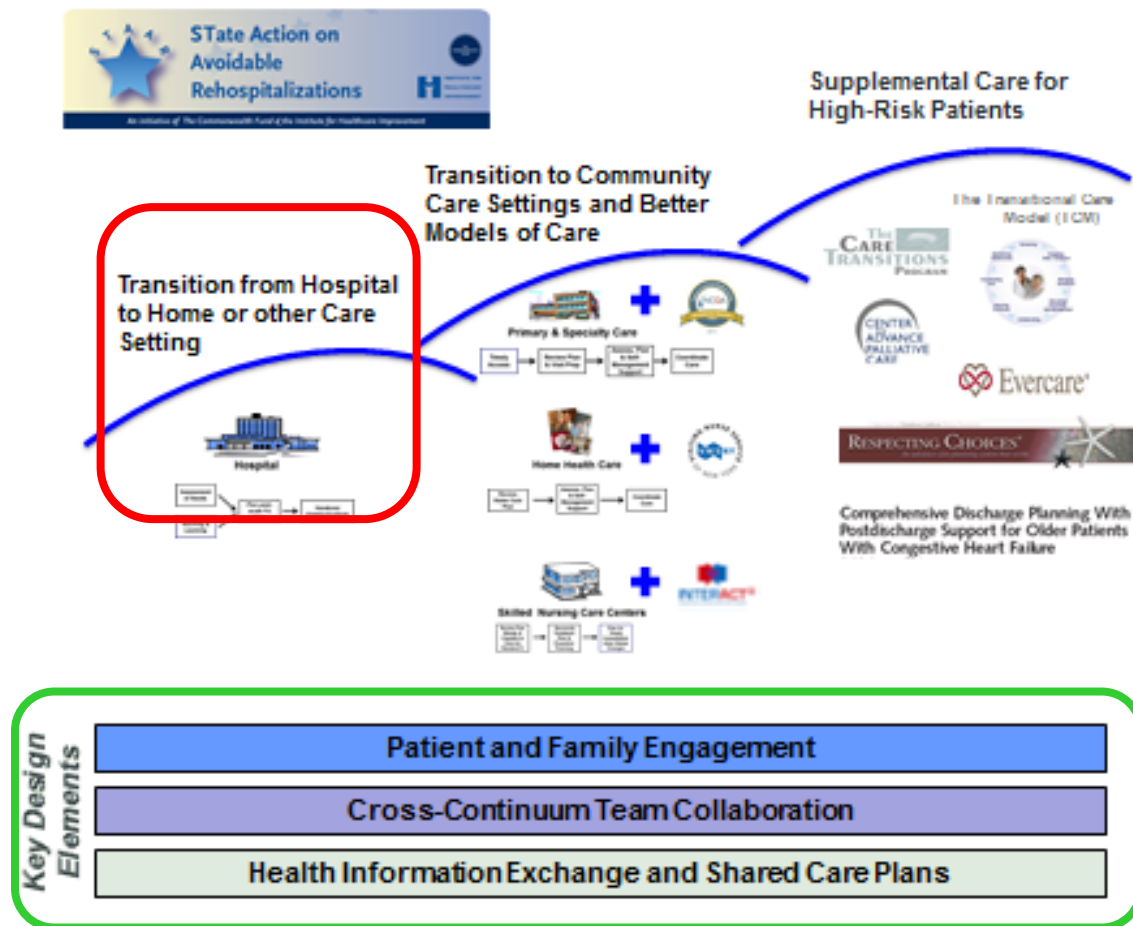
How-to Guide: Improving Transitions from the Hospital to Home Health Care to Reduce Avoidable Rehospitalizations

This How-to Guide is designed to support home health care improvement teams and their hospital and community partners in co-designing and reliably implementing improved care processes to ensure that patients who have been discharged from the hospital have an effective transition into home health care.

Based on the growing body of evidence and IHI's experience to date in improving transitions in care after a hospitalization and reducing avoidable rehospitalizations, IHI has developed a conceptual framework or roadmap (Figure 1) that depicts the interventions and elements of care needed to dramatically improve care of patients after they are discharged from the hospital.

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Figure 1: IHI's Roadmap for Improving Transitions in Care after Hospitalization and Reducing Avoidable Rehospitalization

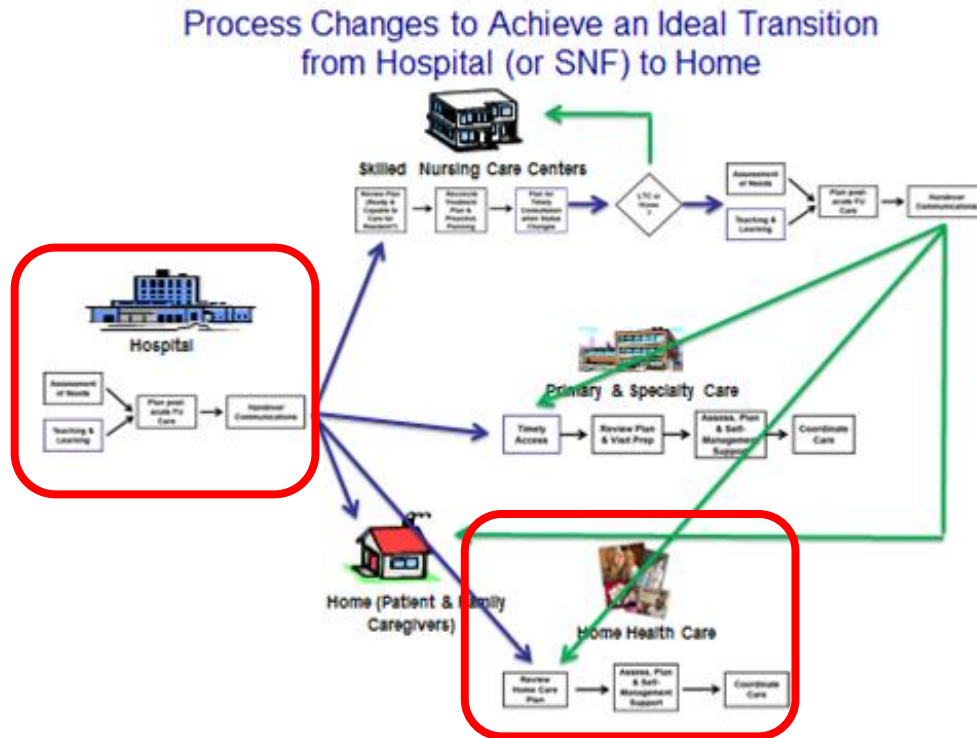


The transition from the hospital to home and post-acute care settings of care, which is depicted in the red box in Figure 1, has emerged as an important cornerstone in IHI's work to reduce avoidable rehospitalizations, and it is a major focus of this How-to Guide. "Although the care that prevents rehospitalization occurs largely outside of the hospital, it starts in the hospital."⁵ Guidance for leveraging the key design elements to improve care transitions (depicted in the green box in Figure 1) is also included in Section III of this How-to Guide.

Effective transitions in care after hospitalization involve both an improved transition out of the hospital (and from post-acute care and rehabilitation facilities) and an activated and reliable reception into the next setting of care, such as a home health care agency, a primary care practice, a specialist, or a skilled nursing facility. The process steps to improve care transitions in each care setting are depicted in Figure 2. An example of an activated community setting of

care is a home health care agency that meets the patient and caregiver in the hospital or front-loads home visits in the first 48 hours of admission to home health care.

Figure 2: Process Changes to Achieve an Ideal Transition from the Hospital to Home Health Care.



The processes to improve care transitions from hospitals to home health care are highlighted by the red boxes in Figure 2, and three recommended changes for improving the transition into home health care in the first 48 hours are included in Section II of this Guide. IHI provides additional How-to Guides for the other process changes and improvements recommended for hospitals discharging to community settings, clinical office practices, and skilled nursing facilities. These How-to Guides are designed to assist clinicians and staff in these sites of care in developing processes that ensure a timely and reliable transition from the hospital to each of the community-based care settings. Section IV of this How-to Guide also includes guidance on a recommended infrastructure and strategies for achieving results.

- [How-to Guide: Improving Transitions from the Hospital to Community Settings to Reduce Avoidable Rehospitalizations](#)

- [How-to Guide: Improving Transitions from the Hospital to Skilled Nursing Facilities to Reduce Avoidable Rehospitalizations](#)
- [How-to Guide: Improving Transitions from the Hospital to the Clinical Office Practice to Reduce Avoidable Rehospitalizations](#)

Another important resource for providing more evidence-based care and quality improvement support is the Home Healthcare Quality Improvement (HHQI) National Campaign (<http://www.homehealthquality.org/Home.aspx>). The HHQI Campaign website contains many resources to support significant improvement for home health care agencies, including Best Practice Intervention Packages, success stories, and assistance with obtaining and using data for improvement purposes. Many of these resources are referred to in this How-to Guide. Access to HHQI National Campaign resources is free; however, a short registration on the site is required to access the materials.

II. Key Changes

The *How-to Guide: Improving Transitions from the Hospital to Home Health Care to Reduce Avoidable Rehospitalizations* outlines three recommendations for improving the transition home in the first 24 to 48 hours (Figure 3): 1) meet the patient, family caregiver(s), and inpatient caregiver(s) in the hospital and review the transition home plan; 2) assess the patient, initiate the plan of care, and reinforce patient self-management at the first post-discharge home health care visit; 3) engage, coordinate, and communicate with the full clinical team.^{6-10,11}

Changes 2 and 3 are considered by many to be the standard of care; however, there are challenges to staff being able to always carry them out as needed. The intention is to support home health care agencies and their partners to improve care delivery processes so that these changes are delivered reliably, effectively, and efficiently to each patient, every time.

Figure 3: Key Changes to Create an Ideal Transition Home

<p>1. Meet the Patient, Family Caregiver(s), and Inpatient Caregiver(s) in the Hospital and Review Transition Home Plan.</p> <p>A. Whenever possible, home health care nurse or liaison meets the patient, family caregiver(s), and at least one inpatient caregiver (e.g., nurse, hospitalist, social worker, discharge case manager) in the hospital and reviews the transition home plan. It is important to identify and collaborate with the appropriate responsible caregiver whenever possible.</p> <p>B. Reinforce to patient, family caregiver(s), and inpatient caregiver(s) that a follow-up appointment should be made before discharge to ensure timely follow-up after hospitalization with primary care or managing clinician.</p>
<p>2. Assess the Patient, Initiate Plan of Care, and Reinforce Patient Self-Management at First Post-Discharge Home Health Care Visit.</p> <p>A. Evaluate the patient's clinical status since leaving the hospital.</p> <p>B. Reconcile all medications including all medications in the home.</p> <p>C. Assess, reinforce, and improve patient's and family caregiver's understanding and ability to manage medications and clinical procedures required for self-care with Teach Back.</p>
<p>3. Engage, Coordinate, and Communicate with the Full Clinical Team.</p> <p>A. Ensure early, consistent, real-time consultation with primary care provider or other managing clinicians.</p> <p>B. Use a patient-centered health record to communicate to all caregivers.</p> <p>C. Advocate as necessary to ensure referrals are completed and needed services are received to assist the patient in remaining in the community.</p>

1. Meet the Patient, Family Caregiver(s), and Inpatient Caregiver(s) in the Hospital and Review Transition Home Plan.

Recommended Changes:

1A. Whenever possible, home health care nurse or liaison meets the patient, family caregiver(s), and at least one inpatient caregiver (e.g., nurse, hospitalist, social worker, discharge case manager) in the hospital and reviews the transition home plan. It is important to identify and collaborate with the appropriate responsible caregiver whenever possible.

1B. Reinforce to patient, family caregiver(s), and inpatient caregiver(s) that a follow-up appointment should be made before discharge to ensure timely follow-up after hospitalization with primary care or managing clinician.

A proactive approach to receiving patients into home health care has been identified as a key strategy to improve transitions in care.^{6,10-12} There may be staffing constraints to this approach; however, many home health care agencies are finding ways to partner with hospitals to make this “warm handover” possible by working with their cross-continuum teams. Some agencies have adopted strategies such as use of liaisons in the hospital and telephone contact between home health care staff, patient, and/or caregiver prior to discharge.

How to identify your typical failures and opportunities for improvement:

Review the findings from Step 3: Identify Opportunities for Improvement ([page 28](#))

1A. Whenever possible, home health care nurse or liaison meets the patient, family caregiver(s), and at least one inpatient caregiver (e.g., nurse, hospitalist, social worker, discharge case manager) in the hospital and reviews the transition home plan. It is important to identify and collaborate with the appropriate responsible caregiver whenever possible.^{5,13}

- Identify the primary caregiver(s) and include in assessments, teaching and care planning.

- Review the transition home plan with the patient, family, and inpatient caregivers. Using principles of coaching and motivational interviewing, ask what the patient's/caregiver's primary concern is about going home. Review clinical information, including diagnosis, medications, depression screening results from PHQ2 or PHQ-9, and home treatments needed.
- Identify potential barriers to a successful transition home. Elicit potential problems by describing typical problems patients and caregivers encounter when going home; work to uncover and discover undetected or unarticulated problems; and engage the patient and family caregiver in problem solving.
- Evaluate patient's and family caregiver's ability to teach back key medication information.
- Create a list of personalized "red flags" indicative of a deteriorating condition in terms understood by patient and care partners, including whom to contact when red flag occurs. Identify and include the patient and family caregiver goals for care, and identified challenges, such as unsuccessful Teach Back, resource constraints, or cognitive issues.

HHQI Success Story: HHQI Success story:

Meeting hospital case managers helps Texas home health agency coordinate care: http://www.homehealthquality.org/cms/getfile/bc8aa03d-8e9e-40b1-ad9c-7f22b012cae7/PACE_Success.aspx?chset=cf5cfba4-778f-40e4-a31d-f0b05df98447

See the Resources section in this How-to Guide for example transfer forms and HHQI National Campaign resources for this Key Change.

1B. Reinforce to patient, family caregiver(s), and inpatient caregiver(s) that a follow-up appointment must be made before discharge to ensure timely follow-up after hospitalization with primary care or managing clinician.

- Ensure that follow-up visit with primary care physician or managing clinician is scheduled according to risk. Many readmissions occur in the first seven days after discharge from the hospital. Although home health care staff have little control over whether patients get an appointment when they need it, home health care staff can work with hospital and

office practice partners to improve access to appointments and they can advocate for high-risk patients to get a timely appointment.

- To date, although there are many risk readmission tools, there is no generally accepted tool that predicts the risk for readmission. IHI recommends the simple but powerful rubric in Figure 4 below for a guide as to when patients need to see their managing clinician.
- See Figure 5 below for recommended follow-up schedule with primary care provider or managing clinician post-discharge from the hospital.
- Consider front-loading home health care visits with two visits in the first 48 hours and phone calls.

Figure 4: Categories of a Patient’s Risk of Acute Care Hospitalization

High-Risk Patients	Moderate-Risk Patients	Low-Risk Patients
<ul style="list-style-type: none"> • Patient has been admitted two or more times in the past year • Patient or family caregiver is unable to Teach Back, or the patient or family caregiver has a low degree of confidence to carry out self-care at home 	<ul style="list-style-type: none"> • Patient has been admitted once in the past year • Patient or family caregiver is able to Teach Back most of discharge information and has a moderate degree of confidence to carry out self-care at home 	<ul style="list-style-type: none"> • Patient has had no other hospital admission in the past year <p>Patient or family caregiver has a high degree of confidence and can Teach Back how to carry out self-care at home</p>

Figure 5: Follow-Up Schedule after Discharge

High-Risk Patients	Moderate-Risk Patients	Low-Risk Patients
<p>Prior to discharge:</p> <ul style="list-style-type: none"> • Schedule a face-to-face follow-up visit within 48 hours of discharge. Care teams should assess whether an office visit or home health care is the best option for the patient. • If a home health care visit is initiated in the first 48 hours, also schedule a physician office visit within 5 days. • Initiate intensive care management programs as indicated (if not provided in primary care or in outpatient specialty clinics (e.g. heart failure clinics and patient-centered medical homes) • Provide 24/7 phone number for advice about questions and concerns. • Initiate a referral to social services and community resources as needed. 	<p>Prior to discharge:</p> <ul style="list-style-type: none"> • Schedule a follow-up phone call within 48 hours of discharge and schedule a physician office visit within 5 to 7 days. • Initiate home health care services (e.g. transition coaches) as needed. • Provide 24/7 phone number for advice about questions and concerns. • Initiate a referral to social services and community resources as needed. 	<p>Prior to discharge:</p> <ul style="list-style-type: none"> • Schedule a follow-up phone call within 48 hours of discharge and schedule a physician office visit as ordered by the attending physician. • Provide 24/7 phone number for advice about questions and concerns. • Initiate a referral to social services and community resources as needed.

For more information on timely follow-up after discharge, please see the [1B Resources section of the How-to Guide](#).

2. Assess the Patient, Initiate Plan of Care, and Reinforce Patient Self-Management at First Post-Discharge Home Health Care Visit.

Recommended Changes:

2A. Evaluate the patient’s clinical status since leaving the hospital.

2B. Reconcile all medications, including all medications in the home.

2C. Assess, reinforce and improve patient and family caregiver’s understanding and ability to manage medications and clinical procedures required for self-care with Teach Back

Many patients who are readmitted to the hospital are readmitted in the first seven days. Home health care executives and clinicians state that the acuity of patients being discharged from the hospital and transferred to home health care has increased over the past few years. Most patients discharged to home health care have complex chronic conditions with several co-morbidities and complex medication regimes increasing the need for self-management. Home health care agencies are in an ideal position to assist patients and their family caregivers in this transition as they are able to assess the patient in their home environment, see the barriers and challenges while caring for patients in the community setting, and work directly with the patient and family caregivers in preventing or resolving issues that may occur.

Proactive intervention by home health care staff at the point of a transition for a patient into home health care is a significant strategy to reduce avoidable rehospitalizations. It is at this point that new problems and undetected issues for patients and family caregivers may arise. Home health care staff can coordinate information and care among many caregivers, assist patients and caregivers with direct problem solving, and provide patient-centered support to address issues, barriers and challenges related to stabilizing at home and, over time, to chronic disease management as patients move along the care continuum.

Home health care staff are also in a position to assess the need and desire for palliative care services for the patient. Palliative care services are becoming more readily available in recognition that identifying and honoring patient preferences in care settings when patients are very ill can both improve clinical outcomes and lower health care costs.

Palliative care is defined by the Center to Advance Palliative Care (www.capc.org):

“Palliative care is specialized medical care for people with serious illnesses. This type of care is focused on providing patients with relief from symptoms, pain and stress of a serious illness—whatever the diagnosis.

The goal is to improve quality of life for both the patient and the family. Palliative care is provided by a team of doctors, nurses, and other specialists who work with a patient’s other doctors to provide an extra layer of support. Palliative care is appropriate at any age and at any stage in a serious illness, and can be provided together with curative treatment.

How to identify your typical failures and opportunities for improvement:

- Review the findings from Step 3: Identify Opportunities for Improvement ([page 28](#))

- Collect data on common medication reconciliation errors for patients in the first 24-48 hours. The Care Transitions Program® has developed a Medication Discrepancy Tool that is quite helpful in understanding medication reconciliation issues:

<http://www.caretransitions.org/downloadmdt.asp>.

Recommended Changes

The following changes are based on the Four Pillars of the Coleman Care Transition Model. The pillars identified to prevent rehospitalization from occurring include: (a) assistance with medication self-management; (b) use of a patient-centered health record; (c) early, consistent communication or follow-up with primary care providers and/or the medical specialist; and (d) a list of personalized “red flags” indicative of a deteriorating condition. ⁷

2A. Re-evaluate the patient’s clinical status since leaving the hospital.

- Obtain and review the hospital discharge summary and instructions;
- Front-load visits for high-risk patients with two visits or a visit and a phone call in the first 48 hours;
- Perform a comprehensive physical, functional, and cognitive assessment of the patient – identify any conditions that risk de-stabilizing the patient’s condition and coordinate with managing clinician;
- Follow up on outstanding test results or orders from the hospital that are critical in this first 24-48 hours, e.g., O2 saturation, INR levels, hematocrit, and potassium;
- Identify and report possible medication-related complications; and
- Assess patient self-care goals, abilities, strengths, and barriers, with use of motivational interviewing.

Please see the [2A Resources section of this How-to Guide](#) for resources relating to this change, including a toolkit to tailor assessments to elderly patients.

2B. Reconcile all medications, including all medications in the home.^{6,9,10,12}

- Within 24 hours of hospital discharge, reconcile medications with discharge instructions with patients and caregivers.

- Verify that the patient has the needed medications and that family caregivers are able to reliably obtain the medications.
- Check all medications and include herbal remedies, trial medications, over-the-counter medications, medications taken prior to hospitalization, and physician-administered medications such as injections. Determine which are on the current medication list and which the patient should not take.
- Assure through Teach Back that the patient and family understand which medications have been stopped.
- Verify that the patient is taking medications correctly through use of Teach Back, assess adverse side effects, medication effectiveness, drug/drug interactions, therapeutic duplication, and non-adherence. Use free or relatively inexpensive downloadable tools for drug/drug interactions using smart phones or PDAs that are available. An example of the use of a drug interaction tool would be the entry of the following commonly prescribed drugs into the program: Coumadin, Flexeril, Glucophage, Keflex, lisinopril, omeprazole, and Motrin. The results identified the following interactions: Coumadin plus Motrin may cause increase in INR; Coumadin plus omeprazole may also increase INR; lisinopril plus Motrin may decrease antihypertensive efficacy, as well as increase risk of nephrotoxicity.
- Use a patient-friendly and easily updatable medication list. Write in pencil so the list can be easily updated. Educate patient and caregiver on how to keep the list updated and share it at the time of each medical encounter.
- Look for ways to simplify the medication regime.
 - Check for potentially inappropriate medications.
 - Identify medication schedules that are unrealistic in a home setting and propose a more realistic schedule. For example, if the insulin prescribed is sliding-scale insulin, consider recommending a combination insulin; or identify an easier schedule for medications prescribed every six hours.
 - Provide Personal Health Record for patient to keep and maintain medication list.
 - Help patients link their med times to routine activities – e.g., meals or TV shows or regular activity.

For resources and more information on managing medications, please refer to the 2B Resources section of the How-to Guide. These resources are organized into categories for professionals, patients, and caregivers.

2C. Assess, reinforce, and improve patient's and family caregiver's understanding and ability to manage medications and clinical procedures required for self-care with Teach Back.⁶⁻¹⁰

- Identify key learners and caregivers and discuss their goals for the transition and first 48 hours at home.
- Identify preferred mode of learning for patients and caregivers (e.g., written, verbal, demonstration, etc.).
- Use Teach Back to assess and facilitate the patient's and caregivers' knowledge of key information.
- Engage patients and family caregivers in early identification of red flags indicating a deterioration in condition and actions to take if needed.
- Verify through Teach Back the patient's and family caregivers' understanding of the current medication list, what medication has been stopped, adverse drug side effects to report, what happens when new medications are prescribed/changed, when medications need to be taken and by what route.
- Use motivational interviewing to assess patient and family caregiver confidence and commitment to their medication regimen. Assist the patient and family caregivers in overcoming any barriers to obtaining and taking the medications as prescribed.
- Through coaching, elicit patient self-management goals for the transition home and incorporate clinician care plan into patient goals. Provide supplemental education as needed to the patient and caregiver to enable them to deliver the plan of care.
- Prepare patient and family for their first medical appointment by helping them identify their questions and ensuring that their updatable medication list is current.

Resources such as Ask Me 3TM (available at www.npsf.org/askme3) are useful in helping to structure the conversations. For more resources and information on supporting self-care and the use of Teach Back, please refer to the [2C Resources section of this How-to Guide](#).

3. Engage, Coordinate, and Communicate with the Full Clinical Team Including Patient and Caregivers.

Recommended Changes:

3A. Ensure early, consistent, real-time consultation with primary care provider or other managing clinicians.

3B. Use a patient-centered health record to communicate to all caregivers.

3C. Advocate as necessary to ensure referrals are completed and needed services are received to assist the patient in remaining in the community.

The challenges for home health care agencies in collaborating with the numerous and geographically dispersed primary care and specialty physicians, and the many community agencies that might be involved in a patient's home health care, are daunting. However, the function of communicating and coordinating care in real time is one of the most important care processes to improve the chances of a successful transition home.^{6,8,10,12} Home health care agencies can seek to partner with hospitals, office practices, and others in the community and work together to design communication and coordination processes that are efficient and effective. When possible, participation in a robust cross-continuum team, with good representation from office practices, hospitals, and community agencies, is invaluable to testing the co-design of care processes across sites and learning efficient ways to accomplish this. As in all good improvement work, we recommend that home health care agencies start small and work with partners who are willing to work at improving communication and coordination. As processes are successfully redesigned, the more efficient processes can be spread to other practices and agencies. Criteria to use in choosing partners to work with include the volume of work done with the home health care agency and enthusiastic willingness to test changes.

How to identify your typical failures and opportunities for improvement:

- Review the findings from Step 3: Identify Opportunities for Improvement ([page 28](#))

Recommended Changes:

3A. Ensure early, consistent, real-time consultation with primary care provider or other managing clinician(s).

- Within 24 hours, contact managing clinician with any significant clinical findings or medication issues and obtain physician parameters for managing symptoms in the home.
- As soon as available, send assessment of the clinical status and plan of care, patient's ability to manage self-care, and cognitive, functional, and other barriers, to managing clinician and others as appropriate.
- Coordinate other needed therapies—e.g., wound care, diabetes management, rehabilitation services, and social services—through the home health agency. Ensure that key information about self-management, barriers to self-care, and other contextual information is relayed as soon as possible.
- When providing care and managing symptoms of home health care patients, use evidenced-based guidelines from organizations such as the American Cardiology Association, American Diabetic Association, and Global Obstructive Lung Disease.

For more information on evidence-based guidelines, visit the National Guideline Clearinghouse, AHRQ: www.guideline.gov.

The following HHQI Success Story illustrates how home health care agencies are improving real-time communications within their agencies and with partners in different care settings:

HHQI Success story—improving communication with physicians: Gentiva's communication initiatives decrease ACH rates: <http://www.homehealthquality.org/cms/getfile/56ea753c-a6c7-41ec-8d33-01bf708aa673/Gentiva.aspx?chset=91da17d8-205d-4358-bb97-483223fcaa18>.

3B. Use a patient-centered health record to communicate to all caregivers.

- Assist patient and family to create a clear, concise, and customized Patient Health Record, with an initial focus on a clear, patient-friendly, and updatable medication list.
- Help the patient and family caregivers understand the importance of keeping an updated medication list and the importance of taking their list to all appointments and ensuring it is updated in real time.

Generate a list of patient-centered goals for care through motivational interviewing, e.g., asking what is important to patients and/or their concerns and if they are confident they can manage.

See the 3B Resources section in this How-to Guide for more information on patient-centered health records.

***3C. Advocate for patients and teach patients and care partners to advocate for themselves to ensure referrals are completed and needed services are in place.*¹⁴**

- Establish relationships with other care team members in the community and hospital to facilitate communication.¹¹
- Use SBAR (situation, background, assessment, and recommendation) communication model as an efficient and effective communication strategy around patient issues. Provide patient and care partners with tools to aid in communication with other managing clinicians.
- Work with community partners to establish efficient and effective means to communicate, and especially to trigger when a critical situation occurs. An example would be a back line to a primary care physician's nurse.

For more information on SBAR communications, please refer to the [3C Resources section of the How-to Guide](#).

III. Design Elements

The design elements or principles for improving care transitions and coordination of care after patients are discharged from the hospital include: 1) patient and family caregiver engagement, 2) cross-continuum team collaboration, and 3) health information exchange and shared care plans. These cross-cutting principles are catalysts for the successful implementation of the key strategies and changes to improve care transitions and to reduce avoidable rehospitalizations.

Patient and Family Caregiver Engagement

Engagement with patients and their family caregivers takes many forms, including partnerships in treatment and shared care planning, improving care across the continuum, redesigning care and service processes, and optimizing communication between health care providers and patients and their family caregivers.

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At the annual IHI National Forum in 2002, Don Berwick asked, “Are patients and families someone to whom we provide care? Or, are they active partners in managing or redesigning their care?” If we truly want to transform care processes, patients and family members know the “white spaces” between services and locations of care, and they are in the best position to identify opportunities for improvement. Patients and family caregivers should be engaged in choices, planning, and decisions about their care. We also need them engaged in the redesign of care processes if we are to achieve patient- and family-centered care.

The challenge to health care leaders to “Start Before You Are Ready!” has been stated by Jim Anderson, former Chairman of the Board at Cincinnati Children’s Hospital and Medical Center. Figure 6 shows a document adapted from the Cincinnati Children’s Hospital readiness assessment for *Partnering with Patients and Families to Accelerate Improvement*.

Figure 6. [Readiness Assessment](#) (How-to Guide Resources, page 61)

Partnering with Patients and Families to Accelerate Improvement Readiness Assessment	
Name of Organization _____	
	Current Experience: make a mark (an X, a circle, or anything that is easy to read) in the box that best describes your team or organization's experience.
Area	
Data transparency	We have not discussed the possibility of sharing performance data with Our team is comfortable with sharing improvement...

At St. Luke’s Hospital in Cedar Rapids, Iowa, the Patient and Family Advisory Council (PFAC) for Heart Care Services is dedicated to helping the service fulfill its mission: “To give the health care we’d like our loved ones to receive” and to support the principles and practice of family-centered care. Functions of the FAC include providing feedback on ways to improve:

- Patient and family experience;
- Delivery of services for patients and families;
- Educational programs, classes, and written materials for patients;
- Program development, e.g., for the transitions-in-care team;
- Education/orientation of hospital associates;
- Facility design or renovation;
- Reviewing accomplishments and setting goals; and

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- Recruiting new members.

For more information on partnering with patients and families to transform care, please refer to:

Partnering with Patients and Families to Design a Patient- and Family-Centered Health Care System: A Roadmap for the Future. Institute for Healthcare Improvement. Available at www.ihl.org/knowledge/Pages/Publications/PartneringwithPatientsandFamilies.aspx.

Tools for Advancing the Practice of Patient- and Family-Centered Care. Institute for Patient- and Family-Centered Care. Available at www.ipfcc.org/tools/downloads.html.

Berwick D. What 'patient-centered' should mean: Confessions of an extremist. *Health Affairs (Millwood)*. 2009 Jul-Aug;28(4):w555-65. Epub 2009 May 19.

Taylor J, Rutherford P. The pursuit of genuine partnerships with patients and family members: The challenge and opportunity for executive leaders. *Health Services Management*. 2010 Summer;26(4):3-14. Available at www.ihl.org/knowledge/Pages/Publications/PursuitGenuinePartnershipswithPatientsFamily.aspx.

Cross-Continuum Team Collaboration

Cross-continuum team (CCT) collaboration is a transformational hallmark of the STAAR initiative that promotes the paradigm shift from site-specific care to patient-centered care, where the focus is on the patient's experience over time. Understanding mutual interdependencies between care settings, the agency or hospital-based teams co-design care processes with their community-based clinicians and staff and collaborate to improve patients' transition out of the hospital and reception into community settings of care. This collaborative teamwork reinforces that readmissions are not solely a hospital problem.

Leadership for successful cross-continuum teams varies. In some cases, hospital executives invite representatives from community-based sites of care and community agencies that received their patients to learn and test changes in collaboration with hospital-based teams. Quality Improvement Organizations (QIOs) are bringing together hospitals, nursing homes, patient advocacy organizations, and other stakeholders in community coalitions, often led by a community-based leader. Regardless of the initial leadership, the purposes of the cross-

continuum team collaboration are to work together toward a common goal, to co-design care transition processes that keep patients safe during the transitions between care settings, and to coordinate the care of patients.

The cross-continuum team should meet regularly to facilitate communications and collaboration, assess progress, remove barriers to progress, and support improvement efforts of the front-line teams in all clinical settings. In the STAAR initiative, a few key roles for cross-continuum teams are emerging and are delineated below.

Oversight Role

- Identify opportunities and establish aims to improve care transitions.
 - Identify failures and diagnose systemic gaps in care transitions and identify and/or test new ideas;
 - Review and analyze the readmission data and data about patient/family experiences;
 - Complete periodic diagnostic reviews of cases where patients have been readmitted to engage all clinicians and staff in the community and to continually learn about opportunities for improvement; and
 - Create a common aim and look at linkages of processes where cooperation is required.
- Build capability to partner with patients and family caregivers.
 - Add patients and family caregivers to the cross-continuum team to enhance the focus on patient/family experiences and to enable their participation in improving care processes.
- Build capability and capacity in partnering across organizational boundaries.
 - Develop mutual familiarity with the characteristics and needs of each setting by having members from the cross-continuum team visit each others' sites to observe patient care processes during transitions (e.g., hospital and home care nurses shadow each other in the hospital and home visits); and

- Rotate meetings among the different sites.

Portfolio Management

- Review the comprehensive results and progress over time and support the work of front-line clinicians and staff in the hospital, office practice settings, home health care, and skilled nursing facilities in the co-design and implementation of processes to improve transitions in care.
- Manage a portfolio of community-wide improvement initiatives and review progress of each initiative. Examples of community-wide initiatives include:
 - Create universal handover forms/formats to improve communication and coordination of patient care among all clinical settings;
 - Develop a common evidence-based patient education approach in all clinical settings (e.g., health literacy strategies, www.teachbacktraining.com);
 - Create universal teaching materials for the most common clinical conditions for use in all clinical settings; and
 - Create universal self-management tools to be used in all clinical settings to support patients and family caregivers.
- Facilitate collaboration among payers and post-acute care providers to determine eligibility criteria for intensive care management and to identify the clinical provider who is “in charge of coordinating care” for various patient populations (Care Transitions Intervention, APN Transitional Care, HF Clinic, Patient-Centered Home, Evercare, etc.).
- Health information technology (HIT) and the systems to enable the exchange of electronic information within and across settings in a community (i.e., interoperability) can have a dramatic effect on coordination among providers and between providers and patients. While hospitals have had electronic systems to support financial and management systems for a long time, fewer have electronic clinical information systems that support quality of patient care.¹⁵ Other settings across the continuum of care have only recently begun to implement HIT systems that include clinical information.¹⁶ Recent national initiatives — such as the Health Information Technology for Economic and

Clinical Health (HITECH) Act (P.L. 111-5), intended to promote the adoption of HIT in hospitals and office practices around the country — are helping to accelerate the use of HIT more broadly across the health care system. This section of the How-to Guide shares insights about the current and potential impact of HIT on the components of IHI's Roadmap for Improving Transitions in Care after Hospitalization and Reducing Avoidable Rehospitalizations (Figure 1).

Transition from Hospital to Home

During the hospitalization, clinicians and staff can more easily and consistently complete an enhanced assessment and create a post-discharge care plan if they have immediate access to information about the patient from a number of sources, including primary care and other community providers as well as from members of the care team within the hospital. Medication reconciliation is more effectively accomplished with shared access to patient records across providers. Information gained about the patient during Teach Back sessions, whether conducted in the hospital or in the home health care agency, can become part of continuous documentation of the patient's and family caregivers' ability to understand how to take care of the patient. Shared care plans, such as the Patient Powered system developed in Whatcom County, Washington, can be the vehicle for engaging patients in the development of their care plans and also in the active, ongoing management of their health. With shared care plans, patients have direct access to their medical information and designate others with whom they want to share the information.

Transition to Community Care Settings

The ability of clinicians and staff in skilled nursing facilities, home health care, and primary care practices to effectively receive the patient following a hospitalization depends on their access to information about the patient's course of treatment and the care plan developed during the hospitalization. The lack of timely transmission of the discharge summary is often a key roadblock that can be addressed through shared access to the patient's medical record and the recommendations for follow-up care by the discharging physician.

HIT systems can also play a role in standardizing patient-focused information about the illness and ensuring that the patient receives complementary information across settings and sites of care. In addition, HIT has the potential to capture how effectively the patient and family caregivers are able to Teach Back what they are learning, share that information with clinicians across settings, and link engagement strategies to the level of patient activation.

Evidence-Based Care in Community Care Settings (Better Models of Care)

Information technology enables clinicians and staff in all community settings to manage care for their patients using information about medication history, past treatments, outstanding tests, patient and family understanding and ability to care for the patient, and patterns of hospitalization and ED use. For example, information technology and registries enhance the ability of primary care practices to proactively manage the needs of patients with chronic illnesses and to understand the needs of entire populations of patients with specific clinical conditions.

Supplemental Care for High-Risk Patients

Technology and information systems can be used to provide enhanced care to those at high risk of readmission by enabling not only daily monitoring of key clinical information about the patient, but also daily contact between the patient and his or her care team. For example, a number of approaches to providing supplemental care to high-risk patients combine intensive contact and support with some type of telemedicine.

In spite of the potential that HIT has to impact improvements in transitions in care, current HIT systems have a number of limitations, including the lack of connectivity between different HIT systems in different clinical settings. Even within a single care setting such as a hospital, the systems for data exchange are not transparent and do not encompass all of the needed elements. Most hospitals have fragmented care plans that vary by discipline (different ones for MDs, RNs, pharmacists, etc.). While the HITECH Act also provides funding to support the state and regional efforts that will enable the transfer of electronic data across all settings and sites of care, fully functioning systems are not widespread. The Office of the National Coordinator has released a Request for Information (RFI) on Governance of the Nationwide Health Information Network. The intent of this RFI is to establish a common set of “rules of the road” for privacy, security,

business and technical requirements that will help create the necessary foundation to enable the nation's electronic health information exchange capacity to grow.¹⁷

In addition to the unresolved technical issues, there are other challenges that need to be addressed in order to fully maximize the ability of these systems to help providers and patients improve transitions. Goals include better partnership between IT vendors and quality improvement experts and overcoming the conflict between vendor business strategies and the needs of providers within and/or across regions.

IV. Infrastructure and Strategy to Achieve Results

This section provides guidance to leaders in home health care agencies that prioritize improving the individual's transition in the first 48 hours to home health care. The intention of this How-to Guide is to build upon previous improvement work in home health care, such as the Home Healthcare Quality Improvement (HHQI) National Campaign (<http://hhqi.wordpress.com/>) and the Collaboration for Homecare Advances in Management and Practice (www.champ-program.org/) from the Visiting Nurse Service of New York.

The process changes recommended are, for the most part, considered normal care in home health care. However, we know that there are many barriers that home health care staff face to performing these activities ***each and every time for each patient***. The intent of this How-to Guide is to support home health care agencies in improving their care delivery processes in the first 24-48 hours of admission to home health care to very high levels of reliability – ***so that each patient receives the care they need when and how they need it, each and every time.***

Step 1. The CEO or Executive Director of the home health care agency selects an Executive Sponsor and a Day-to-Day Leader to lead the improvement work in the agency.

The role of the Executive Sponsor is to link the aims of improving transitions in care and reducing readmissions to the strategic priorities of the organization. The Sponsor provides oversight and guidance to his or her improvement teams' work. Depending on the size and organizational structure of the home health care agency, typical Executive Sponsors may include Chief Executive Officers, Chief Operating Officers, Chief Nursing Officers, Medical Directors, or Chief Quality Officers. The Executive Sponsor selects a Day-to-Day Leader who

will coordinate project activities; participate in improving cross-setting care processes with partners in office practices, hospitals, and nursing facilities or on an official cross-continuum team; provide guidance to the front-line improvement team(s); and communicate progress to the Executive Sponsor on a regular basis. The Day-to-Day Leader is often a quality improvement leader, a nurse director, or a director of case management.

When framing the improvement initiative, Executive Sponsors may want to explore the following strategic questions for improving transitions and reducing rehospitalizations:

- Is improving transitions in care and reducing the home health care agency's acute care hospitalization rate a strategic priority for the executive leaders at the agency? Why?
- What is the agency's understanding of the opportunities to improve transitions and reduce rehospitalizations?
- What will help the agency achieve success in quality improvement initiatives?
- Are there initiatives to reduce readmissions already underway or planned in the organization, and how could they be better aligned?
- How much experience do executive leaders, mid-level managers, and front-line teams have in process improvement? What resources (e.g., expertise in quality improvement, data analysis) are available to support improvement efforts?
- How will oversight be provided for the improvement projects?
- Who are the key stakeholders who need to be involved in a project to improve transitions and reduce acute care hospitalizations within 30 days of a prior hospital discharge?
- Has the financial impact of the initiative been considered?

The Executive Sponsor will provide guidance for the quality improvement initiative to achieve breakthrough levels of performance. An IHI white paper, *Execution of Strategic Improvement Initiatives to Produce System-Level Results*, can provide valuable guidance for leaders in setting the improvement work up for success. The paper contains four components:¹⁸

1. Setting priorities and breakthrough performance goals;
2. Developing a portfolio of projects to support the goals;

3. Deploying resources to the projects that are appropriate for the aim; and
4. Establishing an oversight and learning system to increase the chance of producing the desired change.¹⁸

Home health care leaders can also foster relationships with care partners who refer patients to them. While home health care agencies can and should focus improvement efforts on improving internal care processes, much of the work of improving care transitions relies on working with partner hospitals, office practices, and skilled nursing facilities. Please refer to the Cross Continuum Team Collaboration Design Element discussed in this guide ([page 19](#)). The Home Health Quality Improvement National Campaign Best Practice Intervention Package, Cross Setting 1 (www.homehealthquality.org/hh/default.aspx), offers this good advice:

- “Develop relationships with your referral stream
- Where do your patients come from and where do they go next?
- Develop standard referral, communication and transfer processes.
- Develop mechanisms for accountability to those processes.
- Explore web-based sharing instruments to drive improvement.”

Step 2. Convene an Improvement Team

To significantly improve transitions into the home health care setting, care processes within a home health care agency can and, as needed, should be the focus of robust improvement efforts. However, improvements in care processes between home health care agencies and partner hospitals, office practices, skilled nursing facilities and others are most necessary. The following guidance on convening an improvement team starts with how to convene an internal improvement team to understand the agency’s current state. As soon as the agency is internally organized, forming or joining a cross-continuum team focused on improving transitions is recommended.

Improvement involves understanding the agency’s opportunities for improvement, testing changes to care delivery processes, learning from those tests of change, and using data to drive improvement. A front-line improvement team who will be responsible for performing these tests of change and choosing a segment of patients on whom to test the changes will be necessary.

The composition of the front-line improvement team(s) will vary from agency to agency. These teams are most successful when they include staff who participate in care on a regular basis, as

each staff role brings a unique perspective to the work. A typical front-line improvement team for home health care may include some combination of the following:

- A Day-to-Day Leader for the team;
- Home health care nurses;
- Home health care aides;
- Home health care medical director;
- Pharmacists – home health care staff or community pharmacists;
- Social workers, therapists – physical therapy, occupational therapy, speech therapy;
- Palliative care representative or hospice representative;
- Patients and family caregivers; and
- When possible, a quality improvement professional to facilitate the improvement work.

Based on the findings of the agency's opportunities for improvement, the Executive Sponsor and improvement team may consider finding willing partners from referring hospitals, office practices or skilled nursing facilities to join the team and co-design cross-site care processes. Frequently, the discharging hospital and a home health care agency do not have access to all necessary information to take care of the patient on admission to home health care. A cross-continuum team provides the opportunity to co-design, test and refine processes of patient care across settings in ways any one cannot do alone. Information about setting up a cross-continuum team can be found on [page 19](#). The HHQI National Campaign offers two success stories of home health care agencies partnering with hospital and other partners to improve transitions in care (if not registered, you will be asked to do a short, free registration with the site):

Monthly meetings help Seton Home Health reduce rehospitalization rates:

<http://www.homehealthquality.org/cms/getfile/d5b02752-8b3d-443f-ae1d-fba241512ab2/SuccessSeton.aspx?chset=de945c98-47c1-4f48-be43-2739da3180a6>

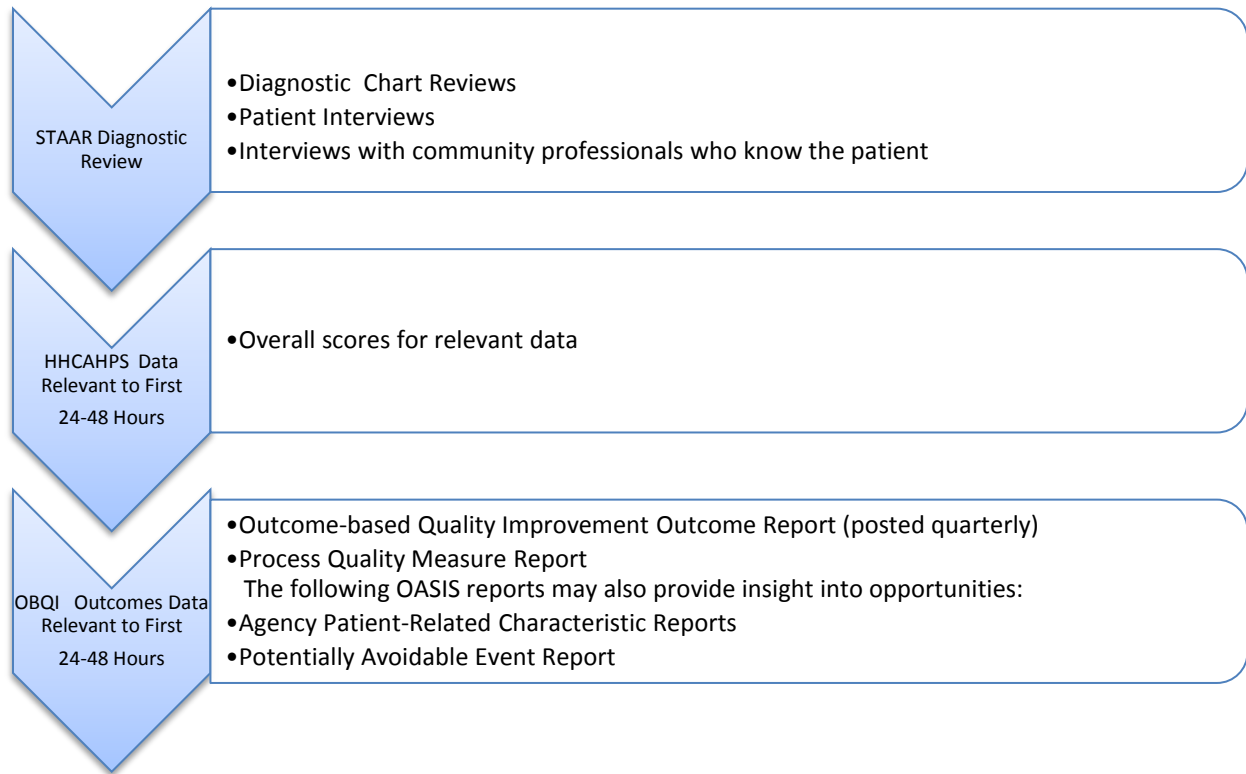
Care transitions work group helps providers understand capabilities, limitations:

<http://www.homehealthquality.org/cms/getfile/d62a4853-44a3-4e4d-b5cf->

overview of common sources of data for home health care agencies (free registration required):

<http://hhqi.wordpress.com/2013/02/05/use-data-to-boost-improvement/>

Figure 7. Sources of Data for Home Health Care



Step 3a. Conduct an in-depth review of the last five of the agency’s hospital admissions to identify opportunities for improvement.

In addition, home health care agencies may want to review acute care hospitalizations within 30 days of a hospital discharge. Conduct chart reviews of the last five patients receiving home health care services who were hospitalized for an acute condition, ideally a readmission from a recent discharge. The purpose of this chart review is to identify opportunities for improvement, not judgment of individual staff. It is important for leaders to continually communicate this message to staff and to support a culture of inquiry and subsequent improvement. Transcribe key information onto Part 1 of the Diagnostic Worksheet (Figure 8).

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Figure 8: [Diagnostic Worksheet \(Part 1\)](#) (How-to Guide Resources, page 63)

Diagnostic Worksheet: In-depth Review of Patients Who Had an Acute Care Hospitalization within 30 days of a Hospital Discharge					
Part 1: Chart Review					
Conduct chart reviews of the last five patients with an acute care hospitalization within 30 days of a hospital discharge. Reviewers should be nurses experienced in the clinical setting and in chart review for quality and safety. Reviewers should not look to assign blame, but rather to discover opportunities to improve the care of patients. The intent is to learn how we might prevent these failures that we once thought impossible to prevent.					
Question	Patient #1	Patient #2	Patient #3	Patient #4	Patient #5
Number of days between the last discharge and this acute care hospitalization date?	___ days	___ days	___ days	___ days	___ days
Was the follow-up physician	Yes	No	Yes	No	Yes

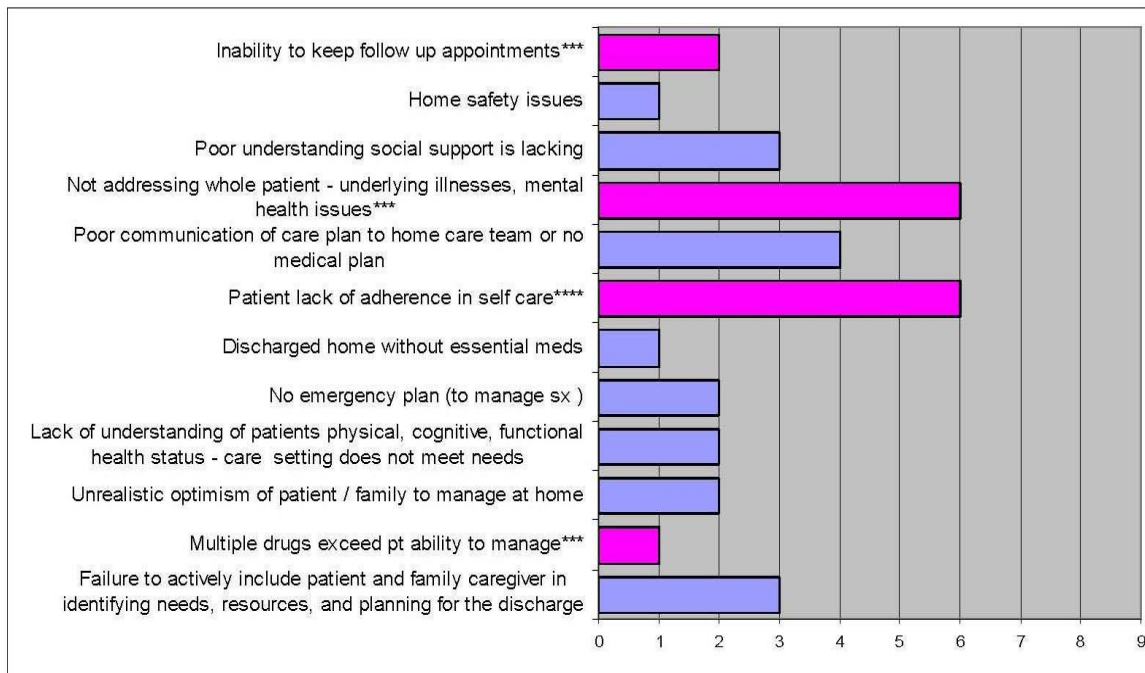
- Conduct interviews with patients who were recently hospitalized (ideally a rehospitalization) and their family members. If possible, interview the same patients whose charts were reviewed. These interviews are key to ensuring a well-rounded view of the care delivery processes and will provide valuable information to the improvement team *not available from any other source*.
- Next, conduct interviews with inpatient caregivers, clinicians in the community who also know the admitted patient (e.g., physicians, nurses in the skilled nursing facility, home health nurses, etc.), to identify problem areas from their perspective. These interviews also provide a perspective not typically available to home health care staff.
- Transcribe information from these interviews onto Part 2 of the Diagnostic Worksheet (Figure 9).
- Create a histogram of common themes that emerge from the chart reviews and interviews. Figure 10 below is a histogram from chart reviews of the Visiting Nurse Service of New York.

Figure 9: [Diagnostic Worksheet \(Part 2\)](#) (How-to Guide Resources, page 65)

Diagnostic Interview Worksheet: In-depth Review of Patients Who had an Acute Hospitalization within 30 days of Hospital Discharge	
Part 2: Interviews with Patients, Family Members, and Care Team Members in the Community	
If possible, conduct the interviews on the same patients from the chart review. Use a separate worksheet for each interview.	
Ask Patients and Family Members:	
How do you think you became sick enough to go back to the hospital?	
<div style="border: 1px solid black; height: 20px; width: 100%;"></div>	
Did you see your doctor or the doctor's nurse in the office before you came back to the hospital?	
If yes, which doctor/PCP?	

Figure 10: Histogram of Issues Found in Chart Reviews

Emerging Trends from Cross-Continuum Team Hospitalization Reviews



Blue = trends from all cases reviewed
 Pink = trends identified in one case

Step 3b. Review data on patient experience and discharge preparations.

Trend the data for the questions below from your organization’s Home Health Consumer Assessment of Healthcare Providers and Systems (HCAHPS) patient response data in a time series chart for the entire agency, by month, for the last 12 months. (Refer to [Outcome Measures](#), page 52). If you do not yet have 12 months of data for these questions, you can begin to trend what you have.

- In the last two months of care, how often did home health providers from this agency explain things in a way that was easy to understand? (HCAHPS Q17)
- In the last two months of care, how often did home health providers from this agency listen carefully to you? (HCAHPS Q18)

Step 3c. Trend Acute Care Hospitalizations (ACH) within 30 days of admission to home health care in time series charts.

Collect historical data and display monthly acute-care hospitalization rates in a time series chart. Display data for the last 12 months, if possible. Consider segmenting acute-care admissions rates by certain diagnoses, such as heart failure. Additional outcome measures are recommended.

Recommended Readmissions Measures

- Acute care hospitalizations (ACH) within 30 days of admission to home health care
- Acute care hospitalizations within 30 days of admission to home health care for a specific clinical condition

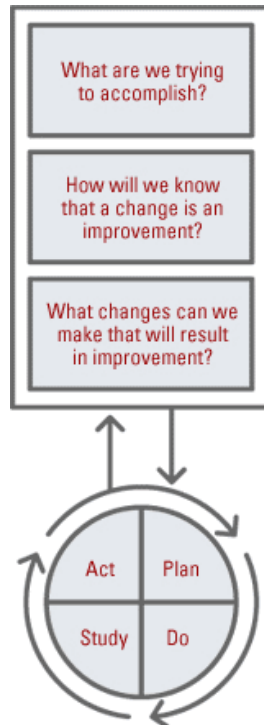
Step 4. Use the Model for Improvement

Developed by Associates in Process Improvement, the Model for Improvement (Figure 11) is a simple yet powerful tool for accelerating improvement that has been used successfully by hundreds of health care organizations.

The model has two parts:

- Three fundamental questions that guide improvement teams to 1) set clear aims, 2) establish measures that show whether changes lead to improvement, and 3) identify changes that are likely to lead to improvement.
- The Plan-Do-Study-Act (PDSA) cycle to conduct small-scale tests of change in real work settings — by planning a test, trying it, observing the results, and acting on what is learned. This is the scientific method, used for action-oriented process improvement.

Figure 11: The Model for Improvement



Learn more about the Model for Improvement at www.ihl.org.

Question 1: What are we trying to accomplish?

Craft an aim statement to guide the work. Aim statements communicate what a team hopes to accomplish and the magnitude of the desired change. Aim statements have four parts: what the team expects to do; by when; for whom; and measurable goals.

Sample aim statements:

- 1) *The Best Home Health Care Agency will improve transitions home for all patients as measured by a decrease in their acute care hospitalization rate within 30 days of the last day of hospital stay by 30 percent within 24 months. We will start with patients being cared for by Teams A and B and will expect to see a decrease in readmissions for patients being cared for by those teams of at least 15 percent within 12 months.*
- 2) *The Best Home Health Care Agency will improve the transition between the hospital and their agency by improving the handover and focusing on medication management during the first week of service so that within the next 12 months we will reduce ED visits by 50 percent and acute care hospitalizations within 30 days of discharge by 20 percent. OASIS data will show improvement in medication management and medication stabilization by 15 percent or more.*

For more on setting aims, please refer to:

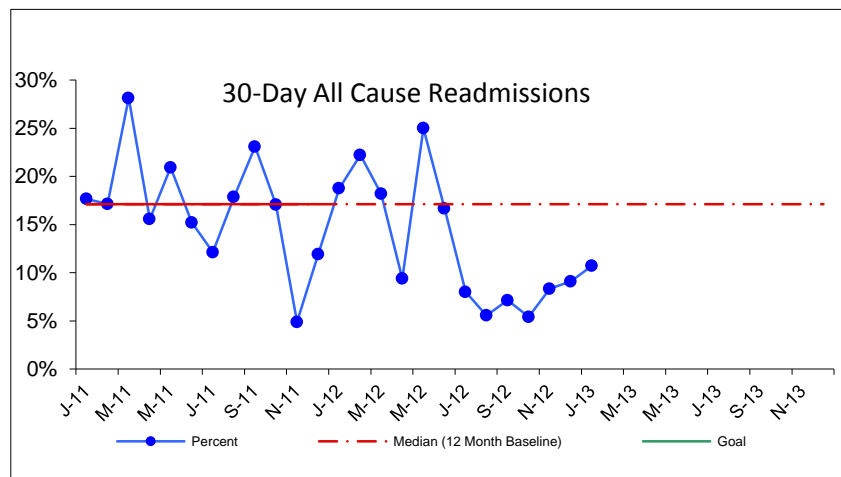
www.ihl.org/knowledge/Pages/HowtoImprove/ScienceofImprovementSettingAims.aspx.

Question 2: How will we know that a change is an improvement?

Data to reduce acute-care hospitalizations and readmission is intended for learning, not judgment. Outcome, process, and balancing measures inform improvement. Outcome measures directly relate to the aim — in this case, to reduce readmissions or rehospitalizations. Process measures reflect how work gets done around the key changes. Balancing measures help ensure that we are not causing detriment to an important part of the system. When data is displayed in a time series graph or in a run chart, trends and improvement are easy to observe (Figure 12).

A comprehensive list of all of the measures can be found in the [System Measures Section](#) on page 52.

Figure 12: Example Run Charts for 30 Day All Cause Readmission



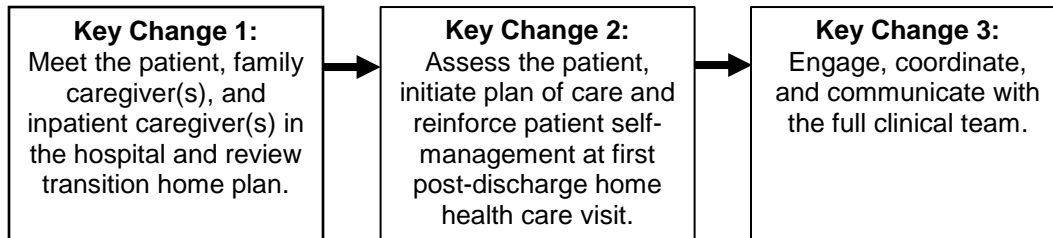
Question 3: What changes can we make that will result in improvement?

Select the changes needed to bring about improvement from among the key changes outlined in Section II. The categories of the key changes are listed below.

The key changes represent the temporal journal of a patient at discharge from the hospital and into home health care. First, the patient is visited in the hospital for an assessment of specific patient needs as they transition home and into the care of home health care staff. The second key change occurs during the first home visit post-discharge and involves acting to identify

issues with potential to lead to readmission. This change includes using Teach Back to improve teaching and assess the patient's or the designated learner's understanding. The third key change is to communicate important information to all clinical service providers and coordinate services with them.

Figure 13: Flowchart of Key Changes



Using Plan Do Study Act Cycles for Learning and Improvement

The Plan-Do-Study-Act (PDSA) cycle drives improvement; it is a pragmatic version of the scientific method, used for action-oriented process improvement. A team conducts small-scale tests of change in real work settings — by planning a test, trying it, and observing the results — because observation yields significant learning as a team tests and then implements changes.¹⁹⁻²² The key change descriptions in section II include suggestions for observation. Then action is taken based on what is learned. A test is expanded, adapted to be more useful, or sometimes abandoned altogether.

Why Test Changes?

- To increase your belief that the change will result in improvement
- To decide which of several proposed changes will lead to the desired improvement
- To evaluate how much improvement can be expected from the change
- To decide whether the proposed change will work in the actual environment of interest
- To decide which combinations of changes will have the desired effects on the important measures of quality
- To evaluate costs, social impact, and side effects from a proposed change

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- To minimize resistance upon implementation

How to Test a Change

A first test of change usually happens on a small scale (e.g., using Teach Back with one nurse or one patient or for one day). Use a Plan-Do Study-Act Worksheet like the one below and predict what will happen as a result of trying something different. Observe the results, learn from them, and continue to the next test. Use iterative PDSA cycles to test under a variety of conditions. This increases the team's belief that the change will work reliably when implemented.

See the PDSA Worksheet (Figures 14 and 15).

Figure 14: [PDSA Worksheet](#) (How-to Guide Resources, page 67)

MODEL FOR IMPROVEMENT **DATE** _____

Change or idea evaluated: _____

Objective for this PDSA Cycle: _____

Figure 15: [Example Completed PDSA Worksheet](#) (How-to Guide Resources, page 68)

MODEL FOR IMPROVEMENT **DATE** 8/10/2010

Change or idea evaluated: Use HF Zone handout to improve pt learning

Objective for this PDSA Cycle: Improve pt understanding of HF using the zone worksheet, improve nurse teaching

Most changes require a series of successive tests before implementation. Testing should include a variety of conditions, e.g., adding a variety of types of patients and families, testing on different shifts, on the weekdays and on the weekends, when short-staffed, well-staffed, on days with many admissions, few admissions, etc. The point is to learn as much as possible to determine whether the change is an improvement prior to implementation, and to create a

process that is reliable. An iterative series of PDSA cycles that involved learning about Teach Back is outlined below.

Example of Iterative PDSA Cycles to Improve Patient Understanding Using Teach Back

- Cycle 1: One nurse, on one day, tests whether using Teach Back with one patient who has heart failure helps the patient learn the reasons to call the physician for help after discharge. The nurse learned that the materials were confusing to the patient.
- Cycle 2: Nurse revises the teaching materials to identify key points by circling them for the patient on the teaching handout. The nurse runs a second PDSA cycle with the same patient the next day and the patient can Teach Back the signs and symptoms, and when and how to call his doctor.
- Cycle 3: The nurse expands Teach Back to two more patients, one of whom has a designated learner, his daughter.
- Cycle 4: The nurse tries a cycle of setting a learning appointment with a designated learner. This cycle is later abandoned due to complexity.
- Cycle 5: Nurse expands Teach Back to all patients with heart failure.
- Cycle 6: Nurse expands Teach Back to all her patients and designated learners.
- Cycle 7: Teach Back is introduced to the weekend staff and two nurses from each shift are trained. Nurses begin sharing results of learning in shift report to coordinate who teaches what.
- Cycle 8: The nurse manager observes that staff struggle with how to ask the patients to Teach Back and develops three alternative scripts for testing.
- Cycle 9: Staff try the scripts and like two of the three; they adopt those two.

Suggestions for Conducting PDSA Cycles

- Keep tests small; be specific.
- Make a prediction about what will happen if the tests succeed.
- Each test informs the next.
- Expand test conditions to determine whether a change will work under a variety of conditions:
 - Different times of day (e.g., day and night shifts, weekends, holidays) when the unit is adequately staffed;
 - At times of staffing challenges; or
 - Different types of patients (those with lower health literacy, non-English speaking patients, short stay or long stay patients).
- Collect sufficient data to evaluate whether a test has promise, was successful, or needs adjustment. Compare data to findings to learn more and design future tests.

Test to Increase Process Reliability

Reliability is failure-free operation over time so that processes produce desired results every time, for every appropriate patient. As PDSA cycles ramp up and are ready for implementation, make sure to precisely specify the work, who does what, when, how, where, etc. To make processes more reliable, make use of “human factors” principles (e.g., build on existing habits, use checklists to avoid relying on memory, foolproof the process so that it is impossible to do the wrong thing, use standard protocols and training). To increase reliability, for example, consider auto-reminders for Teach Back and documentation. Another method to determine process reliability is to interview staff about how they do particular work, like patient teaching and the use of Teach Back. If the responses vary, this may reveal a lack of reliability in how the work is done. Use peer observers and coaches to help build new competencies among the staff and develop needed reliability.

Make sure there is a process in place that identifies process failures, e.g., a patient is ready for discharge but never received any Teach Back, or a patient cannot Teach Back important aspects of his or her self-care and nothing was changed in the discharge plan. Learn where failures occur and then use problem-solving to design solutions, redundancies, or remedies if they occur. This is especially useful when patients have been readmitted.

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Improving Reliability of Teach Back:

When redesigning your patient education processes to teach patients about home-going instructions (as described in the example PDSA cycles above), work with staff who conduct the tests to precisely describe the work. The following questions may help improve reliability and specify work. Below is an example of how to customize the questions around Teach Back.

- Who will do it (be specific — e.g., include the name of the nurse assigned to the patient)?
- What will they do (e.g., use Ask Me 3™ framework to organize teaching for all patients, and all patients are asked [in a non-shaming way] to describe in their own words what was learned)? Learning is documented in the patient's record so that at discharge, details on the patient's ability to Teach Back the key points can be transferred to the next site of care.
- When will they do it (e.g., during second hourly rounding of shift)?
- Where will they do it (e.g., in the patient's room)?
- How do they do it (include tools that are used — e.g., Teach Back documentation tool kept in patient's chart)?
- How often will they do it (e.g., once each day)?
- Why should they do it (e.g., to enhance learning and identify patients who are at risk of problems while caring for themselves post-discharge)?

Continue to test the process under a variety of conditions (e.g., different nurses, different kinds of patients). Adapt the change iteratively until it optimally meets the needs of both patients and staff and demonstrates a high level of reliability (i.e., the process works as designed at least 95 percent of the time).

Learn from failure as well as from success. Understanding common failures (situations when a process is not executed as expected) helps the team to redesign the new processes to eliminate those failures.

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Learning from a failed test:

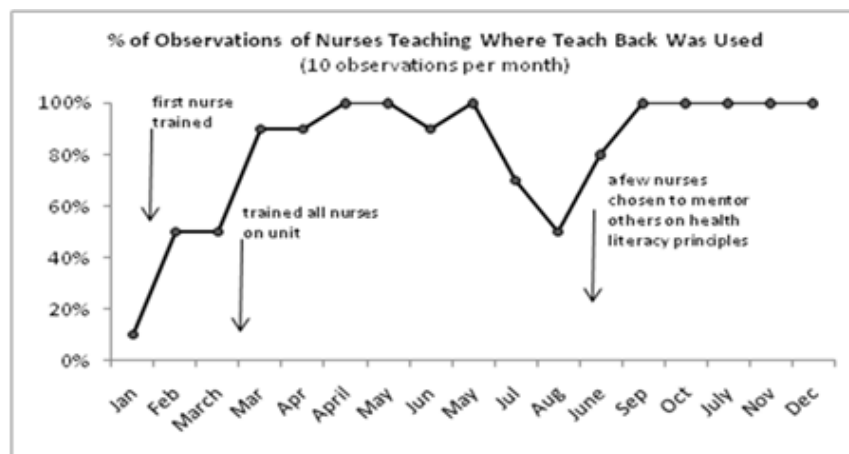
The nurses used the Ask Me 3™ framework and Teach Back with all patients. A nurse caring for a patient with chronic depression was unsure about the relevant Teach Back questions to assist her with patient education. The nurses, physicians, and social workers met to delineate the relevant Teach Back questions for patients with mental health conditions and redesigned education.

After successful testing under varying conditions with desired results, document the process so there is no ambiguity and all involved can articulate the exact same steps in the process.

Use data to understand if the changes you are making result in improvement. For example, display in a time series graph the percentage of observations of teaching opportunities where nurses use Teach Back. Annotate graphs to note when specific changes are tested and implemented. Continue to collect and display this data to see whether your changes result in improvement. Augment quantitative data with feedback solicited from patients about their experience (consider using the [Diagnostic Worksheet](#), How-to Guide Resources, page 63).

Use process measures to track whether new and improved processes are executed as expected. Learn whether and how specific changes work as planned. Figure 16 shows an example of an annotated time series graph for a process measure for *Provide Effective Teaching and Facilitate Enhanced Learning*. The annotations show when specific changes were tested or implemented.

Figure 16: Example Time Series Graph for Process Measure



When data suggest a lack of process reliability, ask the people who do the job what barriers they face. Identify opportunities to execute the new processes more reliably. Avoid blaming staff

who do the work. Assume the problem is from poor process design. Work with the team to fix it. For example, if the team observes that nurses are not using Teach Back, the team should ask nurses about barriers to using Teach Back and then increase the likelihood that Teach Back will be used.

Note, for example, how the data in the graph above (Figure 16) enable the team to see when performance declined and to test new interventions to improve reliability. Share data with unit staff, physicians, and senior leaders. Reflect on lessons learned from both successful and unsuccessful tests of change.

Step 5. Implementation, Scale-up, and Spread

Implementation of Changes

After testing a change on a small scale, learning from each test, and expanding tests to cover a wide range of conditions, the team is ready to implement a change. Implementation occurs when the staff are ready for the change, there is a high degree of certainty that the change is an improvement, and the cost of implementation is low or the change can easily be removed or redone. If all of these conditions apply, the change is ready to be made permanent and routine. This usually requires revisions to written policies, hiring, training, compensation, electronic work aides in the electronic medical record (EMR), equipment, and other aspects of the organization's infrastructure that were not engaged in the testing phase. Pay attention to communication (i.e., publicizing the benefits of the change), documenting improvement, and keeping in contact with the pilot team to support it during implementation.

Implementation Example: During the testing process, a few nurses learned Teach Back. Once the processes and support materials were adapted so that these nurses taught the identified learners effectively over 90 percent of the time, those processes could be implemented across the unit. Making these processes the default system (i.e., the way the work is done rather than the way a few nurses do the work from time to time) requires a training system for all nurses currently on the unit, and changes to orientation programs for new nurses. To scale up the change across the hospital might require changes to an IT documentation system. Communication to all staff about new expectations for teaching and learning might be developed to generate interest in implementing the redesigned process in other parts of the hospital (e.g., in other units or service lines) or with other disciplines (e.g., physicians or pharmacists) in preparation for spread.

During implementation, attend to social aspects of the change as well as the technical infrastructure. Leaders need to communicate not only the *what*, and the *why*, but also the *how* of the change, and address questions and concerns. It is common for processes to work reliably during testing and less reliably, temporarily, during implementation. This is because a larger group, some unfamiliar with and/or unsympathetic to the purpose, must implement a change.²³ There may be resistance, or simply confusion. It may take some cycles of testing to put in place an effective infrastructure to support the change(s). After implementation, continue to monitor whether processes are reliable and act on that information to adapt the processes and the related infrastructure to support the change. Make it easy to do the right thing, and hard to do the wrong thing.

Tips for Sustaining Improvements

- Communicate aims and successful changes that achieved the desired results (e.g., through newsletters, storyboards, patient stories, etc.).
- “Hardwire” processes so that the new processes are difficult to reverse (e.g., IT template, yearly competencies, role descriptions, policies and procedures).
- Assign ownership for oversight and ongoing quality control to “hold the gains.”
- Assign responsibility for ongoing measurement of processes and outcomes. Intervene if the data slips and shows a deteriorating trend.

Planning for Scale-up of Changes

Scale-up involves overcoming system and infrastructure issues that arise during implementation. For example, after pilot testing Teach Back, a hospital unit identified it as a successful improvement in patient learning. The hospital leadership then undertook a deliberate implementation of this change in the whole hospital. The infrastructure required to scale up and sustain Teach Back on a unit may be different from the infrastructure required for implementation throughout the hospital (i.e., documentation in the electronic medical record or annual competency training). If there are barriers to scale-up, they should be noted and removed as the work is scaled up across units.

An important leadership consideration is to ensure staff adequate time and resources to adopt the changes as well as to support overcoming the barriers that inhibit scale-up.

Spreading Changes

Leaders should plan for spreading the improvement developed in the pilot population or unit during the early stages of the initiative. After successful implementation of the key changes in the pilot unit or with a patient population, leaders develop a spread plan. Even though the changes have been tested and implemented, spread efforts benefit from testing and adaptation (using PDSA cycles) in new patient populations or organizations.

Successful spread of reliable processes requires leaders to commit sufficient resources to support spread. Pilot unit staff also play an important role in spread activities by 1) making the case that the changes contribute to better patient transitions and reduced readmissions, and 2) generating information and materials that leaders can package to ease spread. They may teach and mentor others.

A key responsibility of leaders is to develop a plan and timetable for spread and then to measure and monitor progress. Figure 17 shows an example of a tool to monitor spread of changes. This tool allows a leader to visualize the spread progress of each change and the spread of changes across the locations.

Figure 17: Tool to Monitor Spread

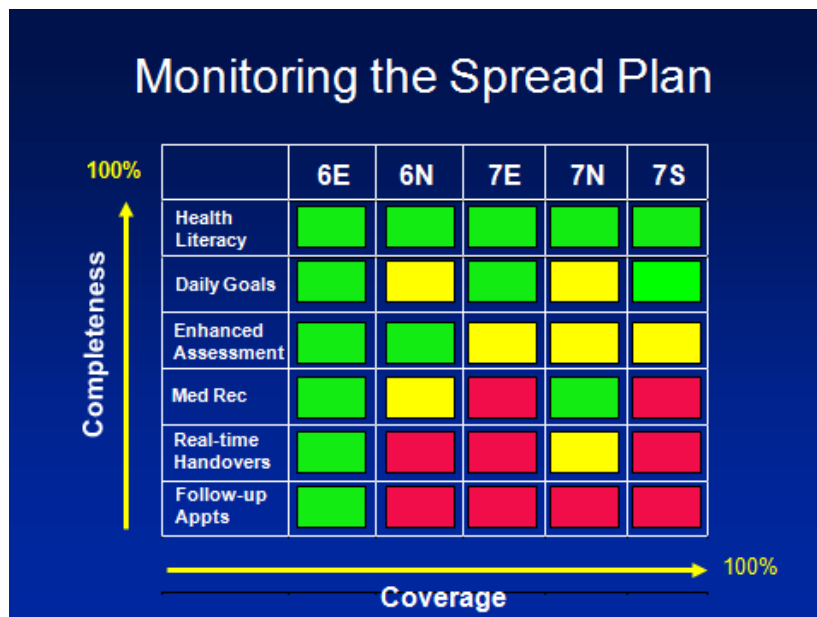
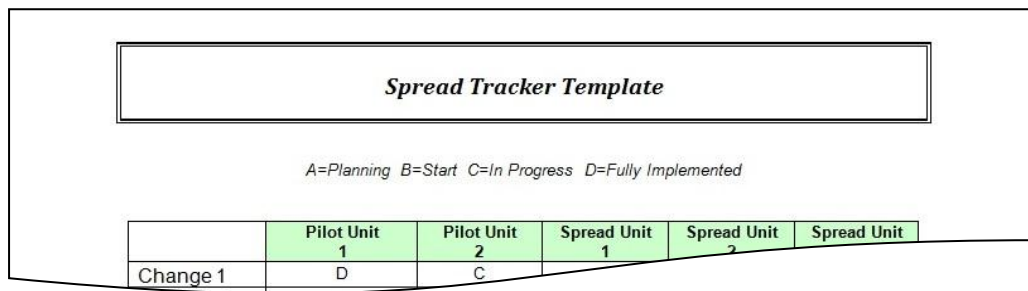


Figure 18: [Spread Tracker Template](#) (How-to Guide Resources, page 72)



Leaders determine if further guidance and support might accelerate progress and results. It is recommended that outcome measures be reported and tracked at the hospital or system level as well as at the unit level in order to provide leaders, unit managers, and front-line staff with regular feedback on their progress.

Books and articles:

Womack JP, Jones DT, Simon, Audio S. *Lean Thinking*. Simon & Schuster Audio; 1996.

Kenagy J. *Designed to Adapt: Leading Healthcare in Challenging Times*. Second River Healthcare Press, Bozeman MT; 2009.

Langley GJ, Moen R, Nolan KM, Nolan TW, Norman CL. *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance*. Jossey-Bass; 2009.

Massoud, MR, Nielsen, GA, Nolan, K., Schall, MW, Sevin, C. *A Framework for Spread: From Local Improvements to System-Wide Change*. IHI Innovation Series white paper. Institute for Healthcare Improvement; 2006. (Available on www.IHI.org)

Nolan KM, Schall MW (editors). *Spreading Improvement Across Your Health Care Organization*. Joint Commission Resources and the Institute for Healthcare Improvement; 2007:1-24.

Web tools and resources:

On Demand Presentation: An Introduction to the Model for Improvement. Institute for Healthcare Improvement. Available at: www.ihl.org/offerings/VirtualPrograms/OnDemand/ImprovementModelIntro/Pages/default.aspx.

Quality Improvement 101-106. *IHI Open School for Health Professions*. Available at www.ihl.org/offerings/IHIOpenSchool/Courses/Pages/default.aspx. The Institute for Healthcare Improvement offers online courses, through the IHI Open School for Health Professions, that are available free to medical students and residents and for a subscription fee for health care professionals.

Recommended Resources on Quality Improvement

IHI did the HHQI Pave Your Path Webinar Series for the HHQI National Campaign. This webinar call series covers the foundational elements of quality improvement science, tailored for the home health care audience: <http://www.homehealthquality.org/Webinars/Pave-Your-Path-Webinar-Series.aspx>

Books and articles:

Ohno T. *Toyota production system: Beyond large-scale production*. Productivity Press; 1988.

Womack JP, Jones DT. *Lean Thinking*. Simon & Schuster Audio; 1996.

Kenagy J. *Designed to Adapt: Leading Healthcare in Challenging Times*. Second River Healthcare Press, Bozeman MT; 2009.

Langley GJ, Moen R, Nolan KM, Nolan TW, Norman CL. *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance*. Jossey-Bass; 2009.

Massoud MR, Nielsen GA, Nolan K, Schall MW, Sevin C. *A Framework for Spread: From Local Improvements to System-Wide Change*. IHI Innovation Series white paper. Institute for Healthcare Improvement; 2006. (Available on www.IHI.org)

Nolan KM, Schall MW (editors). *Spreading Improvement across Your Health Care Organization*. Joint Commission Resources and the Institute for Healthcare Improvement; 2007:1-24.

Spear S. *The High Velocity Edge* (released in its first edition as: *Chasing the Rabbit: How Market Leaders Outdistance the Competition*). McGraw Hill; 2009.

Resources for Key Change 1A

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Your Discharge Planning Checklist. Centers for Medicare and Medicaid Services. Available at www.medicare.gov/publications/pubs/pdf/11376.pdf.

Universal Transfer Form. American Medical Directors Association. Available at www.amda.com/tools/universal_transfer_form.pdf.

New Jersey Universal Transfer Form:

http://web.doh.state.nj.us/apps2/documents/ad/hcab_hfel7_0610.pdf.

Resident/Patient Continuum of Care Transfer Form. Colorado Foundation for Medical Care. Available at http://www.cfmcc.org/integratingcare/toolkit_PDF.htm

Resources for Key Change 1B

Top 10 Reasons You Need a Physician Follow-up within 7 Days. Colorado Foundation for Medical Care. Available at:

www.cfmcc.org/caretransitions/files/toolkit/intervention/QIO%20Developed%20Tools/PA_10%20Reasons%20to%20schedule%20followup%20visit%20with%20your%20Physican.pdf.

IPRO Discharge Criteria Flyer—with criteria for referral to Home Health Care. Available at: <http://champprogram.org/static/IPROFlyer1.pdf>.

Patient PASS from Project BOOST. Available at: <http://champ-program.org/static/PASS.pdf>.

Resources for Key Change 2A

A toolkit developed by CHAMP can help home health care staff tailor their assessments and interventions to elderly patients: Geriatric Care Transitions Toolkit:

<http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/Downloads/HHQIOBQMManual.pdf>

The following HHQI Success Story illustrates how one home health care agency leveraged their Electronic Health Record (EHR) to ensure that their staff had the most up-to-date patient information and evidence-based resources at their fingertips:

HHQI Success Story—use of EHR to lead to evidence-based and best practices in real time and real-time information sharing: <http://www.homehealthquality.org/cms/getfile/5d20657b-1b6d-48ca-b4b2-7a7a1190b631/Complete.aspx?chset=c499578c-a3c5-465a-9cce-b87eb348df2e>

Resources for Key Change 2B

Medication Management resources for professionals:

Improving the Management of Oral Medications, HHQI, BPIP:

<http://www.homehealthquality.org/Education/BPIPS/Improving-Management-of-Oral-Medications-BPIP.aspx>

Medication Management Evidence Brief VNSNY Center for Home Care Policy & Research
April 2009. <http://champ-program.org/static/CHAMP-Medication%20Management.pdf>

Medications Management in Home Health Care Toolkit:

www.homemeds.org/landing_pages/21,3.html

Review of the Three-Step Medication Reconciliation Process: http://champ-program.org/static/Review_MedicationReconciliation.pdf

Medication Reconciliation Essentials Data Specification. National Transitions of Care
Coalition. Available at www.ntocc.org/Portals/0/Medication_Reconciliation.pdf

Medication Reconciliation Toolkit. American Society of Hospital Pharmacists. Available at
www.ashp.org/Import/PRACTICEANDPOLICY/PracticeResourceCenters/PatientSafety/ASH_PMedicationReconciliationToolkit_1.aspx. This online resource center provides tools,
references, recommendations, innovative ideas, and examples of success stories and
lessons learned.

My Medicine List™— Information for Health Professionals. American Society of Health-
System Pharmacists. Available at

www.ashpfoundation.org/MainMenuCategories/PracticeTools/MyMedicineList/InformationforHealthProfessionals.aspx

Prevent Adverse Drug Events (Medication Reconciliation) How-to Guide. Institute for
Healthcare Improvement. Available at

<http://preview.ih.org/knowledge/Pages/Tools/HowtoGuidePreventAdverseDrugEvents.aspx>.

*American Geriatrics Society Updated Beers Criteria for Potentially Inappropriate Medication
Use in Older Adults:*

www.americangeriatrics.org/files/documents/beers/2012BeersCriteria_JAGS.pdf

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American Geriatrics Society Updated Beers Criteria Pocket Card:

www.americangeriatrics.org/files/documents/beers/PrintableBeersPocketCard.pdf

HHQI Success Story: Large agency relies on teamwork to improve, sustain oral medication

rates: <http://www.homehealthquality.org/cms/getfile/a85fe9db-f601-48ca-963a-7782e999fedd/Dominican.aspx?chset=dfd0daa7-ff0d-43b5-a2b2-dcb6156f8c84>

National Council on Aging Webinar on Medication Safety:

<http://www.ncoa.org/calendar-of-events/medication-management.html>

Medications at Transitions and Clinical Handoffs (MATCH) Toolkit for Medication

Reconciliation: <http://www.ahrq.gov/professionals/quality-patient-safety/patient-safety-resources/resources/match/index.html>

Medication Management resources for patients and caregivers:

HHQI Patient Resource Center: <http://www.homehealthquality.org/Education/Patient-Resource-Center.aspx>

Medication Action Plan. Available at www.medactionplan.com

My Medicine List. National Transitions of Care Coalition. Available at www.ntocc.org/Portals/0/My_Medicine_List.pdf. Also available in Spanish and French.

Resources for Key Change 2C

Resources for professionals to support patient self-management:

Patient Activation Assessment. The Care Transitions Program™. Available at www.caretransitions.org/documents/Activation_Assessment.pdf.

HHQI BPIP Patient Self-Management:

<http://www.homehealthquality.org/Education/BPIPS/Focused-Patient-Self-Management.aspx>

Clinician education on motivational interviewing:

www.motivationalinterview.org/quick_links/about_mi.html

Best Practice: Evidence-based Health Coaching: A Lever for Better Home Health Outcomes. HHQI, BPIP Cross Settings 1, pages 24-29:

<http://www.homehealthquality.org/Education/BPIPS/Cross-Settings-I-BPIP.aspx>

Principles of Motivational Interviewing—An excerpt from MassPro's "Planned Care: Self-Management Support in Home Healthcare HHQI, BPIP Cross Settings 1:

<http://www.homehealthquality.org/Education/BPIPS.aspx>

Patient Resources. Care Transitions Quality Improvement Organization Support Center (QIOSC). Available at www.cfmc.org/caretransitions/patient_resources.htm.

Taking Care of Myself: A Guide for When I Leave the Hospital. Agency for Healthcare

[AHRQ Toolkit - Taking Care of Myself: A Guide for When I Leave the Hospital](#)

Resources for Teach Back

Teach Back Laminated Cards. Colorado Foundation for Medical Care. Available at

http://www.cfmc.org/integratingcare/files/toolkit/intervention/TX_TeachBack%20laminated%20cards.pdf

Teach Back Method Tool: <http://nchealthliteracy.org/teachingaids.html>

Resources for Health Literacy:

American College of Physicians Foundation Health Literacy Video:

<http://www.youtube.com/watch?v=lmnlptxIMXsAHRQ>

Health Literacy Universal Precautions Toolkit: <http://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/literacy-toolkit/index.html>

Resources for Key Change 3A

No resources for Key Change 3A posted.

Resources for Key Change 3B

Patient-Centered Personal Health Record. The Care Transitions Program™.

www.caretransitions.org/documents/phr.pdf.

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Top 10 Reasons to Complete a PHR. Colorado Foundation for Medical Care. Available at: www.cfmc.org/caretransitions/files/toolkit/intervention/QIO%20Developed%20Tools/PA_10%20Reasons%20to%20schedule%20followup%20visit%20with%20your%20Physican.pdf

Sample forms for personal health record. Templates available at <http://office.microsoft.com/en-us/templates/my-health-record-TC006106559.aspx>

HHQI Success Story using a personal planner: HHQI success story—use of personal planner: Personal health planner helps Amedysis' patients reach goals:

http://www.homehealthquality.org/cms/getfile/461e04ba-9acd-4d9a-a9e1-34df5326459d/SuccessAmedysis_final.aspx?chset=29ff3bd5-44bc-4764-a767-4e9a648eea46

Resources for Key Change 3C

SBAR-A Home Health Package Quality Insights of Pennsylvania: http://champ-program.org/static/Entire_SBAR_Package.pdf

SBAR Toolkit: For more information on patient-centered health records, please refer to the following *SBAR Assessment and Competency Assessment*. Institute for Healthcare Improvement.

<http://www.ihl.org/knowledge/Pages/Tools/SBARTrainingScenariosandCompetencyAssessment.aspx>

Effective Teamwork as a Care Strategy: SBAR and other tools for improving communication between caregivers. A no-cost On Demand audio resource:

www.ihl.org/IHI/Programs/AudioAndWebPrograms/Effective+Teamwork+as+a+Care+Strategy+SBAR+and+Other+Tools+for+Improving+Communication+Between+Careg.htm

HHQI Success Story: Program gives Miami agency new take on care transitions:

http://www.homehealthquality.org/cms/getfile/e912f0f5-f49d-4159-8fb8-746997d8c85c/ThePalaceatHome_Success.aspx?chset=f3ffccf-d033-48b5-ad4d-67570633912d

SBAR for patients and families: www.empoweredpatientcoalition.org/publications/factsheets/157-sbar-communication-technique

Web tools and resources:

**Institute for Healthcare Improvement
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Rehospitalizations**

Spreading Changes. Institute for Healthcare Improvement. Available at <http://preview.ihi.org/knowledge/Pages/HowtoImprove/ScienceofImprovementSpreadingChanges.aspx>.

Oasis-C. Centers for Medicare and Medicaid Services. Available at www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/OASISC.html.

On Demand Presentation: An Introduction to the Model for Improvement. Institute for Healthcare Improvement. Available at <http://www.ihl.org/offerings/VirtualPrograms/OnDemand/ImprovementModelIntro/Pages/default.aspx>

Transforming Care at the Bedside (TCAB). Institute for Healthcare Improvement. Available at <http://preview.ihl.org/offerings/Initiatives/PastStrategicInitiatives/TCAB/Pages/default.aspx>.

Transforming Care at the Bedside How-to Guide: Engaging Front-Line Staff in Innovation and Quality Improvement. Institute for Healthcare Improvement. Available at <http://preview.ihl.org/offerings/Initiatives/PastStrategicInitiatives/TCAB/Pages/default.aspx>.

How to Improve. Institute for Healthcare Improvement. Available at <http://preview.ihl.org/knowledge/Pages/HowtoImprove/default.aspx>.

Quality Improvement 101-106. IHI Open School for Health Professions. Available at <http://preview.ihl.org/offerings/Pages/openschool.aspx>. The Institute for Healthcare Improvement offers online courses, through the IHI Open School for Health Professions, that are available free to medical students and residents and for a subscription fee for health care professionals.

Home Health Quality Improvement National Campaign. A free and short registration is required to access resources. Available at: <http://hhqi.wordpress.com/>

V. System of Measures

Data Reporting Guidelines

The following measures are recommended for use when actively working to improve transitions in care in the first 24-48 hours into home health care. It is recommended that the following outcome measures and the process measures pulled from OASIS and HHCAPHS data be used as a monthly dashboard to track and drive the improvement work. Process measures that need manual data collection can be used when focusing on those specific care processes to ensure effective and reliable new processes are developed and implemented.

Outcome Measures				
Measure	Description	Numerator	Denominator	Data Collection Strategy
Acute Care Hospitalizations (ACH) within 30 days of admission to home health care	Percent of acute care hospitalizations within 30 days of admission to home health care.	Number of home health episodes of care that indicate the patient had unscheduled admission to a hospital.	Number of home health episodes of care ending with a home health care agency discharge or a transfer to hospital during the reporting period. *Exceptions include other than those covered by <i>generic</i> or <i>measure-specific</i> exclusions. <i>Generic exclusions</i> include those patients not evaluated with the OASIS-C document: 1) pediatric home health patients, 2) home health patients receiving maternity care only, 3) home health clients receiving non-skilled care only or 4) home health patients for whom the payment source is neither Medicare nor Medicaid. <i>Measure Specific Exclusions</i> include: Home health episodes of care that end in patient death (Medicare 1a, 2011). Ref: Medicare.gov. (2011, 1a). About the Data: Process and Outcome Quality Measures: Rate Calculations accessed March, 2011 at: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/Downloads/HHQIOBQMManual.pdf	Option 1: Pull your agencies' OASIS data on ACHs as often as the data is reported by CMS and put into a run chart. This data is annualized (includes the last 12 months of data) and case mix adjusted. This makes this data less sensitive to showing improvement from the change efforts. Option 2: Track the number of ACHs at the agency level and track monthly. For the improvement work, there is no need to annualize or case mix adjust. This is the recommended option as it will be more sensitive to showing changes due to the improvement work. It is therefore more useful to the improvement team.

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<p>Optional Measure for when the improvement work focuses on a sub-population, e.g. heart failure: Acute Care Hospitalizations within 30 days of admission to home health care for a Specific Clinical Condition</p>	<p>Percent of acute care hospitalizations within 30 days of admission for home health care for Specific Clinical Condition.</p>	<p>Count of acute care hospitalizations within 30 days of hospital discharge with a specific clinical condition who were hospitalized for any cause within 30 days of discharge.</p>	<p>Number of home health episodes of care with a specific clinical condition ending with a home health care agency discharge or a transfer to hospital during the reporting period.</p>	<p>Track the number of ACHs with specific clinical conditions and patients with the specific clinical condition who had ACH at the agency level and track monthly.</p>
<p>HHCAHPS Question 17 Home health care providers explained things in a way that was easy to understand.</p>	<p>In the last 2 months of care, how often did home health providers from this agency explain things in a way that was easy to understand?</p>	<p>Number patients surveyed in the month who answered, "Always"</p>	<p>Number of surveys completed in the month with an answer for this question</p>	<p>Every month, pull your agencies HHCAHPS data for this question.</p>
<p>HHCAHPS Question 18 The home health care providers listened carefully to me.</p>	<p>In the last 2 months of care, how often did home health providers from this agency listen carefully to you?</p>	<p>Number patients surveyed in the month who answered, "Always"</p>	<p>Number of surveys completed in the month with an answer for this question</p>	<p>Every month, pull your agencies HHCAHPS data for this question.</p>

Process Measures				
Measure	Description	Numerator	Denominator	Data Collection Strategy
<p>Change 1. Meet the patient, family caregiver(s), and inpatient caregiver(s) in the hospital and review transition home plan.</p> <p>Choose one of the measures below.</p>				
Patients and family included in home needs prior to hospital discharge.	Percent of home health admissions where patients and family caregivers were included in assessing home needs prior to hospital discharge “Family” is defined by the patient and includes any individual(s) who provide support. “Family caregivers” is the phrase used to represent those family members who are directly involved in care of the patient outside hospital or other community institutions.	Number of patients admitted to home health care for whom the patient and family caregivers were included prior to hospital discharge.	Number of admissions in the sample	<ul style="list-style-type: none"> Option 1: Review charts of 10-20 patients discharged from the pilot team: 2-5 per week for 4 weeks a month. Option 2: Build data collection into discharge process – i.e., at discharge, review record to determine if patients and family caregivers were included in assessing home needs prior to hospital discharge. Enter data monthly.
Vital information is obtained and conveyed to home health care provider in the first 24 hours.		Number of patients admitted to home health care for whom vital information is obtained and conveyed to the home health care provider in the first 24 hours post-discharge.	Number of admissions in the sample	<ul style="list-style-type: none"> Option 1: Review charts of 10-20 patients discharged from the pilot team: 2-5 per week for 4 weeks a month. Option 2: Build data collection into discharge process – i.e., vital information was obtained within 24 hours. Enter data monthly.
<p>Change 2: Assess the patient, initiate plan of care and reinforce patient self-management at first post-discharge home health care visit.</p>				
Medication Management				
HHCAHPS Question 5 Did home health care staff ask to see all prescriptions and over-the-counter medicines?	When you started getting home health care from this agency, did someone from the agency ask to see all the prescription and over-the-counter medicines you were taking?	Number of patients in the survey for the month who answered “Always”.	Number of surveys in the month with an answer to this question.	Every month, pull your agencies HHCAHPS data for this question.

Process Measures				
Measure	Description	Numerator	Denominator	Data Collection Strategy
HHCAHPS Question 4 Did home health care staff talk with you about all the prescription and over-the-counter medicines you were taking?	When you started getting home health care from this agency, did someone from the agency talk with you about all the prescription and over-the-counter medicines you were taking?	Number of patients in the survey for the month who answered "Always".	Number of surveys in the month with an answer to this question.	Every month, pull your agencies HHCAHPS data for this question.
Engaging Patients and Family Caregivers in Self-Care				
1 self-care goal documented in the first 24-48 hours.	Percent of patients or family caregivers with at least 1 self-care goal documented in the first 24-48 hours.	Number of times at least one self-care goal is documented in the first 24 hours.	Number of patients or caregivers in the population of focus. The population of focus is the group of patients for whom tests of change are being run, or the change is being implemented or spread.	Review charts of 10-20 patients from the pilot team: 2-5 per week for 4 weeks a month. Enter data monthly.
OASIS M2010: Patient/caregiver high-risk drug education.	Percentage of home health episodes of care in which patients/caregivers were educated about high-risk medications at the start/resumption of care including instructions on how to monitor the effectiveness of drug therapy; how to recognize potential adverse side effects, and how and when to report problems.	Number of home health episodes of care during which patient/caregiver was instructed on how to monitor the effectiveness of drug therapy, how to recognize potential adverse effects, and how and when to report problems.	Number of home health episodes of care ending with a discharge or transfer to inpatient facility during the reporting period, other than those covered by generic or measure-specific exclusions. <u>Exclusions</u> Home health episodes for which the patient was not taking any drugs between start/resumption of care and discharge/transfer, OR an assessment for recertification or other follow-up was conducted between start/resumption of care and transfer or discharge, OR the patient	Sample 20 charts a month Consider segmenting patients based on a chronic condition like heart failure.

Process Measures				
Measure	Description	Numerator	Denominator	Data Collection Strategy
			died. http://www.medicare.gov/homehealthcompare/?AspxAutoDetectCookieSupport=1	
Teach Back on managing medications.	Percent of patients who can teach back 75% or more of what they are taught to manage their medications.	Number of documented sessions of nurses where the patient or family caregiver can teach back how to manage their medications.	Number of documented sessions where nurse is teaching about medication management	Option 1: Observe 5 teaching opportunities per week from the pilot care team for 4 weeks a month. Option 2: Nurse documents Teach Back response rate with every teaching session. Enter data monthly
Teach Back of content vital for a successful transition home.	Define three or four “vital few” elements for transition instructions, medications, and/or self-care needs, e.g., when to call the physician, dietary needs or when a follow-up appointment is scheduled. Then track: Percent of patients who can teach back 75% or more of what they are taught when content is broken into easy-to-learn segments.	Number of patients in your sample who were able to teach back 3 out of 3 or 3 out of 4 content elements by the time of transition	Number of patients in the sample where Teach Back is used	At last teaching opportunity (preferably at transition) document which of the 3 or 4 key elements of the transition instructions the patient is able to Teach Back
Change 3: Engage, coordinate, and communicate with the full clinical team.				
OASIS M2002 Potential Medication Issues Identified and Timely Physician Contact at Start of Episode.	Percentage of home health episodes of care in which the patient’s drug regimen at start/resumption of home health care was assessed to pose a risk of clinically significant adverse effects or drug reactions and whose physician was contacted within one calendar day.	Number of times the managing physician or clinician is contacted within 24 hours of start /resumption of episodes due to significant clinical finding or medication issue.	Number of episodes in which there was an assessment of clinically significant risk.	Sample 20 charts a month Consider segmenting patients based on a chronic condition like heart failure.
Follow-Up Appointment	Percentage of patients who can tell the home health staff in the first 48 hours of care, when their follow-up appointment with their managing clinician is.	Number of patients or family caregivers who were able to tell the home health staff when their follow-up appointment with their	Number of new home health care admissions.	Sample 20 charts a month Consider segmenting patients based on a chronic condition like heart failure.

Process Measures				
Measure	Description	Numerator	Denominator	Data Collection Strategy
		managing clinician is, in the first 48 hours.		
Managing Clinician Identified	Percent of patients who can identify their managing clinician.	Number of patients or family caregivers who were able to tell the home health staff who their managing clinician is.	Number of new home health care admissions.	Sample 20 charts a month Consider segmenting patients based on a chronic condition like heart failure.

VI. How-to Guide Resources

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Summary of Typical Failures Observed in the Transition from Hospital to Home Health Care

Key Change 1: Meet the patient, family caregiver(s), and inpatient caregiver(s) in the hospital and review transition home plan.

Typical failures associated the transition to home health care include the following: include:

- Inadequate communication with physicians and other caregivers;
- Inadequate problem detection before or on admission to home health care;
- Inadequate assessment of functional and cognitive abilities and ability to self-manage;
- Inadequate care plan development;
- Not addressing palliative care needs;
- Referral to home health care made too late to be proactive in the transition; and
- Lack of implemented standards and specific care delivery processes within agencies and between hospitals, primary care providers, specialists, and others post-discharge.

Key Change 2: Assess the patient, initiate plan of care, and reinforce patient self-management at first post-discharge home health care visit.

Typical failures associated with assessing, initiating the plan of care, and reinforcing patient self-management at the first post-discharge home health care visit include:

- Inadequate completion of comprehensive assessment, problem identification, and care plan development;
- Lack of timely and thorough medication reconciliation and proactive medication management;
- Patient and family caregiver unable to overcome challenges of self-managing medications. This may include knowledge deficits, cognitive and functional challenges, financial constraints, conflicting care goals between patient and clinicians, lack of communication with managing clinician, or ineffective problem solving.

- Focus on completing the OASIS assessment and documentation may be a barrier to focusing on the immediate needs of the patient and their caregivers. A more important focus must be the on the immediate clinical and personal goals of the patient to achieve and/or maintain clinical stability.


Key Change 3: Engage, coordinate, and communicate with the full clinical team.

Typical failures associated with coordinating care with primary care and other providers in the community include the following:

- Lack of a shared understanding of the patient's current status, situation, and comprehensive care plan;
- Lack of a clear, designated clinician to coordinate needed care and care decisions;
- When primary care physician is designated as the lead clinician, often they are not current on hospitalization, discharge instructions, and current status;
- Financial and other patient constraints are a barrier to receiving needed services;
- Inadequate care plan development and implementation due to incomplete understanding of the whole patient context;
- Too many "care managers" calling post-discharge, which can be confusing and/or overwhelming to the patient and family caregivers;
- Confusion for patient when given different approaches and or instructions; and
- Lack of "health literacy" regarding navigating the health care system to have self-care goals met.

Partnering with Patients and Families to Accelerate Improvement Readiness Assessment

Name of Organization _____

			
Area	Current Experience: Make a mark (an X, a circle, or anything that is easy to read) in the box that best describes your team or organization's experience.		
Data transparency	We have not discussed the possibility of sharing performance data with patients and family caregivers.	Our team is comfortable with sharing improvement data with patients and families related to the current improvement project.	This organization has experience with sharing performance data with patients and families.
Flexibility around the aims and specific changes of the improvement project	We have limited ability to refine the project's aims or planned changes.	We have some flexibility to refine the project's aims and the planned changes.	We are open to changing both the aims and specific changes that we test based on patient and family team members' perspectives.
Underlying fears and concerns	We have not discussed our concerns about involving patient and families on improvement teams.	We have identified several concerns related to involving patients and families on improvement teams, but have no plan for how to address or manage them.	We have a plan to manage and/or mitigate issues that may arise due to patient and family caregiver involvement on our team.
Perceived value and purpose of patient and family involvement	There is no clear agreement that patient and family involvement on improvement teams is necessary to achieve our current improvement aim.	A few of us believe patient and family involvement would be beneficial to our improvement work, but there is not universal consensus.	There is clear recognition that patient and family involvement is critical to achieving our current improvement aim.

Senior leadership support for patient and family involvement	Senior leadership do not consider patient and family involvement a top priority.	Senior leaders are aware of and communicate support for patient and family involvement in our team.	Senior leaders consider our participation in this program as a pilot for organizational spread.
Experience with patient and family involvement	Beyond patient satisfaction surveys or focus groups, our organization does not have a formal method for patient and family feedback.	We have an active patient and family advisory panel.	Patient and families are members of standing committees and make decisions at the program and policy level.
Collaboration and teamwork	Staff in this organization occasionally work in multidisciplinary teams to provide care.	Staff in this organization work effectively across disciplines to provide care to patients.	Patients and families are included as valued members of the care team in this organization.
<ol style="list-style-type: none"> 1. What supports moving in this direction? 2. What are your current challenges? 3. How confident are you on successfully involving patients and families on your team (1-10 scale)? 			

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Diagnostic Worksheet: In-depth Review of Patients Who Had an Acute Care Hospitalization within 30 days of a Hospital Discharge

Part 1: Chart Review

Conduct chart reviews of the last five patients with an acute care hospitalization within 30 days of a hospital discharge. Reviewers should be nurses experienced in the clinical setting and in chart review for quality and safety. Reviewers should not look to assign blame, but rather to discover opportunities to improve the care of patients. The intent is to learn how to prevent failures once thought impossible to prevent.

Question	Patient #1	Patient #2	Patient #3	Patient #4	Patient #5					
Number of days between the last discharge and this acute care hospitalization date?	_____ days	_____ days	_____ days	_____ days	_____ days					
Was the follow-up physician visit scheduled prior to discharge based on risk assessment of patient?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, was the patient able to attend the office visit?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Were there any urgent clinic/ED visits before this acute care hospitalization?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Functional status of the patient on admission?	Comments:		Comments:		Comments:		Comments:		Comments:	
Was a clear discharge plan documented?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Was evidence of "Teach Back" documented?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
List any documented reason/s for acute care hospitalization.	Comments:		Comments:		Comments:		Comments:		Comments:	
Did any social conditions (transportation, lack of money for medication, lack of housing) contribute to the readmission?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Diagnostic Worksheet: In-depth Review of Patients Who Were Readmitted
Part 1: Reflective Summary of Chart Review Findings

What did you learn?

What themes emerged?

What, if anything, surprised you?

What new questions do you have?

What are you curious about?

What do you think you should do next?

What assumptions about readmissions that you held previously are now challenged?

Diagnostic Interview Worksheet: In-depth Review of Patients Who had an Acute Hospitalization within 30 days of Hospital Discharge

Part 2: Interviews with Patients, Family Members, and Care Team Members in the Community

If possible, conduct the interviews on the same patients from the chart review. Use a separate worksheet for each interview.

Ask Patients and Family Members:

How do you think you became sick enough to go back to the hospital?

Did you see your doctor or the doctor's nurse in the office before you came back to the hospital?

Yes

If yes, which doctor (PCP or specialist) did you see?

No

If no, why not?

Describe any difficulties you had to get an appointment or getting to that office visit.

Has anything gotten in the way of your taking your medicines?

How do you take your medicines and set up your pills each day?

Describe your typical meals since you got home.

Ask Care Team Members in the Community:

What do you think caused this patient to be readmitted?

After talking to the care team members about why they think the patient was readmitted, write a brief story about the patient's circumstances that contributed to the readmission.

Diagnostic Worksheet: In-depth Review of Patients
Part 2: Summary of Interview Findings

What did you learn?

What themes emerged?

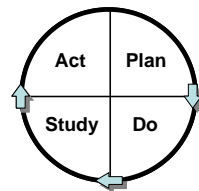
What, if anything, surprised you?

What new questions do you have?

What are you curious about?

What do you think you should do next?

What assumptions about readmissions that you held previously are now challenged?



PDSA Worksheet **DATE** _____

Change or idea evaluated: _____

Objective for this PDSA Cycle: _____

What question(s) do we want to answer on this PDSA cycle?

Plan:

Plan to answer questions (test the change or evaluate the idea): Who, What, When, Where

Plan for collection of data needed to answer questions: Who, What, When, Where

Predictions (For each question listed, what will happen if plan is carried out? Discuss theories.)

Do:

Carry out the Plan; document problems and unexpected observations; collect data and begin analysis.

Study:

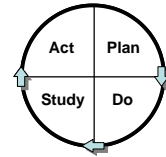
Complete analysis of data: What were the answers to the questions in the plan (compare to predictions)? Summarize what was learned.

Act:

What changes are to be made? Plan for the next cycle.

Sample PDSA Worksheet

DATE 8/10/2010



Change or idea evaluated: **Use Heart Failure Zone handout to improve patient learning**

Objective for this PDSA Cycle: **Improve patient understanding of HF self-care by using the zone worksheet, improve nurse teaching skills.**

What question(s) do we want to answer on this PDSA cycle?

If we use health literacy principles and Teach Back, will (1) our nurses be comfortable using the Teach Back technique, and (2) our patients have a better understanding of their care?

Plan:

Plan to answer questions (test the change or evaluate the idea): Who, What, When, Where

Emily will talk to Jane (a nurse we know is interested in this project) and ask her to try the change
A HF patient with sufficient cognitive ability (Jane will decide) will be identified on Aug 10.
Jane will use HF zone handout example from St. Luke's as teaching tool.
Jane will ask four St. Luke's sample questions:

- What is the name of your water pill?
- What weight gain should you report to your doctor?
- What foods should you avoid?
- Do you know what symptoms to report to your doctor?

Plan for collection of data needed to answer questions: Who, What, When, Where

Jane will write down which answers patients were able to Teach Back successfully and which they had trouble with and come to the next team meeting on the 11th and report on her experience.

Predictions (for each question listed, what will happen if plan is carried out? Discuss theories)

- 1) Nurse may have trouble remembering not to say "do you understand"
But will like the change, be able to use the technique, and
- 2) The patient will be able to Teach Back (will choose someone with sufficient cognitive Ability for the test).

Do:

Carry out the Plan; document problems and unexpected observations; collect data and begin analysis.

There wasn't an appropriate patient on the 10th, but there was on the 11, Jane reported to the team the next day that the patient was able to Teach Back three of the four questions – had trouble remembering weight gain to report to doctor. Jane reported that she really liked the new teaching style and wanted to practice it with other patients.

Study:

Complete analysis of data: What were the answers to the questions in the plan (compare to predictions)? Summarize what was learned.

Jane reported that she did say “do you understand” a couple of times and then would catch herself, but she had explained the test in advance to the patient and they liked the idea, too.

Act:

What changes are to be made? Plan for the next cycle

Find one or more patients willing to work with Jane on redesigning patient materials and continue to test the Teach Back technique – Jane will try on more patients and try to recruit another nurse to test with her. Will report back at next meeting. Jane will create a paper tool that will help her keep track of which items the patients Teach Back so that she can continue to collect the data.

Observation or Self Audit Guide: Current Processes for Patient Teaching

Observe or conduct self audit of patient teaching as it exists today. Observe or self audit three teaching sessions (done in the usual way) conducted by nurses. Reflect upon what you discovered went well and where there are opportunities for improvement.

What do you predict you will observe?

Did you or the care team member(s)...	Patient # 1		Patient # 2		Patient # 3	
	Yes	No	Yes	No	Yes	No
Use simple language and terminology?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use patient-friendly teaching materials?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Request the patient teach back what was understood in patient's own words?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use non-shaming language in the Teach Back request?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Display a warm attitude?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use a friendly tone of voice?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Display comfortable body language?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ask "Do you understand?" or "Do you have any questions? (THEY or YOU SHOULD NOT)"	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use teaching materials in patient's language of choice?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Reflections after findings are completed (to be shared with the entire team):

What did you learn?

Observation or Self Audit Guide: Current Processes for Patient Teaching

How did your findings compare to the predictions?

What, if anything, surprised you?

What new questions do you have? What are you curious about?

What assumptions about patient education that you held previously are now challenged?

As a result of the findings from these observations, what do you plan to test?

- 1.
- 2.
- 3.
- 4.
- 5.

Spread Tracker Template

A=Planning B=Start C=In Progress D=Fully Implemented

	Pilot Team 1	Pilot Team 2	Spread Team 1	Spread Team 2	Spread Team 3
Change 1	D	C	A	B	C
Change 2	D	C	B	B	C
Change 3	D	C	A	A	C
Change 4	D	C	B	A	B
Change 5	C	D	C	C	A
Change 6	C	D	C	C	A
Change 7	C	D	A	C	A
Change 8	C	D	A	C	A

**Institute for Healthcare Improvement
How-to Guide: Improving Transitions from the Hospital to Home Health Care to Reduce Avoidable
Rehospitalizations**

Spread Tracker Template-EXAMPLE

A=Planning B=Start C=In Progress D=Fully Implemented

	Nurse Team 1	Home Health Aide Team 2	Spread Team 1
Change 1-Thorough medication reconciliation at 1 st visit.	D	n/a	A
Change 2- Use Teach Back for medications and self-care	D	C	B
Change 3-Assure timely follow-up with PCP	D	C	A
Change 4-Document Teach Back in medical record to convey to others on the clinical team.	D	C	B
Change 5- Meet pt in hospital	C	n/a	C
Change 6-Identify key learners and caregivers	C	D	C

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