Home Health In Action: Successful Implementation of Home Health Quality Improvement (HHQI) Tools and Resources

Objectives

At the conclusion of this session, the participant will be able to:

• Design evidence-based change strategies to improve hospitalization and oral medication rates utilizing the HHQI tools and resources

• Interpret their agency’s HHQI Data Reports and focus quality improvement in identified areas of need

• Identify and describe similarities and differences between QI programs
Riverside Action
In Reducing Acute Care Readmissions

At Riverside our ACH Scores are evaluated monthly. We do this through the use of a benchmarking program. It provides real time data so that adverse outcomes can be assessed and interventions can be communicated and implemented quickly.
Collaboration with ACF

Home Health collaborated with the Hospital to reduce readmissions. The realization of penalties for ACH readmissions was a reality for October 1. Penalties assessed as much as 1% of Medicare reimbursement.

Patient Centered Care Projects
- CHF Readmission Project
- COPD
- Diabetes
- Venous Thrombosis/Embolus
- Delirium in the Elderly

Patient Centered Care Projects
- CHF Readmission Project
- COPD
- Diabetes
- Venous Thrombosis/Embolus
- Delirium in the Elderly

Measures Initiated

We found that not one single method of BPIP produced the results but a combination depending on the population we were serving. The Emergency Care Plan was incorporated into our orientation booklet and every patient has that reviewed on the first visit.

Frontloading Visits
- Telehealth
- Chronic Disease Management Training for all Nursing Staff
- 911/ GYR Form
- Medication Reconciliation
- Case Management Model of Care
• Case Management Model
  ◦ Discussion of Start of Care- Hospital Risk Assessment
  ◦ Issues with CG/Family
  ◦ Medication Reconciliation
  ◦ Fall Risk
  ◦ Braden Scale

Measures Initiated

We found that the recommendation found in the BPIP of using the Interdisciplinary Group setting produced a better look at Readmission Risk.

• Care Management
  ◦ Collaborative endeavors to identify risk on admission
  ◦ Transition Coordinators available to identify needs and risks
  ◦ Central Intake approach as another level to identify challenges/opportunities

Hospital Care Management

Incredible opportunity to collaborate and assess readmission risk.
IPOC and LIPOC

Interdisciplinary Plan's of care are a part of our target for Patient-Centered, Interdisciplinary Team-Based Health Care. They have been extended to Longitudinal Interdisciplinary Plans of Care that encompass the entire continuum of care in our Health System.

• Community Partnerships
  ◦ Area Agency on Aging program-
  ◦ Virginia Partnership for Patient Care Transitions
• Pharmacies

Community Help

The Area Agencies on Aging in our area partnered with us not only for the home health patient but those who are discharged from our hospitals who are not eligible for home care.
• Telehealth
  ◦ Daily Communication
  ◦ High Touch
  ◦ Phone Calls
  ◦ Rearranging Visits to fit the need of the patient

  **Measures Initiated**

  Telehealth provided an avenue to touch the patient every day.

• Monitor Home Health
• Reviewing Adverse Events
• Using Benchmark Program
  ◦ Monitor monthly readmits
  ◦ Zero in on Clinicians who may be more apt to send patients back for readmission

  **Monitoring our Progress**

  Monitoring gave us an opportunity to remediate clinicians in a more timely fashion to impact our outcomes.
Hospital and Health System Collaboration

Being Hospital-Based has given us a wonderful opportunity and needed help in reducing ACH. We now have many partnerships established and a great collaborative work for improving patient outcomes.

Focus is on Care Transitions
- Robust Chronic Disease Management Program
- Health Coaches
- Certified Diabetes Educator
- Certified Wound-Ostomy Certified Nurse
- SBAR
- Teach Back

Our Mission Right Now

The Riverside Home Health Agencies are a part of a health system wide initiative to reduce costly hospitalizations.
Staff Participation and Collaboration

The HHQI Best Practice Campaign encourages communication about our Quality Initiatives. We believe that is very important to our success. At the present time, our scorecard includes ACH, Oral Medication Management, and Ambulation as the three projects. Senior Leadership in our organization looks at that Quarterly.

RHS Culture
- Every staff person is evaluated annually on their participation in the Quality Program
- RHS has a scorecard and ACH is on that for our Agencies

VHQC and HHQI Initiative

Riverside Agencies have found the BPIP to be valuable tools for reducing hospital readmissions. The tools are very comprehensive and evidence-based. Don’t reinvent the wheel.
LivinRite Home Health Program Goals

- LivinRite home health agency and hospitals working closely to reduce the hospital’s risk of patient re-admissions.
- Two of the most commons reasons for hospital re-admissions are medication errors and failure to see a physician.

- Both could be reduced if patients were supervised through home care visits after discharge.
60% of re-admissions are in the first 7 days

By revamping discharge policies in collaboration with the “Rite” HH company, hospitals can more fully utilize collaborative community relationships

Develop ‘grass root’ partnerships with SNFs, ALFs and Hospice agencies within the local area(s)

LivinRite created an “ER on wheels” concept

LIVINRITE HOME HEALTH SERVICES
READMISSION REDUCTION PROGRAM
EXCELLENCE IN TRANSITIONS
**ACH PROGRESS?**

Introduced in 2011, a national quality improvement initiative to reduce unnecessary readmissions for cardiovascular patients.

The goal was to reduce re-admission rates among patients discharged with heart failure or acute myocardial infarction by 20% by Dec 2012.

*LivinRite Achieved 21%. This has been maintained.*

- **LivinRite 2013**: 26%
- **LivinRite 2012**: 26%
- **LivinRite 2011**: 33%
- **Virginia Average**: 26%
- **National Average**: 27%

---

**How often the home health team began their patients’ care in a timely manner**

SOC with 48 hours

- **LivinRite**: 99%
- **Virginia Average**: 91%
- **National Average**: 91%

This information comes from the Home Health Outcome and Assessment Information Set (OASIS) C during the time period *April 2012 - March 2013*
How often the home health team taught patients (or their family caregivers) about their drugs.

Medication Reconciliation @ Each Visit

- LivinRite: 98%
- Virginia Average: 92%
- National Average: 92%

This information comes from the Home Health Outcome and Assessment Information Set (OASIS) C during the time period April 2012 - March 2013.
Following guidelines for management of comprehensive patient education “disease management programs.” These guidelines are established in conjunction with hospital based coalitions, i.e. Prince William and LEAP initiative.

LEARNING from our community to apply EXPERTISE in an ACTION-oriented PARTNERSHIP)

LivinRite Home Health services utilizing VHQC resources to gain success
www.vhqc.org/quality-CareTransitions.asp

Interact Tools
- SBAR (Situation Background Assessment Recommendation) Heart Failure (HF)
- 30-day Readmission Patient Interview
- Best Practice Intervention Packages (BPIP)
- Transitional Care Model (TCM)
Maximizing hospital to home transition, with lower risk.

- Providing 12 hr RN shift coverage (8am-9.30pm) / 7 days per week to ‘front load’ Hospital & SNF discharges.
- Ensures ability to provide evening & weekend admissions.
- 99% of Cases opened within 48 hrs of discharge (1% with MD order)
- SOC nurses are ICU, CCU, ER & ‘step down unit’ trained.
- Inter-disciplinary team, MD, SN, PT, OT, RD, HCA, MSW.

- Mobile in-home chest X-rays, EKG, Doppler, PS02 & vitals monitoring.
- Strong infusion & medication management focus
- In-office supervisors to provide follow up patient calls to strengthen care provision. Includes daily Tele-medicine calls from in-office RN.
- RDs & MSWs on staff for maximum patient education.
Tele-Medicine -> Daily RN calls
Tele-Health -> Biometrics
In-home X-ray, EKG, ABI
IV Diuretics In-home
Home Health In Action: Successful Implementation of Home Health Quality Improvement (HHQI) Tools and Resources

Cindy Sun, MSN, RN
HHQI Lead Cardiovascular RN Project Coordinator

Home Health Quality Improvement

- Goal: Improve the quality of care home health patients receive
- Special Project funded by Centers for Medicare & Medicaid Services
- Evidence-based practice
- Free tools, resources, & networking

Focusing on quality of home health care measured by:

- Reduction of avoidable ACH
- Improvement in oral medication management
- Improvement of immunization rates
- Improvement of cardiovascular health

Continuing HH focus, but all care settings and patients encouraged to participate

Introducing Underserved Population Network (UP)

More than 10,000 participants

Readmissions

- Almost one-fifth of the Medicare beneficiaries who had been discharged from an acute care facility were rehospitalized within 30 days, and 34.0% were rehospitalized within 90 days (Jencks, Williams, and Coleman, 2009)
- Nearly 90% of readmissions are unplanned and potentially preventable, which translates into $17 billion or nearly 20% of Medicare’s hospital payments (Hernandez et al., 2010)
ACH Essential Interventions

• ACH risk assessment
• Emergency Care Planning
• Front loading based on risk assessment
• Easy access to a nurse (24/7 call, office nurse)
• Phone monitoring and/or telehealth
• Patient self-management programs

www.HomeHealthQuality.org
Welcome to the HHQI National Campaign

Since 2007, the Home Health Quality Improvement (HHQI) National Campaign has been dedicated to improving the quality of care provided to America’s home health patients. Whether you are a home health practitioner directly providing patient care, or an allied partner with a stake in improving the quality of care that home health patients receive, we are here to help you with evidence-based tools, timely data reports and a wealth of ongoing educational opportunities. All of our resources are absolutely free and available to everyone. Please explore our site to learn more about the initiative of the Centers for Medicare & Medicaid Services (CMS). Working together, we can make a real difference in patients’ health care and ultimately, their quality of life.

Campaign Resources Discover our free resources to help improve your patients’ outcomes, including Best Practice Intervention Packages (BPIPs), Data Access Reports, Webinars and the unique HHQI Community of engaged stakeholders united to improve.

Quick Links

Best Practice Intervention Packages (BPIPs)

Cardiovascular Health Part 1
The Cardiovascular Health Part 1 BPIP focuses on the evidence-based practices for using appropriate aspirin or antplatelet therapy with patients who need it, as well as assessments and strategies to assist patients with controlling their blood pressure to prevent heart attacks and strokes.

Immunization and Infection Prevention
The Immunization and Infection Prevention BPIP is designed to guide leaders to ensure agency immunization and infection prevention programs are evidence-based and focus on patient and employee safety. This BPIP will assist leaders to develop strategies to improve immunizations for both patients and employees. Immunization and infection prevention tools and Web links on current guidance and standards are included in the BPIP.

Focused Medication Management
Focused BPIPs are succinct intervention packages designed to support or enhance best practices. The patient tool in the Focused BPIP on Medication Management was designed for the patient (recently, in Improve Health Literacy).

Underserved Populations (UP)
The UP BPIP provides agencies foundational information on significant topics that are affecting healthcare quality and costs across all settings, including home health. The main topics in the package are related to the following:

- Underserved
- Dual Eligible
- Health Disparities
- Small Non-Profit Home Health Agencies

The issues and barriers associated with these topics are enormous and affect day-to-day care for our patients. The UP BPIP is intended to begin a dialogue and awareness at some agencies, while other agencies will be adding improvement efforts to overcome the barriers for all patients to receive equitable healthcare.
Cross Settings I

Main Package Resources
The Full Contents of the BPIP are below, as well as the broken-out discipline sections.

- Full Contents BPIP
  - Nursing Track
  - Therapy Track
  - Medical Social Worker Track
  - Home Health Aide Track
  - Focus on Care Transitions and Coaching
  - Success Stories

Multimedia
- Cross Settings I Video

Associated Resources
The following tools and resources complement the Cross Settings I BPIP.
- Case Studies
- Case Conference Worksheet
- Coaching Forms - Developed by Eddy Valding Nurse Association
  - Full PDF
- Discharge Criteria - Developed by PPRO - New York’s Quality Improvement Organization
  - Discharge Flyer 1
  - Discharge Flyer 2
- I-SBAR - Developed by Glineda Health Care
- Phone Monitoring Assessment Guides

BPIP Schedule

<table>
<thead>
<tr>
<th>Release Date</th>
<th>Focused BPIP</th>
<th>Primary BPIP</th>
<th>LAN Creation</th>
</tr>
</thead>
<tbody>
<tr>
<td>November 1, 2012</td>
<td>Patient Self-Management</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>February 1, 2013</td>
<td>Underserved Populations (UP)</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>April 2, 2013</td>
<td>Medication Management</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>June 3, 2013</td>
<td>Immunization &amp; Infection Prevention</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>August 1, 2013</td>
<td>Cardiovascular Health Part 1: Aspirin as appropriate &amp; Blood pressure control</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>November 1, 2013</td>
<td>Cardiovascular Health Part 2: Cholesterol management &amp; Smoking cessation</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>February 3, 2014</td>
<td>Disease Management: Part 1</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>April 1, 2014</td>
<td>Disease Management: Part 2</td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>
Educational Resources: ACH

Reducing Hospitalization in Home Health Patients with CHF

ACH Risk Assessment Screening Tool

1. Is the patient 65 or older? Y N
2. Does the patient have moderate to severe functional decline? Y N
3. Does the patient have a history of mental/behavioral illness? Y N
4. Does the patient have 3 or more diagnoses, co-existing health conditions? Y N
5. Is the patient taking 3 or more prescribed medications? Y N
6. Has the patient had one or more hospitalizations within the past 12 months? Y N
7. Has the patient experienced an emergency room visit or hospitalization in the past 90 days? Y N
8. Does the patient have an inappropriate support system? Y N
9. Does the patient have a ‘fair’ or ‘poor’ self-reporting of health? Y N
10. Does the patient have a documented history of non-adherence to the therapeutic regimen (i.e., drug therapy, diet, etc.) Y N

Calculate the number of ‘yes’ responses. A patient with 2 or more of these items is subjective at risk of hospitalization. These patients should be considered for home health visits and more intense and frequent monitoring.

Patient’s name ___________________________ Date __ / __ / __________
Nurse’s signature __________________________

Patient Hospitalization Risk Form
Educational Resources: ACH

- SBAR
- Physician Communication Tool
- Specific for High Risk Patients

Educational Resources - HF
Educational Resources

Staff Education Tool: Heart Failure Phone Monitoring Assessment Guide

- Are patient symptoms getting worse?
- Have any new symptoms occurred?
- Are patient symptoms resolving?
- Are patient symptoms improving?
- Are patient symptoms staying the same?
- Are patient symptoms getting better?
- Are patient symptoms getting worse?
- Are patient symptoms staying the same?
- Are patient symptoms improving?
- Are patient symptoms getting better?

- Does the patient have access to medications?
- Does the patient have the correct dose of medications?
- Does the patient have the correct route of medications?
- Does the patient have the correct timing of medications?
- Does the patient have the correct formulation of medications?
- Does the patient have the correct frequency of medications?
- Does the patient have the correct dosage of medications?
- Does the patient have the correct indication of medications?
- Does the patient have the correct action of medications?
- Does the patient have the correct side effects of medications?

- Are patient symptoms getting worst?
- Have any new symptoms occurred?
- Are patient symptoms resolving?
- Are patient symptoms improving?
- Are patient symptoms staying the same?
- Are patient symptoms getting better?
- Are patient symptoms getting worse?
- Are patient symptoms staying the same?
- Are patient symptoms improving?
- Are patient symptoms getting better?

- Does the patient have access to medications?
- Does the patient have the correct dose of medications?
- Does the patient have the correct route of medications?
- Does the patient have the correct timing of medications?
- Does the patient have the correct formulation of medications?
- Does the patient have the correct frequency of medications?
- Does the patient have the correct dosage of medications?
- Does the patient have the correct indication of medications?
- Does the patient have the correct action of medications?
- Does the patient have the correct side effects of medications?

- Are patient symptoms getting worst?
- Have any new symptoms occurred?
- Are patient symptoms resolving?
- Are patient symptoms improving?
- Are patient symptoms staying the same?
- Are patient symptoms getting better?
- Are patient symptoms getting worse?
- Are patient symptoms staying the same?
- Are patient symptoms improving?
- Are patient symptoms getting better?

- Does the patient have access to medications?
- Does the patient have the correct dose of medications?
- Does the patient have the correct route of medications?
- Does the patient have the correct timing of medications?
- Does the patient have the correct formulation of medications?
- Does the patient have the correct frequency of medications?
- Does the patient have the correct dosage of medications?
- Does the patient have the correct indication of medications?
- Does the patient have the correct action of medications?
- Does the patient have the correct side effects of medications?

- Are patient symptoms getting worst?
- Have any new symptoms occurred?
- Are patient symptoms resolving?
- Are patient symptoms improving?
- Are patient symptoms staying the same?
- Are patient symptoms getting better?
- Are patient symptoms getting worse?
- Are patient symptoms staying the same?
- Are patient symptoms improving?
- Are patient symptoms getting better?

- Does the patient have access to medications?
- Does the patient have the correct dose of medications?
- Does the patient have the correct route of medications?
- Does the patient have the correct timing of medications?
- Does the patient have the correct formulation of medications?
- Does the patient have the correct frequency of medications?
- Does the patient have the correct dosage of medications?
- Does the patient have the correct indication of medications?
- Does the patient have the correct action of medications?
- Does the patient have the correct side effects of medications?

- Are patient symptoms getting worst?
- Have any new symptoms occurred?
- Are patient symptoms resolving?
- Are patient symptoms improving?
- Are patient symptoms staying the same?
- Are patient symptoms getting better?
- Are patient symptoms getting worse?
- Are patient symptoms staying the same?
- Are patient symptoms improving?
- Are patient symptoms getting better?

- Does the patient have access to medications?
- Does the patient have the correct dose of medications?
- Does the patient have the correct route of medications?
- Does the patient have the correct timing of medications?
- Does the patient have the correct formulation of medications?
- Does the patient have the correct frequency of medications?
- Does the patient have the correct dosage of medications?
- Does the patient have the correct indication of medications?
- Does the patient have the correct action of medications?
- Does the patient have the correct side effects of medications?
Educational Resources: Warfarin

YOUR BLOOD THINNER AND YOU

Informational brochure provided by Dominican Sisters Family Health Service, Inc.

Educational Resources: Warfarin

(PREVENTION INTERACTION NOTIFICATION

A regularly prescribed medication can cause a serious or life-threatening problem called a patient interaction.

To:

By:

The untold story of warfarin is a crime committed by a small group of medical professionals who have refused to tell the truth about the drug's potential for serious or life-threatening problems. This brochure is designed to help you understand the full extent of the problem and to encourage you to seek alternative treatments.

Additional Resources:

Your doctor: Dr. John Smith
Your pharmacist: Store 123
Patient Interaction Network: 1-800-INTERACT

Birthdate: Date: 

This brochure is designed to help you understand the full extent of the problem and to encourage you to seek alternative treatments.

1. Preventing warfarin interactions:

- Avoid taking warfarin with aspirin or blood-thinning medications.
- Check with your doctor before taking any new medications.
- Report any symptoms of warfarin interaction to your doctor immediately.

2. Using alternative treatments:

- Consider natural remedies such as garlic or ginger.
- Consult with a professional to explore alternative treatments.

3. Monitoring your blood thinner:

- Keep regular blood tests and monitor your medication levels.
- Report any changes in your blood thinner levels to your doctor.

4. Additional resources:

- Patient Interaction Network: 1-800-INTERACT
- Your doctor: Dr. John Smith

This brochure is designed to help you understand the full extent of the problem and to encourage you to seek alternative treatments.
Educational Resources: Mobility

Timed Up and Go
9:15 AM
This video shows how to perform the Timed Up and Go Test. This test helps healthcare professionals assess function and help plan for interventions to restore function.

Perspectives on Home Health FlashFly
9:50 AM
More adult nurses and healthcare professionals see value in home health care, and the reality is that they care in hospitals.

The Role of the Home Health Experience FlashFly
10:05 AM
This video shows the differences and similarities between home health care in hospitals and in the community. The video provides an overview of the role of the home health nurse in hospitals.

Evaluation of Nurses in the Hospital Environment
10:15 AM
In this video, nurses present at St. John Medical Center discuss the importance of evaluation in the hospital environment.

St. John Medical Center
Medical Excellence - Compassionate Care

Educational Resources: Mobility
My Action Plan

1. Goal: Choose 1 thing to do today... go to church.

2. Describe How: Need a ride to church 5+ blocks away
   Where: Work with social worker on ride
   Why: Social worker visit this
   How: Call social worker

3. Barriers: Sugar is up sometimes - not feeling good
   How to overcome barriers: cut sweets, breads

4. Am I confident that I can do this? See chart on the other ...
    (chart with confidence levels)

5. Am I confident that I can do this? See chart on the other ...
    (chart with confidence levels)

6. Follow-up: Get carbs info for Social Worker
   Sugar 2x/day
   HHQI 1 month book

[Chart with confidence levels]
Teach Back

“Teach Back” Nurse Practice Exercise

Pick a Medication

1. Use a medication you are comfortable with that can be given to a variety of patients.
2. Ask the patient to repeat back the dose, route, and frequency.
3. Ask the patient to explain the purpose of the medication.
4. Ask the patient to identify the side effects of the medication.
5. Ask the patient to report any allergies to the medication.
6. Ask the patient to identify the expected outcome of the medication.
7. Ask the patient to report any questions or concerns they have about the medication.

Table: Medication Non-Adherence - A Staff Education Tool

<table>
<thead>
<tr>
<th>Task</th>
<th>Task Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teach</td>
<td>Instruct the patient to take the medication as prescribed.</td>
</tr>
<tr>
<td>Teach</td>
<td>Instruct the patient to report any side effects immediately.</td>
</tr>
<tr>
<td>Teach</td>
<td>Instruct the patient to return the medication if they cannot complete the regimen.</td>
</tr>
<tr>
<td>Teach</td>
<td>Instruct the patient to identify any difficulties with the medication.</td>
</tr>
</tbody>
</table>

Assessment Questions

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you understand the purpose of the medication?</td>
<td></td>
</tr>
<tr>
<td>Do you understand the dosage and frequency?</td>
<td></td>
</tr>
<tr>
<td>Do you have any questions or concerns about the medication?</td>
<td></td>
</tr>
</tbody>
</table>

References

Cardiovascular Health
November 2nd 4:00 pm

Aspirin as appropriate
Blood pressure control
Cholesterol management
Smoking cessation

Welcome to the HHQI National Campaign

Since 2007, the Home Health Quality Improvement (HHQI) National Campaign has been dedicated to improving the quality of care provided to America's home health patients. Whether you are a home health practitioner directly providing patient care, or an allied partner with a stake in improving the quality of care that home health patients receive, we are here to help you with evidence-based tools, timely data reports and a wealth of ongoing educational opportunities. All of our resources are absolutely free and available to everyone. Please explore our site to learn more about the initiative of the Centers for Healthcare & Medical Services (CHS). Working together, we can make a real difference in patients' health care and ultimately, their quality of life.

Campaign Resources: Discover our free resources to help improve your patients' outcomes, including Best Practice Intervention Packages (BPIPs), Data Access Reports, Webinars and the unique HHQI Community of engaged stakeholders united to improve
Acute Care Hospitalization Monthly Report

Name: ACH Sample Agency
Medicare#: 999999
Location: Any City, PA
Report Date: 12/19/2012

Monthly Hospitalizations vs. Transfers/Discharges
Number of Monthly Hospitalizations out of Total Transfers/Discharges (Excludes planned hospitalizations)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitalizations</td>
<td>250</td>
<td>246</td>
<td>232</td>
<td>233</td>
<td>259</td>
<td>259</td>
<td>254</td>
<td>255</td>
<td>230</td>
<td>233</td>
<td>28</td>
<td>252</td>
</tr>
<tr>
<td>Transfers/Discharges</td>
<td>932</td>
<td>943</td>
<td>916</td>
<td>911</td>
<td>1019</td>
<td>974</td>
<td>1005</td>
<td>1024</td>
<td>915</td>
<td>942</td>
<td>969</td>
<td>11397</td>
</tr>
<tr>
<td>Hospitalization %</td>
<td>26.6</td>
<td>26.1</td>
<td>25.3</td>
<td>25.6</td>
<td>25.6</td>
<td>25.4</td>
<td>25.3</td>
<td>24.9</td>
<td>25.1</td>
<td>24.7</td>
<td>27</td>
<td>24.1</td>
</tr>
<tr>
<td>State Rate %</td>
<td>23.6</td>
<td>22.6</td>
<td>25.4</td>
<td>23.7</td>
<td>22.6</td>
<td>23.5</td>
<td>22.2</td>
<td>22.1</td>
<td>23.7</td>
<td>22.4</td>
<td>23</td>
<td>25.5</td>
</tr>
<tr>
<td>National Rate %</td>
<td>26.6</td>
<td>26.9</td>
<td>27</td>
<td>25.6</td>
<td>26.8</td>
<td>25.4</td>
<td>25.6</td>
<td>26.9</td>
<td>25.5</td>
<td>26</td>
<td>28</td>
<td>26.4</td>
</tr>
</tbody>
</table>

Monthly Hospitalization %

ACH Risk-Adjusted Rate, State and National Percentile Rates

Acute Care Hospitalization: Benchmarking Report
All Data Based on Rolling 12 Month Rates and Calculated from OASIS-C Outcome Measure Values

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Your Agency's Observed Rate %</td>
<td>25.7</td>
<td>25.2</td>
<td>26.5</td>
<td>26.4</td>
<td>26.4</td>
<td>26.1</td>
<td>26.2</td>
<td>26.2</td>
<td>26.1</td>
<td>25.7</td>
<td>25.8</td>
</tr>
<tr>
<td>Your Agency's Risk-Adjusted Rate %</td>
<td>26.8</td>
<td>26.2</td>
<td>27.5</td>
<td>27.4</td>
<td>27.5</td>
<td>27.3</td>
<td>27.4</td>
<td>27.2</td>
<td>27.0</td>
<td>26.6</td>
<td>26.6</td>
</tr>
<tr>
<td>Your Agency's National Percentile</td>
<td>49th</td>
<td>47th</td>
<td>53th</td>
<td>53th</td>
<td>54th</td>
<td>53th</td>
<td>54th</td>
<td>54th</td>
<td>52th</td>
<td>50th</td>
<td>50th</td>
</tr>
<tr>
<td>National 20th Percentile Rate %</td>
<td>21.1</td>
<td>20.9</td>
<td>20.9</td>
<td>20.9</td>
<td>20.8</td>
<td>20.8</td>
<td>20.8</td>
<td>20.7</td>
<td>20.7</td>
<td>20.7</td>
<td>20.5</td>
</tr>
<tr>
<td>National 10th Percentile Rate %</td>
<td>17.6</td>
<td>17.5</td>
<td>17.5</td>
<td>17.4</td>
<td>17.3</td>
<td>17.3</td>
<td>17.3</td>
<td>17.1</td>
<td>17.0</td>
<td>17.0</td>
<td>16.9</td>
</tr>
<tr>
<td>Your Agency's Statewide Percentile</td>
<td>65th</td>
<td>58th</td>
<td>70th</td>
<td>67th</td>
<td>71th</td>
<td>69th</td>
<td>70th</td>
<td>71th</td>
<td>70th</td>
<td>67th</td>
<td>65th</td>
</tr>
<tr>
<td>Statewide 20th Percentile Rate %</td>
<td>21.0</td>
<td>20.9</td>
<td>21.1</td>
<td>21.2</td>
<td>21.0</td>
<td>21.1</td>
<td>20.9</td>
<td>21.1</td>
<td>21.0</td>
<td>21.0</td>
<td>21.2</td>
</tr>
<tr>
<td>Statewide 10th Percentile Rate %</td>
<td>18.9</td>
<td>17.9</td>
<td>18.3</td>
<td>18.0</td>
<td>17.5</td>
<td>17.9</td>
<td>18.2</td>
<td>18.6</td>
<td>18.7</td>
<td>18.4</td>
<td>18.7</td>
</tr>
</tbody>
</table>
Reasons for Hospitalizations

Reason for Hospitalizations of Total (Excludes planned hospitalizations)

- Acute Mental/Behavioral
- Cardiac Arrhythmia
- Dehydration, Natriaution
- DVT Pulmonary Emboli
- GI Issues
- Heart Failure
- Hypertension
- Inpatient Medication Administered
- Injury Caused by Fall
- IV Catheter Infection/Complication
- Other Infection
- Other Heart Disease
- Other Respiratory Problem
- Other
- Procedure Unknown
- Respiratory Infection
- Stroke (CVA or TIA)
- Uncontrolled Pain
- Urinary Tract Infection
- Wound Infection/Dehiscence

Monthly Report for Improvement in Management of Oral Medications (M2020)

<table>
<thead>
<tr>
<th>Name:</th>
<th>OralMed Sample Agency</th>
<th>Medicare:</th>
<th>999999</th>
</tr>
</thead>
<tbody>
<tr>
<td>Location:</td>
<td>AABD, NY</td>
<td>Report Date:</td>
<td>12/10/2012</td>
</tr>
</tbody>
</table>

Monthly Improvement vs. Discharges (Monthly Report for Improvement in Management of Oral Medications (M2020))

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Improvement %</td>
<td>189</td>
<td>165</td>
<td>162</td>
<td>183</td>
<td>225</td>
<td>210</td>
<td>251</td>
<td>239</td>
<td>236</td>
<td>230</td>
<td>224</td>
<td>224</td>
<td>256</td>
</tr>
<tr>
<td>Discharges</td>
<td>375</td>
<td>377</td>
<td>392</td>
<td>379</td>
<td>402</td>
<td>435</td>
<td>479</td>
<td>470</td>
<td>451</td>
<td>450</td>
<td>394</td>
<td>461</td>
<td>5106</td>
</tr>
<tr>
<td>Improvement %</td>
<td>50.4</td>
<td>43.8</td>
<td>48.4</td>
<td>49.5</td>
<td>49.8</td>
<td>50.3</td>
<td>52.4</td>
<td>50.9</td>
<td>52.8</td>
<td>52.0</td>
<td>56.9</td>
<td>56.0</td>
<td>51.1</td>
</tr>
</tbody>
</table>

State %

| State % | 51.2 | 50.1 | 50.5 | 51.2 | 51.4 | 51.3 | 51.2 | 51.7 | 51.7 | 52.1 | 52.2 | 53.0 | 51.5 |

National %

| National % | 48.4 | 47.9 | 47.9 | 48.4 | 48.9 | 49.0 | 49.2 | 49.2 | 48.9 | 48.9 | 49.5 | 49.9 | 48.8 |

Monthly Improvement Rate (%) for Management of Oral Medications (M2020)
### Assistance – How Can HHQI Help?

<table>
<thead>
<tr>
<th>Archive Topic</th>
<th>Presenter(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Readmissions and the Role of Home Care</td>
<td>Steve Landers, MD, MPH, Director, Center for Home Care and Community Rehab., Cleveland Clinic</td>
</tr>
<tr>
<td>Home Health and Care Transitions</td>
<td>Jane Breck, MD, MPH, Chief Medical Officer, Colorado Foundation for Medical Care</td>
</tr>
<tr>
<td>Implementing the Coaching Model</td>
<td>Tasha Mears, Senior Vice President of Clinical Operations – Amedisys Beverly Taylor, Care Transitions Coordinator – Amedisys Georgia</td>
</tr>
<tr>
<td>Conversations Across the Discharge Divide</td>
<td>Luke Hanise, MD, MHS</td>
</tr>
<tr>
<td></td>
<td>Jessica Sado Pavlovski</td>
</tr>
<tr>
<td></td>
<td>Robert Young, MD</td>
</tr>
<tr>
<td></td>
<td>All of Northwestern University</td>
</tr>
<tr>
<td>Integrating Home Care into Primary Practice to Improve Patient Outcomes</td>
<td>Alan Goldblatt, MD</td>
</tr>
<tr>
<td></td>
<td>Linda Murphy, RN</td>
</tr>
<tr>
<td></td>
<td>Caretenders of Gainesville (FL)</td>
</tr>
</tbody>
</table>
Assistance – How Can HHQI Help?

- Promoting Your Successes through:
  - Agency of the Month
  - Blogs
  - BPIPs
  - e-Bulletins

Questions?
Thank You!

To reach me:

csun@wvmi.org

And of course, we can always be reached at

hhqi@wvmi.org

References


This material was prepared by the West Virginia Medical Institute, the Quality Improvement Organization supporting the Home Health Quality Improvement National Campaign, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The views presented do not necessarily reflect CMS policy. Publication Number: 105OW-WV-HH-MD-081313.