Ohio Council for Home Care and Hospice

Move to Improve Campaign for Excellence

Final Report
July 2012
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Executive Summary

The leadership of the Ohio Council for Home Care and Hospice recognized the significant consequences of having hospitalization rates for home care agencies in the state of Ohio that were in the bottom third of the country. They understood that rates this high would put agencies at a substantial disadvantage when it came to partnering with larger groups looking to form Accountable Care or other “bundled care” organizations. They also recognized that these rates would devastate agencies in a value based purchasing system, and most importantly, they created an undue and unnecessary burden on the patients that are cared for by home health agencies throughout the State of Ohio. In a health care system that is too costly to sustain, it is clearly recognized that reform efforts, however implemented, will be focused on improving quality and reducing cost. The Ohio Council for Home Care and Hospice recognized the need to help their member agencies improve their hospitalization rates. The Council engaged Fazzi Associates to create an 18 month program that was open to member agencies and designed to assist agencies in developing and implementing a plan to reduce avoidable hospitalizations. At the initiation of the campaign, Ohio home care agencies, per CMS Home Health Compare, had an average hospitalization rate of 31%.

The concept for the campaign began in July 2010 with data collection scheduled to occur between December 2010 and proceed through June 2012.

Over the course of that time a significant amount of time and energy was dedicated to developing a plan on how the campaign would be implemented to obtain the greatest outcomes, how to measure results, and how to assist agencies in managing their strategies.

On November 16, 2010 a webinar was conducted with representatives from the Ohio Council for Home Care and Hospice and Fazzi Associates to promote the campaign, titled the “Move to Improve” (MTI Campaign for Excellence), to recruit participants. Following this webinar, 78 agencies registered and submitted required information.
On January 5, 2011 a “Kick-Off” webinar was conducted to welcome all participants to the campaign, set expectations, and define the objectives and what the plan was for meeting them. The participants were encouraged to publicize the event throughout the organization so that each and every individual was aware of what was occurring and how they contributed to the effort.

Throughout the duration of the campaign, Fazzi Associates connected with participants and attempted to keep them engaged on a regular basis with webinars that covered a variety of campaign related topics, clinical, managerial, and technical. Topics included education on campaign related tools, such as how to use the dashboards and audit tools, clinically related topics including how to implement front loading, and managerial topics including how to improve the management and supervision of clinical staff.

The initial six months of 2011 focused on data collection and establishing a baseline of information on what the agencies “looked like.” This was accomplished with surveys, OASIS submission, claims data, and focus group. The goal of this effort was to identify the reasons for readmission and whether or not there were situations or conditions that were unique to Ohio.

After evaluating the data, we decided that for the purpose of comparison, we would divide participants into three groups based on their hospitalization rate at the initiation of the campaign.

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<tr>
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<th>Percentage Rate</th>
<th>Number of Agencies</th>
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<td>Low Hospitalization-(best)</td>
<td>16% - 27%</td>
<td>23</td>
</tr>
<tr>
<td>Moderate Hospitalization-(mid)</td>
<td>28% - 32%</td>
<td>28</td>
</tr>
<tr>
<td>High Hospitalization-(poorest)</td>
<td>33% or greater</td>
<td>25</td>
</tr>
</tbody>
</table>
On June 14, 2011 the Ohio Council for Home Care and Hospice sponsored an all-day summit/forum for the MTI participants as they embarked upon the “improvement phase” of the campaign. Bob Fazzi and Fred Pordum presented an overview of the future of home care, a summary of the research that had been completed to date, and the recommendations that were developed to assist the agencies in improving their hospitalization rates. The intent of this meeting was to have a least one representative from each participating agency present so that we could have interactive dialogue on strategies for how to implement the required changes and manage the campaign, and provide concrete recommendations to be taken back to agencies for immediate implementation.

Fifty-nine agencies were represented with 79 attendees to engage in a fruitful discussion regarding the research behind the recommendations and suggestions for how to implement the recommendations. The recommendations revolved around the themes of:

1. Data tracking and analysis
2. Clinical structure
3. Management processes
4. Clinical processes

Fazzi staff created a one-hour educational webinar that was made available to accommodate all participants that could not attend the Summit.

Fazzi staff attended the OCHCH Fall Conference & Tradeshow on September 15, 2011. They participated in an informal gathering of Move to Improve Participants during the lunch intermission, at which time there was a brief review of campaign status, some findings, and clarification of expectations. There was an opportunity for participants to ask questions and have open discussion about the campaign. Participants received a brief overview of the preliminary finding of the Delta National Best Practice Study to Reduce Hospitalizations. There was also a conference call for all agencies focused on helping them to understand the need for investing the necessary time to become more engaged in
the campaign, not only to improve hospitalization rates, but to improve overall publicly reported quality measures.

**Campaign Revisions**

The Move to Improve Campaign Team reviewed the status of the campaign on a regular basis to identify opportunities for improvement. In the fall of 2011, issues were identified with compliance, coordination, and how practices were being implemented. Based on results from the Delta project and the issues identified with the MTI campaign, revisions to the campaign were made. Agencies in the campaign were educated about the changes in November 2011, and all changes were implemented in January of 2012.

The changes to the Move to Improve Campaign in Ohio focused on the following components:

**Accountability–Leadership**

The CEO of the agency must focus on the agency’s hospitalization rate and what it means for the future viability of the agency in light of how they are to be positioned for health reform. Clear lines of accountability for each component of the campaign need to be implemented with associated tracking of outcomes. Each lead needs to be accountable for their component. A goal needs to be established for the number of patients hospitalized on a monthly basis in order to reach a desired hospitalization rate. The CEO or senior leader must hold monthly meeting with Leads to review all campaign outcomes.

**Lead Positions**

**Project Lead Responsibilities**

- Recommended to be the CEO or designee no more than one level down on the organizational chart.
- Responsible for conducting a monthly meeting with other leads to ensure that everyone on the team is completing their part of the campaign.
- Engages clinicians and staff to maintain focus on the initiative.
Data Tracking and Analysis Lead Responsibilities

- Recommended to be someone who serves in a Quality/PI function.
- Tracks and trends audit results to identify areas of agency deficiency based on audit results.
- Pulls Dashboard data, monitors number of hospitalized patients.
- Provides data from Hospitalization Management Dashboard, reasons for emergent care, and composite hospitalization audit results to MTI team, including Practice Lead, to develop education and interventions to address the deficits.

Real Time Hospitalization Lead Responsibilities

- Once a patient is hospitalized, the Real Time Hospitalization Lead performs a focused chart audit within 2 days of hospitalization with clinician. Interviews to evaluate if agency protocol and process was followed.
- They present the audit reports to the Data Analyst for tabulation and trending.
- Should be key “go-to” person in office to address patient concerns when patients are considering hospitalization.

Practice Lead Responsibilities

- Recommended to be someone in Clinical Supervision or Staff Development.
- Responsible for implementation of training and accountability of selected practice strategies.
- Responsible for teaching to trended deficits identified by data analysis lead.
**Dashboard Revisions**

We created a new and considerably more streamlined dashboard report to allow for agencies to focus on hospitalization rates. The new dashboard automatically generates itself after 50 transfer or discharge OASIS are submitted to Fazzi and provides agencies with the number of patients that were hospitalized, the associated percentage rate, a historical trend, and how they compare to other state and national benchmarks. We also provide the agency with a specific number of hospitalizations that they would need to reduce their numbers by in order to reach or exceed the national benchmarks.

**Overall Results**

In evaluating the results of data collection, the average decrease in hospitalization rate for all agencies that participated in the campaign was a six percentage point drop in hospitalization rate when comparing the first six months of data collection (December 2011 to May 2011) to the last six months of data collection (January 2012 to June 2012). This equates to an average of 14.8% reduction in hospitalization rates for all agencies in the campaign.
The High group reduced their rate by the greatest percentage at 19.9%, the moderate group about 6% less at 13.9%, and the low group about 6% less than that at 8.2%. The Moderate group moved from an average hospitalization rate above the Ohio average of 31% (in Dec 2010) to 27%; a rate below the Ohio average and more in line with the National average of 27%. The Low group reduced their scores on average from 26% to 23.9%, a number that now places them in the top 33% in the nation.

### Audits

<table>
<thead>
<tr>
<th>Hospitalization Grouping at Initiation</th>
<th>Group % Reduction</th>
<th>Hosp Rate Change of Agencies Performing Audits</th>
<th>% Reduction Agencies Performing Audits</th>
</tr>
</thead>
<tbody>
<tr>
<td>High</td>
<td>19.9%</td>
<td>-11.1%</td>
<td>21.5%</td>
</tr>
<tr>
<td>Mod</td>
<td>13.9%</td>
<td>-5.3%</td>
<td>15.6%</td>
</tr>
<tr>
<td>Low</td>
<td>8.2%</td>
<td>-2.8%</td>
<td>10.1%</td>
</tr>
<tr>
<td>Average</td>
<td>14.8%</td>
<td>-6.6%</td>
<td>15.7%</td>
</tr>
</tbody>
</table>

In evaluating the data specific to what agencies were completing audits, the data suggests that those agencies that completed chart audits of patients that were hospitalized consistently achieved a greater reduction in hospitalization rates that their peer groups and an overall greater reduction in hospitalization rates.
In comparing the overall hospitalization reduction change for those agencies that reviewed their hospitalization dashboard against their total peer group, it is apparent that those agencies that reviewed their dashboard report had a greater reduction in their hospitalization rate in each grouping. Similar to the overall hospitalization reduction rates, we see that the high hospitalization group had the greatest reduction, while the low hospitalization group had a lower reduction.

At the conclusion of this campaign, the average reduction in hospitalization rate was 6%, which on average would bring the hospitalization rate down to 25%. This rate is not only better than the current Ohio average of 29% but also exceeds the national average of 27% (per CMS Home Health Compare). As the data analysis demonstrates, reducing hospitalization rates is not just something that happens by chance over the long term. It takes a focused effort by all involved in the agency to develop a plan, monitor outcomes, and continuously audit the processes involved to make a difference. Those agencies that dedicated an adequate amount of time to perform audits, review their dashboard reports, and lead the change achieved better than average reductions in hospitalization rates. While it was not clear exactly what one or two particular actions had the greatest impact on hospitalization rates (as action items should be specific to your agency), the fact that there was accountability in following up on those plans seems to have made the ultimate difference.
Campaign Design

With all of the reforms being instituted by CMS and the government’s approach to healthcare reform, the Ohio Council for Home Care and Hospice recognized the need to help their member agencies improve their hospitalization rates. At the initiation of the campaign, Ohio home care agencies had hospitalization rates that were in the bottom third of the country at 31%. Medication management rates were also ranked in the bottom third of the country. Understanding that these outcome scores would not benefit member agencies in a pay for performance environment or more imminently with the upcoming financial penalties for hospitals that have re-hospitalizations in 30 days, the OCHCH engaged Fazzi Associates to develop a campaign with a focus on assisting member agencies with reducing their hospitalization rates.

The initiative was commenced in July 2010, and planning began immediately on the methods and tools that would be implemented to assist agencies improve their hospitalization scores. A plan was established that would include a comprehensive survey of all participating agencies, the inclusion of an automated data collection tool and analysis system, development of best practice strategies, and a plan for ongoing support for participating agencies throughout the process. The ultimate goal was to reduce hospitalization rates by providing the agencies with a better understanding of the methodologies and tools that they need to improve their hospitalization rates, as well as to measure their progress.

The Request for Participants

On November 16, 2010 Fazzi staff hosted a webinar for all members of the Ohio Council for Home Care and Hospice. There were 74 agencies that participated on the call. This webinar:

- Summarized the current performance outcomes on key metrics for home health agencies in the state of Ohio and detailed what the goals of the Move to Improve Campaign would be.
• Provided a timeline of what would occur at different time points through June 2012.

• Discussed eligibility criteria:
  o Medicare certified for three years or longer
  o Must have annual census of 60 or more patients
  o Agree to name a Lead Person to coordinate the effort in their agency
  o Agreement to participate in tracking and improvement efforts

The expectations that we set for participants were as follows:

• A “Lead” person to coordinate the “Move to Improve” effort in their agency.
• Commitment by Senior Leadership to making the campaign a success.
• Agreement to use the automated OASIS Tracker/Plus to monitor key outcome measures.
• Provide feedback on periodic surveys.
• Participate in webinars or conference calls.
• Lead Person and Clinical Leadership attend Move to Improve kick-off and development conference in May.
• Agency implements hospitalization reduction campaign in May and June 2011.
• Participate in support phone calls, webinars, surveys and/or training during the 12 month campaign.

Finally we provided agencies with direction on how to register for the campaign through the Council. At the conclusion of this effort, we recruited 78 agencies for the campaign.

As agencies registered for the campaign, a profile was obtained on each agency that would allow the ability to analyze the data in various ways. Instruction was provided
on transmitting OASIS and billing information to Fazzi for analysis. This process proved to be more challenging than originally anticipated, as there were many agencies that had difficulty transmitting OASIS data to us in a format that we could manipulate. Some agencies declined to provide billing data despite communication with them focused upon the protection of data and the provision of metrics useful to them. We requested that agencies provide us their data from October 2010 forward. We began collecting this data to establish a baseline for each agency.

**Kick-off Webinar**

On January 5, 2011 a webinar was hosted by Fazzi staff. We also reached out to Kathleen Anderson and two Board Members to join us on the call. The focus of this campaign was to review the goals and objectives of the campaign so that everyone was clear on what we wanted to accomplish by the end of the campaign.

- We again discussed the importance of making the campaign a priority in the organization and making *everyone* aware of this, having a strong leader, committing to attend the Summit to provide the plan for improvement, and committing to making the changes in the organization that will make them successful.

- We provided a month by month summary of what events were going to occur.

- We provided the participants with a quick overview of the OASIS Tracker and Tracker Plus Dashboards that they were going to receive in the near future.

- We provided a review of what agencies could expect from Fazzi and what Fazzi would expect from the participating agencies.

At this time, we were still making a final push to get as many agencies as possible involved in the campaign. We had approximately 95 agencies registered; however, some later backed out when they determined that they could not make the commitment to what was expected of them, or they determined that they were otherwise not interested. When
we concluded the registration and followed up with agencies that had not moved forward with the process, we had a total of 78 agencies participating.

Agency Organizational Practice Survey

In late January, we sent each participating agency a link to a survey on Survey Monkey that included questions on:

• Current interventions/programs in place for hospitalizations.
• Awareness of different levels of people in the organization regarding the agency’s goal to reduce hospitalizations.
• Frequency and effectiveness of communication from senior leaders to the agency on the importance of reducing hospitalizations.
• Interventions implemented for a fall prevention program.
• Information about “on-call” schedules.
• Medication management.
• Use of telehealth.
• Any disease management programs that are in place.
• Use of electronic documentation system.
• Awareness of Move to Improve initiative throughout the organization.
• Staffing patterns.

The survey was at least partially completed by 60 of the 78 agencies, and the results are summarized in Appendix A.

OASIS Tracker and Hospitalization Management Dashboard

One of the tools provided to agencies was the OASIS Tracker, which can be found in Appendix B. Agencies received their first OASIS Tracker, based on January data, at the end of February. The report provided agencies with:
• Average revenue per episode with the associated financial impact and a comparison to the national average.
• Average case mix weight at RAP, trended over a six month period.
• Top five primary diagnoses of the agency.
• Therapy utilization.

For this campaign, Fazzi Associates created a specialized “Hospitalization Management Dashboard” report for each participating agency that extracts specific and relevant data from OASIS assessments to determine hospitalization metrics, and distributed surveys to agencies to evaluate their clinical and operational practices. This report was generated to provide agencies with specific information with measures from the OASIS that, based on our experience, could significantly influence the probability of hospitalization. This report included:

• Percentage of patients admitted to the hospital by month, trended over 4 quarters.
• Reason for hospitalization based on the primary diagnosis at SOC and on Transfer.
• Average days between a number of time points (ex. referral and SOC).
• Patient living situation at SOC and ROC.
• Evaluation of reason for Emergent Care.
• Intervention synopsis at transfer based on M2400.
• Average visits by discipline.
• Home Health Compare Measures.
• Home Health Process Measures.
• Medication Management Measures.

On Friday March 11, 2011, a webinar was provided by Fazzi Staff to participating agencies to educate participants on where the report data comes from and how agencies should interpret the report to drive changes in the organization.
Focus Group

On March 24, 2011 representatives from 13 agencies met with Fazzi staff at the Ohio Council offices to have a discussion regarding the major issues are that were driving this higher than average re-hospitalization rate and what could potentially be done to better manage them. The goals of this meeting were to get a better understanding of the unique issues in the State of Ohio, determine what other initiatives were under way in the state, and determine which, if any, initiatives have been successful by participating agencies. A summary of this meeting and those agencies that have participated can be found in Appendix C.

Frequently Asked Questions

To support participants with the volume of information that we were providing to them, we created a “Frequently Asked Questions” page on the Fazzi website. This webpage provided a reference for agencies with an explanation of definitions that we used on the Tracker documents and concepts that were presented on the tools provided to them. Nearly each table from the Tracker and Hospitalization Dashboard had information provided regarding what OASIS data was being used to generate the report as well as why we were using the indicators that we did.

Webinar Review of Tracker, Operational Survey, and Focus Group

On April 27, 2011 a webinar was hosted by Fazzi staff to provide participants with feedback on some of the information that had been collected. We also wanted to provide participants with some background on their reports.

The webinar presented very specific information on each piece of data found in the Tracker and Hospitalization Management Dashboards. As the tool evolved, it was felt necessary to provide very specific information to all participants on where the data was originating and what reference and compare groups we had used. We also provided
participants with recommendations on how to interpret their results and the implications of their data.

We provided the participants a high level overview of the findings of our Operational Survey and Focus Group.

Finally, we promoted registration for the Move to Improve Conference Kick Off event at the Quest Business and Conference Center to be held in June and to be focused upon the “implementation of improvement phase” of the campaign. The conference became known as “The MTI Summit.”

**Bifurcation of Data**

In conducting our analysis of what different agencies were doing specific to reducing hospitalizations, we needed to differentiate the agencies. One of the methods we used to accomplish this was to divide the participants into three groups: those with high hospitalization rates, those with average hospitalization rates, and those with low hospitalization rates. Once we established our groups, we then attempted to identify differences between them, looking at the practices, programs, or methods implemented by the agencies with lower rates vs. those implemented by the agencies with higher rates. We had a largely equal distribution of the number of agencies in each group, as reflected below:

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Program Implementation

Move to Improve Summit

All of the OASIS data collection, the focus group meeting, the operational surveys, and the research was conducted to identify opportunities for improvement and to provide direction to participants at the Move to Improve Summit so that they could begin to implement the improvement strategies.

On June 14, 2011 the Ohio Council for Home Care and Hospice sponsored an all day summit/forum for the MTI participants. Bob Fazzi and Fred Pordum presented an overview of the future of home care, a summary of the research that had been completed to date, and the recommendations that were developed to assist the agencies in improving their hospitalization rates. The intent of this meeting was to have a least one representative from each participating agency present so that we could have interactive discourse on strategies on how to implement the required changes and manage the campaign, and so that we could provide concrete recommendations to be taken back to agencies for immediate implementation.

Fifty-nine agencies were represented with 79 attendees engaged in a fruitful discussion regarding the research behind the recommendations and suggestions for how to implement the recommendations. The recommendations revolved around the themes of:

1. Data tracking and analysis
2. Clinical structure
3. Management processes
4. Clinical processes

Each theme had a number of practice recommendations, listed in Appendix D, with tangible ideas on how to implement them. There was also dialogue on the importance of staying focused on the recommendations that were being chosen and the
need to have a point person in the agency to be accountable for ensuring that the recommendations get hardwired into the agency practices. To promote follow-through and assist us with tracking, the agencies were provided a form to complete that identified which two or three recommendations they were going to implement (Appendix E) and a form to specify which person was going to be accountable for them (Appendix F). The participants were also provided with a number of additional tools to use to assist them in carrying out their plans.

Another tool that we provided to participants was a two page audit tool that we encouraged all agencies to use on all patients that were hospitalized (Appendix G). By auditing the records of patients that were hospitalized, the intent of this tool was to help agencies identify the objective reasons why patients were going to the hospital so that they could then address those specific issues with their clinicians.

Required documentation was completed by Fazzi Assoc. to allow the OCHCH to provide CEUs to those that attended the MTI Summit.

To accommodate all participants that could not attend the Summit, Bob Fazzi and Fred Pordum created a one-hour summary webinar that was made available for all agencies. This webinar focused on the recommendations that were made and ideas on how to implement them into agency practice. Participants were provided with all of the tools available at the summit and were asked to return the forms to notify Fazzi what recommendations they would be focusing on and who would be accountable for driving the implementation of them. This was posted on the Ohio Council for Home Care and Hospice website and was available on-demand.

In reviewing the forms that listed what recommendations agencies were choosing to pursue, the two most frequently selected recommendations were:

1. Improving management’s support of hospitalization efforts
2. Implementing front loading of visits
One of the critical and required tools provided for all agencies to use was a hospitalization audit tool. This tool was developed by Fazzi to be used to review the medical records of patients that were hospitalized during their episode of care. On July 6, 2011, a webinar was conducted by Fazzi’s staff to educate the agencies on how to use the audit tool, the rationale behind the tool, and what to look for in performing a chart audit. With their knowledge and experience in OASIS and in performing chart audits, Fazzi’s staff provided additional insight into the auditing process, specifically on what to look for in chart reviews that may relate to hospitalizations. Agencies were requested to provide a monthly summary to Fazzi Associates on the outcome of their audits.

To support Move to Improve agencies with the popular recommendation selections of front loading and increasing management support of hospitalization effort, a webinar was presented on September 15th with ideas on how to facilitate advancing these objectives. Fazzi provided an overview of front loading, its significance related to hospitalizations, indications for when to implement, and how to create a system for utilization. Principles of management theory to improve clinician performance were also discussed. This webinar educated participants on how to access an enhanced feature on the Fazzi website where agencies can log in and access the names of all of their hospitalized patients to make conducting audits easier.

**OCHCH Fall Conference & Tradeshow–September 15, 2011**

Bob Fazzi attended the OCHCH Fall Conference & Tradeshow. In addition to presenting some of the scheduled sessions, Fazzi staff also attended an informal gathering of Move to Improve participants during the lunch intermission. During this time, there was a brief review of campaign status, some findings, and clarification of expectations. There was also an opportunity for participants to ask questions and have open discussion about the campaign. Participants received a brief overview of the preliminary finding of the Delta National Best Practice Study to Reduce Hospitalizations. There was a call for all agencies to invest the necessary time to become more engaged in the campaign, not only to improve hospitalization rates, but to improve overall publicly reported quality measures.
Campaign Revisions

The Move to Improve Campaign Team reviewed the status of the campaign on a regular basis to evaluate opportunities for improvement. Based on findings from the Delta project, an evaluation of MTI current outcomes by Fazzi staff, and feedback from agencies, it was determined to refocus the MTI campaign.

The major reasons for this were:

1. Based on Fazzi’s current research with the Delta study, the answer to reducing avoidable hospitalizations may not lie in the current initiatives implemented. Continued learning through the latest research demonstrates that many agencies are doing the “things” that are intended to reduce hospitalization (front loading, fall prevention, med management) but are getting different results. Therefore, it is most likely that what agencies are doing is not as important as how they are doing it, as the level of accountability for assuring processes are followed, and as what follow up is conducted when practice patterns demonstrate inefficacies.

2. Fazzi Associates, committed to the success of the MTI campaign, wanted to make revisions that would allow the agencies to focus on what we believe was most important to their individual success within the campaign. Leadership and data tracking was the major focus of the revisions and the support provided to the group.

3. Issues with staff turnover surfaced as each agency had unique rolls for Lead personnel, and therefore it was unclear what the exiting staff was doing. Finally, it was clear that the critical audits, the key driver of what agencies should be focusing on, were not getting completed.

4. Participant compliance was low. There are many components to the campaign with different agencies working on different initiatives, which could lead to
challenges supporting the individual needs. Additionally, turnover in staff leads in agencies is continuous, and the degree of CEO commitment to the campaign would benefit from being revisited. Audits are not being conducted and participation in webinars is decreasing.

Fazzi, in conjunction with the Ohio Council for Home Care and Hospice decided to make some changes to the campaign with the goal of improving effectiveness and efficiency as well as compliance from the agencies. Adjusted focus was to be on core management and practice issues, which would allow the MTI campaign and participants to benefit from the latest findings from the Fazzi studies (Delta project). There are four critical activities that were identified for successful implementation of the revised campaign. These four activities heavily emphasized accountability, communication and coordination. Project leads were seen as critical to success.

The changes to the Move to Improve Campaign in Ohio focused on the following components:

*Accountability - Leadership*

The CEO of the agency focuses on the agency’s hospitalization rate and what it means for the future viability of the agency in light of how they are to be positioned for health reform. Clear lines of accountability for each component of the campaign need to be implemented with associated tracking of outcomes. Each lead needs to be accountable for his/her component. A goal needs to be established for the number of patients hospitalized on a monthly basis to reach a desired hospitalization rate. CEO must hold monthly meeting with Leads to review all campaign outcomes.

*Lead Positions*

*Project Lead*

- Recommended to be the CEO or designee no more than one level down on the org chart.
• Responsible for conducting a monthly meeting with other leads to ensure that everyone on the team is completing their part of the campaign.
• Engages clinicians and staff to maintain focus on the initiative.

Data Tracking and Analysis Lead

• Recommended to be someone who serves in a Quality/PI function.
• Tracks and trends audit results to identify areas of agency deficiency based on audit results.
• Pulls Dashboard data, monitors number of hospitalized patients.
• Provides data from Hospitalization Management Dashboard, reasons for emergent care, and composite hospitalization audit results to MTI team, including Practice Lead, in order to develop education and interventions to address the deficits.

Real Time Hospitalization Lead

• Once a patient is hospitalized, the Real Time Hospitalization Lead performs a focused chart audit within two days of hospitalization, with clinician interviews, to evaluate if agency protocol and process were followed.
• They present the audit reports to the Data Analyst for tabulation and trending.
• Should be key “go-to” person in office to address patient concerns when patients are considering hospitalization.

Practice Lead

• Recommended to be someone in Staff Development.
• Responsible for implementation of training and accountability of selected practice strategies.
• Responsible for teaching to trended deficits identified by data analysis lead.
On November 3, 2011 a webinar was presented by Fazzi staff with an invitation to all CEOs to make them aware of the changes regarding the Move to Improve Campaign. This webinar provided a high level overview of what the changes were, why we were making them, and what their responsibility would be in this model. Despite the critical tone of the request for participation, only 18 CEOs participated in the call.

On November 15, 2011 another webinar was presented by Bob and Fred with the intended audience being the Lead Personnel in the agencies. While similar in content to the CEO webinar, this presentation provided much greater detail of what each lead individual was going to be responsible for and how they were to work and collaborate with the other individuals leading this initiative. There were 39 agencies that participated in this call.

Follow up emails were sent to agencies that did not participate on either call to encourage them to obtain the link to the recordings and request the tools (Appendix H) that were developed to facilitate implementation including:

- A monthly checklist of items requiring follow through.
- The organizational structure.
- An operational flow sheet.
- A new abbreviated audit tool.
Dashboard Revision

In light of what was learned from our research and discussions with participants, we recognized that agencies did not have a clear understanding of what their target was, how many patients could be hospitalized, and what the corresponding hospitalization rate would be. Because of the significant delay in Home Health Compare scores, agencies are at a disadvantage when evaluating if their interventions to reduce hospitalizations are effective. To counter this, we created a new and considerably streamlined dashboard, which can be found in Appendix I. The new dashboard automatically generates itself after 50 transfer or discharge OASIS are submitted to Fazzi and provides agencies with the number of patients that were hospitalized, the associated percentage rate, a historical trend, and how they compare to other state and national benchmarks. We also provided the agency with a specific number of hospitalizations that they would need to reduce their numbers by in order to reach or exceed benchmark data.

A webinar was presented to participants on February 27, 2012 on the new dashboard with Fazzi staff. Discussion ensued regarding the rational for creation, the origination of data created, and how best to utilize the dashboard to improve hospitalization rates. It was attended by 26 agencies.

Ohio Hospital Association Conference—December 9, 2012

Fazzi staff attended and presented the Move to Improve Campaign at a conference of participants in the Ohio STARR project. The purpose of the meeting was to allow hospitals that are participating in the STARR initiative to discuss their actions and progress made in reducing avoidable hospitalization. Recognizing the importance that home care plays in potentially reducing avoidable hospitalizations, the OHA invited OCHCH to attend the meeting in an attempt to educate hospitals on how home health can partner with them and how their performance is measured. The presentation was well received with a number of attendees asking follow up questions after the event. It appears that minimally there was a greater understanding and appreciation of the efforts that
participating agencies are engaging in to be a part of the avoidable hospitalization solution.

**MTI Conclusion Survey**

In late April Fazzi sent out a survey to all Move to Improve participants requesting that they take a short survey so that we could obtain feedback on the campaign. The survey asked participants to rate their level of involvement, how frequently they monitored hospitalizations, who was responsible for leading the specific roles that we proposed, how often they held the Monthly Accountability and Planning Meeting, and how often they did audits and reviewed their dashboard reports. We used this data in our analysis to determine what the key drivers were in successfully reducing hospitalization rates.

**Closing Conference**

Conference to be held on August 1, 2012. At that time, Bob Fazzi and Fred Pordum will present the findings from this study and the Delta Hospitalization Study, which attendees can take back to their agencies and use to improve outcomes.
Results

Based on previous research at Fazzi Associates, we believed that there were a few key components that home health agencies could focus on and implement that would result in an improvement in their hospitalization rates, including:

1. Having the CEO or senior administrative leader engaged in the initiative.

2. Performing real time audits of patients that were hospitalized. This is to gain immediate feedback regarding the reason for hospitalization and to identify any opportunities that could be used to reduce the chance of future occurrences.

3. Obtaining real time feedback of what the agency’s hospitalization rate is and having a specific number of hospitalizations that an agency would have to achieve to reach a certain percentage rate.

4. Having true agency engagement and involvement in the campaign. This initiative was designed to provide agencies recommendations of what actions they could take and to provide feedback to let them know how they are progressing toward achieving their goal.

Overall Results

In evaluating the results of data collection, the average decrease in hospitalization rate for all agencies that participated in the campaign was a 6% point reduction in overall hospitalization scores (home health compare score equivalent) when comparing the first 6 months of data collection (December 2011 to May 2011) to the last 6 months of data collection (January 2012 to June 2012). This equates to an average 14.8% reduction in hospitalization rates for all agencies in the campaign.
At the initiation of the campaign, we divided all agencies into three groups; those with high, moderate, and low hospitalization rates. There appears to be a correlation between the three groups and the amount that they reduced their hospitalization rates. The High group (poorest hospitalization scores) reduced their rate by the greatest percentage at 19.9%, the Moderate group about 6% less at 13.9%, and the Low group (best hospitalization scores) about 6% less than that at 8.2%. The Moderate group moved from an average hospitalization rate above the Ohio average of 31% (in Dec 2010) to 27%, a rate below the Ohio average and more in line with the National average of 27%. The Low group reduced their scores on average from 26% to 23.9%, a number that now places them in the top 33% in the nation.

The fact that agencies with higher hospitalizations had the greatest improvement and the agencies with the lowest hospitalizations had the smallest improvement seems to indicate that there is a floor at some point as to how low you can move your hospitalization rate. There is consensus that a certain percentage of patients receiving home health truly do need to return to the hospital to receive the most appropriate level of care for their condition. The space between the floor and an agency’s hospitalization rate then equates to the agency’s avoidable hospitalizations.
Audits

<table>
<thead>
<tr>
<th>Hospitalization Grouping at Initiation</th>
<th>Group % Reduction</th>
<th>Hospitalization Rate Change of Agencies Performing Audits</th>
<th>% Reduction Agencies Performing Audits</th>
</tr>
</thead>
<tbody>
<tr>
<td>High</td>
<td>19.9%</td>
<td>-11.1%</td>
<td>21.5%</td>
</tr>
<tr>
<td>Mod</td>
<td>13.9%</td>
<td>-5.3%</td>
<td>15.6%</td>
</tr>
<tr>
<td>Low</td>
<td>8.2%</td>
<td>-2.8%</td>
<td>10.1%</td>
</tr>
<tr>
<td>Average</td>
<td>14.8%</td>
<td>-6.6%</td>
<td>15.7%</td>
</tr>
</tbody>
</table>

In evaluating the data specific to what agencies were completing audits, the data suggests that those agencies that completed chart audits of patients that were hospitalized consistently achieved a greater reduction in hospitalization rates than their peer groups and an overall greater reduction in hospitalization rates.

The logic and rationale for completing real time hospitalization audits, as supported by this data, is that it provides the agency with objective data regarding the root cause of the hospitalization. This data over time may present the agency with trends that identify training opportunities, the need for changes in policy and procedure, and/or the need for operational changes. The data will provide the necessary support to indicate to the agency what specific changes need to be made to reduce the probability of avoidable hospitalizations. Too often times it seems that agencies decide to implement a program or process in the hope of reducing hospitalization and they are very disappointed and surprised when it doesn’t produce the anticipated results.

**Review of Real Time Hospitalization Dashboard**

When agencies were emailed the link to their Dashboard Report, we were able to determine if the report was accessed by someone in the agency. The percentage of agencies in which at least one person opened their report or that we had sufficient data to make a calculation for is as follows:
In comparing the overall hospitalization reduction changes of those agencies that reviewed their hospitalization dashboard with those of their total peer group, it is apparent that those agencies that reviewed their dashboard report had a greater reduction in their hospitalization rate in each grouping. Similar to the overall hospitalization reduction rates, we see that the high hospitalization group had the greatest reduction, while the low hospitalization group had a lower reduction. This again suggests that agencies that had a greater opportunity to move toward the national average took advantage of it. Those that started closer to the mean had less opportunity for improvement.

**Agency Survey**

In late April, Fazzi requested that each agency complete a survey to obtain feedback on how they implemented the program, requesting information on their level of involvement, change in practices, and who was leading the campaign. We received
responses from 36 of the agencies. The data was sorted and analyzed to determine what practices had the greatest impact on hospitalization scores.

In the High Hospitalization group, agencies that had the greatest reduction in hospitalization rates categorized themselves as “Extensively Involved,” monitored scores “Much More Frequently,” and had the CEO as the lead person in the agency. This appears to speak to the level of commitment of those agencies that were very aware of their high hospitalization rates and the resulting significant decrease in hospitalization rates that they achieved from their effort.

The Moderate and Low Hospitalization groups both categorized themselves as “Moderately Involved” and did not monitor scores as much as the High Hospitalization group. This may suggest that these groups already felt comfortable with their processes and the frequency with which they were evaluating hospitalization rates prior to the campaign. The groups with the greatest reduction also stated that they had a Senior Leader as the Lead of the campaign.

The analysis of this response is open to a few interpretations. The first suggests that the senior leader in the agency may have more daily contact with the clinicians and managers and may be more in tune with what is occurring in the operations of the agency. This person has authority and is accountable to the CEO for meeting the objectives. The other rationale for agencies selecting this person may be the result of ambiguity in the question. For hospital based systems, the actual CEO may be the CEO at the hospital, and the person who is responsible for leading the home care agency is provided a “Senior” level title, which is why “Senior” was selected when in reality this person is the CEO of the home care agency.
Conclusions

When we initiated this campaign in late 2010, home health agencies in the State of Ohio had an average hospitalization rate of 31%. Throughout the duration of this campaign we had discussions on the issues related to hospitalizations, provided recommendations on action plans to reduce them, and provided education, feedback, and tools to assist agencies decrease their hospitalization rates. At the conclusion of this campaign, participating agencies had realized an average of a six percentage point drop in their hospitalization scores, bringing the hospitalization rate down to 25%. This number is not only better than the current Ohio average of 29%, but also exceeds the national average of 27% (per CMS Home Health Compare). As the data analysis demonstrates, reducing hospitalization rates is not just something that happens by chance. It takes a focused effort by all involved in the agency to develop a plan, monitor outcomes, and continuously audit the processes involved to make a difference. Many agencies in the campaign did not consistently participate and engage themselves with the tools that were provided. The survey administered at the end of the campaign suggests that this was the result of “a lack of time or personnel” and/or due to “other competing interest.” Fazzi staff completely understands the pressure that agencies feel with increased regulations and requirements combined with continued reductions in reimbursement. However, the data collected suggests that those agencies that had an executive leader committed to improving the scores and that dedicated an adequate amount of time to perform audits, review their dashboard reports, and lead the change consistently achieved greater reductions in hospitalization rates overall and in each individual peer group.

While there were no “silver bullets” on specific clinical practices that clearly set an agency apart on hospitalization rates, what does seem to have made an impact was the amount and level of accountability and follow through exhibited throughout this campaign. Accountability combined with consistent audits, tracking and trending the data, and regular meetings on the topic clearly resulted in lower hospitalization rates for these agencies.
The only way for this change process to begin and then continue for the duration is to have a leader that is committed to the campaign, conveys its importance to the agency, and consistently follow up on the progress of the initiative so that it does not become the “flavor of the month,” here today, forgotten tomorrow.

Regardless of political ideology, beliefs, or positions, health care delivery in the United States is going to continue to change. While there are varying opinions on how this will happen, there is consensus that providers will be measured and compensated on their performance and the value that they provide. Agencies must dedicate the appropriate level of resources to evaluating the big picture of agency operations and ensure that they are providing value to all customers (hospitals, patients, providers) in terms of both quality and costs. Accountability is the key to success!
Appendix A

Results of Organizational Study

Initial question were agency specific demographic information.

11. What is your average daily census?

Of the 28 agencies that answered the question, the average daily census was 189 patients. The agencies with lower re-hospitalization rates had an average daily census of 127 patients, while those with higher re-hospitalization rates averaged 236 patients.

12. How often do you track your unplanned hospitalizations?

The results are generally evenly distributed between those that track results “Daily or Weekly” at 33.3%, “Monthly” at 29%, and those that “Do not track” at 38%.

13. Prior to January 1, 2011, did you have specific efforts or programs to reduce unplanned hospitalizations?

Yes 71%
No 29%

14. If yes, what were the programs?

The majority of the responses included the following:
- Front loading visits
- Use of telehealth
- Calling at risk patients
- Providing education to patient to call the agency before going to the hospital
- Utilizing a hospitalization risk assessment
- Implementing CHF protocols

15. What was your agency's most recent Home Health Compare hospitalization percentage?

Of those agencies that responded, the average re-hospitalization percentage was 29.9% with a standard deviation of 8.99 and a median of 30.
16. Of the following staff levels, how **aware** were they of your efforts to reduce unplanned hospitalizations prior to January 1, 2011?

This question was scored on a scale from 5 to 1 where 5 was “Very Aware,” 3 was “Somewhat Aware,” and 1 was “Not Aware.”

<table>
<thead>
<tr>
<th></th>
<th>5 or 4</th>
<th>3</th>
<th>2 or 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Senior Leadership</td>
<td>85%</td>
<td>7%</td>
<td>-</td>
</tr>
<tr>
<td>Clinical Managers</td>
<td>89%</td>
<td>11%</td>
<td>-</td>
</tr>
<tr>
<td>Non-Clinical Mgrs</td>
<td>24%</td>
<td>48%</td>
<td>28%</td>
</tr>
<tr>
<td>Clinical Staff</td>
<td>71%</td>
<td>25%</td>
<td>2%</td>
</tr>
</tbody>
</table>

17. Of the following staff levels, how involved were they with your efforts to reduce unplanned hospitalizations prior to January 1, 2011?

This question was scored on a scale from 5 to 1 where 5 was “Very Involved,” 3 was “Somewhat Involved,” and 1 was “Not Involved.”

<table>
<thead>
<tr>
<th></th>
<th>5 or 4</th>
<th>3</th>
<th>2 or 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Senior Leadership</td>
<td>18</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Clinical Managers</td>
<td>23</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Non-Clinical Mgrs</td>
<td>5</td>
<td>3</td>
<td>17</td>
</tr>
<tr>
<td>Clinical Staff</td>
<td>17</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>Non-clinical Staff</td>
<td>3</td>
<td>6</td>
<td>19</td>
</tr>
</tbody>
</table>

18. Between July 1, 2010 and December 31, 2010, how often did senior leadership **communicate** the need to reduce re-hospitalizations?

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Weekly</td>
<td>9%</td>
</tr>
<tr>
<td>Monthly</td>
<td>43%</td>
</tr>
<tr>
<td>A Few Times</td>
<td>36%</td>
</tr>
<tr>
<td>Once</td>
<td>0</td>
</tr>
<tr>
<td>Never</td>
<td>12%</td>
</tr>
</tbody>
</table>
19. Between July 1, 2010 and December 31, 2010, how often did senior leadership initiate specific efforts or programs to reduce re-hospitalizations?

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Once</td>
<td>19%</td>
</tr>
<tr>
<td>Twice</td>
<td>19%</td>
</tr>
<tr>
<td>Three or more times</td>
<td>31%</td>
</tr>
<tr>
<td>Never</td>
<td>31%</td>
</tr>
</tbody>
</table>

20. Does your agency currently use a structured fall prevention program with specific tests and measures that call for additional interventions for a patient when clearly defined criteria are met?

79% of agencies said that they do, and 21% do not.

21. What intervention practices are implemented per your fall prevention practices?

<table>
<thead>
<tr>
<th>Practice</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Additional Disciplines are added to the case.</td>
<td>92%</td>
</tr>
<tr>
<td>Patient/Caregiver is provided with education material addressing risk factors.</td>
<td>96%</td>
</tr>
<tr>
<td>Patient/Caregiver is trained on how to reduce risk factors.</td>
<td>100%</td>
</tr>
<tr>
<td>There is a case conference with the interdisciplinary team.</td>
<td>50%</td>
</tr>
<tr>
<td>Patient is provided with a personal emergency response system.</td>
<td>17%</td>
</tr>
<tr>
<td>A structured home safety assessment is conducted.</td>
<td>54%</td>
</tr>
</tbody>
</table>

22. If a structured Fall Risk Assessment Program is utilized, please indicate which patients receive the assessment.

96% of respondents indicated the program is utilized on all patients, while 5% conduct the assessment based on how the OASIS is answered.

24. The average actual response time for a nurse to call a patient back during "on-call" hours is:

50% respond within 15 minutes, 25% respond between 16-30 minutes, and 25% do not measure their response time.
25. How accessible is pertinent patient information and physician contact information for on-call staff?

79% of respondents responded that it is “Always available,” 21% responded that it is “Sometimes available,” and no respondents felt it was “Never” available.

26. Do you know what time of day most patients in your agency tend to be re-hospitalized?

18% of respondents are aware, while 82% are not aware.

28. Roughly, what percent of your hospital readmissions are reported to you at the time of readmissions?

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Percentage Responding</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>7.1%</td>
</tr>
<tr>
<td>1-10%</td>
<td>17.9%</td>
</tr>
<tr>
<td>11-50%</td>
<td>14.3%</td>
</tr>
<tr>
<td>51-80%</td>
<td>25.0%</td>
</tr>
<tr>
<td>Nearly all</td>
<td>14.3%</td>
</tr>
<tr>
<td>Don’t Know</td>
<td>21.4%</td>
</tr>
</tbody>
</table>

29. Do you provide staff with standard instructions for what to do when a patient is seeking to go to the hospital?

44% of respondents do provide education, while 56% do not provide standard instructions.

30. If so, what are the instructions that you give to your staff?

The general themes of action include assessing the patient over the phone and then calling the physician to see if hospitalization is necessary. Some agencies also attempt to make a home visit that day.
31. With respect to medication management, please indicate any practices that are part of your standard protocol.

<table>
<thead>
<tr>
<th>Practice</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication profile is obtained by clinician at SOC with little or no involvement by the patient.</td>
<td>21%</td>
</tr>
<tr>
<td>Written material is provided on individual medications.</td>
<td>50%</td>
</tr>
<tr>
<td>Agency documentation system is used to screen for duplication or potential adverse reactions for patients.</td>
<td>50%</td>
</tr>
<tr>
<td>Patient is engaged in completion of the medication profile by explaining to the clinician the purpose and dosage of each medication.</td>
<td>96%</td>
</tr>
<tr>
<td>Physician notification if the patient is taking more than a set number of medications.</td>
<td>36%</td>
</tr>
</tbody>
</table>

The additional comments included faxing completed med profile to MD or calling MD with discrepancies.

32. Does your agency use a telemonitoring system?

32% (9 agencies) utilized telehealth, while 68% (19) do not use it.

33. On an average day, what percent of your patients have a telehealth system in their home?

Of the 9 agencies using telehealth, 6 utilize it on less than 10% of their patients, and 3 agencies use it on between 11 and 25% of their patients.

34. Do you use your telehealth system as part of your hospitalization diversion program, i.e. a formal program to reduce unplanned hospitalizations?

Of the agencies that responded, 70% implement as part of a diversion program, while 30% do not.

35. If you use a telehealth system, please indicate which patients are normally given a system.

The majority of agencies (88%) deploy units based on specific diagnoses. This was followed by 2 agencies using their monitors on patients referred from physician offices and 1 response each for using monitors on all patients, patients discharged directly from the hospital, and patients discharged directly from other post acute settings.
36. If patients with specific diagnoses receive telehealth systems, please list the relevant diagnoses below.

Of the respondents that are using telehealth, the majority of agencies use them on patients with CHF, COPD, post-CABG, diabetes, hypertension, post surgical patients, and those with recent medication changes.

37. Has your agency implemented a Disease Management Program that specifically identifies chronic conditions?

68% of the 28 respondents have NOT implemented a disease management program for specific chronic conditions.

38. What are the three Chronic Diseases that your agency places most of its focus on with your Disease Management Programs?

The majority of agencies are focusing on CHF, followed by diabetes. A smaller number of agencies are focusing on COPD and wounds.

39. Does your agency utilize an Electronic Medical Record that interfaces with providers outside your system?

Of the 28 responses, 89% do NOT interface with outside providers, and 11% do interface.

40. If you use an Electronic Medical Record, which of the following systems does your agency interface with?

Two agencies interface with hospitals and one with physician practices. One agency reported an interface with their telehealth system.

41. How aware are the groups listed below in your agency's involvement in the Move to Improve Campaign?

Answered on a 5 point scale where 5 is “Very Aware,” 3 is “Somewhat Aware,” and 1 is “Not Aware.”
42. For your certified services, what is your average number of FTEs?

<table>
<thead>
<tr>
<th></th>
<th>5 or 4</th>
<th>3</th>
<th>2 or 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Board of Directors</td>
<td>35%</td>
<td>16%</td>
<td>49%</td>
</tr>
<tr>
<td>Senior Leadership</td>
<td>87%</td>
<td>9%</td>
<td>4%</td>
</tr>
<tr>
<td>Clinical Managers</td>
<td>77%</td>
<td>15%</td>
<td>8%</td>
</tr>
<tr>
<td>Field Staff</td>
<td>30%</td>
<td>51%</td>
<td>19%</td>
</tr>
<tr>
<td>Fiscal Staff</td>
<td>23%</td>
<td>30%</td>
<td>47%</td>
</tr>
<tr>
<td>Clerical Staff</td>
<td>6%</td>
<td>36%</td>
<td>58%</td>
</tr>
</tbody>
</table>

43. Do you have a nursing shortage?

85% of agencies report that they do NOT have a shortage, while 15% of agencies feel that they do have a shortage.

44. Do you have a physical therapist shortage?

Most of the agencies, 69%, do NOT have a shortage, while 31% believe that they do have a PT shortage.

45. What percent of your visits are made by per diem or PRN nurses?

![Percent of Visits Made by Per Diem or PRN Nurses](chart.png)
46. On average, how many nurses (RN, LPN, etc.) does a patient see in a 60 day episode?

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>One</td>
<td>15%</td>
</tr>
<tr>
<td>Two or Three</td>
<td>50%</td>
</tr>
<tr>
<td>Four or Five</td>
<td>27%</td>
</tr>
<tr>
<td>Six or more</td>
<td>8%</td>
</tr>
</tbody>
</table>

47. How are most patients admitted to your agency?

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission Nurse Model</td>
<td>17%</td>
</tr>
<tr>
<td>Most clinical staff do admissions and OASIS assessments</td>
<td>83%</td>
</tr>
</tbody>
</table>

48. Who manages the care of most patients?

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Case manager who works with their patients in the field</td>
<td>92%</td>
</tr>
<tr>
<td>Case coordinator who works in the office</td>
<td>8%</td>
</tr>
</tbody>
</table>
Appendix B

Tracker Dashboard and Hospitalization Management Report

OASIS TRACKER™ SOC Dashboard

Month Reported: June 2011

June Average Revenue per Episode (Wage Adjusted)

<table>
<thead>
<tr>
<th>Case Mix Weight</th>
<th>Average Revenue/Episode</th>
<th>June 2011 SOC Revenue</th>
<th>June 2011 Financial Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>National: 1.31*</td>
<td>$2,629.68</td>
<td>$131,484.00</td>
<td>N/A</td>
</tr>
<tr>
<td>Your Agency: 1.35</td>
<td>$2,632.78</td>
<td>$131,639.00</td>
<td>$155.01</td>
</tr>
</tbody>
</table>

Average CMW at RAP (6 Month Window)

*CMS Reported National Average SOC

Legend:
- Your Agency
- Missing Data
- Tracker/National

Your Top 5 Primary Diagnoses

<table>
<thead>
<tr>
<th>ICD-9 Code</th>
<th>Diagnosis</th>
<th>Frequency For June</th>
<th>Case Mix Weight Agency Average</th>
<th>Tracker Average**</th>
</tr>
</thead>
<tbody>
<tr>
<td>V54.81</td>
<td>Aftcrare joint replace</td>
<td>14.0%</td>
<td>1.12</td>
<td>1.22</td>
</tr>
<tr>
<td>491.21</td>
<td>Obs chr bronc w(ac) exac</td>
<td>10.0%</td>
<td>1.66</td>
<td>1.37</td>
</tr>
<tr>
<td>486.0</td>
<td>Pneumonia, organism NOS</td>
<td>8.0%</td>
<td>1.20</td>
<td>1.22</td>
</tr>
<tr>
<td>V54.13</td>
<td>Aftcrob trauma fx hip</td>
<td>6.0%</td>
<td>0.85</td>
<td>1.15</td>
</tr>
<tr>
<td>428.0</td>
<td>CHF NOS</td>
<td>6.0%</td>
<td>1.99</td>
<td>1.56</td>
</tr>
</tbody>
</table>

Your M2200 Therapy

<table>
<thead>
<tr>
<th>Percent of Patients with Therapy Visits</th>
<th>Average Projected Therapy Visits/Patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>National: 53.0%*</td>
<td>7.00*</td>
</tr>
<tr>
<td>Your Agency: 62.0%</td>
<td>11.06</td>
</tr>
</tbody>
</table>

**Tracker Averages use up to 6 previous months of SOC ICD-9 data.

*CMS Reported National Averages for Therapy

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Northampton, MA 800.379.0361

MOVE TO IMPROVE FINAL REPORT  PAGE 40
### Hospitalization Management Dashboard - Completed Episodes

**Hospitalization Management:** June 2011

#### Emergent Care

**M2300** Since last OASI, has patient utilized a hospital emergency department?  
<table>
<thead>
<tr>
<th>Yes WITHOUT Hospital admission</th>
<th>Yes WITH Hospital admission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>Percent</td>
</tr>
<tr>
<td>5</td>
<td>45%</td>
</tr>
</tbody>
</table>

**M2310** Reason for Emergent Care

- **Improper medication administration**
- **Injury caused by fall**
- **Respiratory infection**
- **Other respiratory infection**
- **Heart Failure**
- **Cardiac dysrhythmia**
- **Myocardial infarction or chest pain**
- **Other heart disease**
- **Stroke (CVA) or TIA**
- **Hypopyoglycemia, diabetes out of control**
- **GI bleeding, obstruction, constipation, impaction**
- **Dehydration, malnutrition**
- **Urinary tract infection**
- **IV catheter-related infection or complication**
- **Wound infection or deterioration**
- **Uncontrolled pain**
- **Acute mental/behavioral health problem**
- **Deep vein thrombosis, pulmonary embolus**
- **Other than above reasons**
- **Reason unknown**

#### M2400 Intervention Synopsis at Inpatient Facility Admission

<table>
<thead>
<tr>
<th>Measure</th>
<th>Yes Response</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetic foot care including monitoring for the presence of skin lesions on the lower extremities and patient/caregiver education on proper foot care</td>
<td>4</td>
<td>100%</td>
</tr>
<tr>
<td>Falls prevention interventions</td>
<td>17</td>
<td>100%</td>
</tr>
<tr>
<td>Depression intervention(s) such as medication, referral, or treatment, or a monitoring plan for current treatment</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Intervention(s) to monitor and mitigate pain</td>
<td>16</td>
<td>100%</td>
</tr>
<tr>
<td>Intervention(s) to prevent pressure ulcers</td>
<td>6</td>
<td>100%</td>
</tr>
<tr>
<td>Pressure ulcer treatment based on principles of moist wound healing</td>
<td>2</td>
<td>100%</td>
</tr>
</tbody>
</table>
**Hospitalization Management Dashboard - Completed Episodes**

**Hospitalization Management:** June 2011

**Measures for All Patients**

### Home Health Compare Measures

<table>
<thead>
<tr>
<th>Percentage of patients who/whose:</th>
<th>Eligible Agency Patients</th>
<th>Agency</th>
<th>National*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of patients who get better at walking or moving around</td>
<td>66</td>
<td>73%</td>
<td></td>
</tr>
<tr>
<td>Percentage of patients who get better at getting in and out of bed</td>
<td>52</td>
<td>69%</td>
<td></td>
</tr>
<tr>
<td>Percentage of patients who have less pain when moving around</td>
<td>67</td>
<td>72%</td>
<td></td>
</tr>
<tr>
<td>Percentage of patients whose bladder control improves</td>
<td>29</td>
<td>66%</td>
<td></td>
</tr>
<tr>
<td>Percentage of patients who get better at bathing</td>
<td>76</td>
<td>87%</td>
<td></td>
</tr>
<tr>
<td>Percentage of patients who get better at taking their medicines correctly (by mouth)</td>
<td>52</td>
<td>71%</td>
<td></td>
</tr>
<tr>
<td>Percentage of patients who are short of breath less often</td>
<td>59</td>
<td>83%</td>
<td></td>
</tr>
<tr>
<td>Percentage of patients who stay at home after an episode of home health care ends</td>
<td>83</td>
<td>71%</td>
<td></td>
</tr>
<tr>
<td>Percentage of patients whose wounds improved or healed after an operation</td>
<td>35</td>
<td>97%</td>
<td></td>
</tr>
<tr>
<td>Percentage of patients who had to be admitted to the hospital</td>
<td>85</td>
<td>21%</td>
<td></td>
</tr>
<tr>
<td>Percentage of patients who need urgent, unplanned medical care</td>
<td>79</td>
<td>14%</td>
<td></td>
</tr>
<tr>
<td>Percentage of patients who need unplanned medical care related to a wound that is new, worse, or becomes infected</td>
<td>79</td>
<td>1%</td>
<td></td>
</tr>
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</table>

* National Home Health Compare data not yet available from CMS.

### OASIS-C Home Health Process Measures

<table>
<thead>
<tr>
<th>Measure:</th>
<th>Eligible Agency Patients</th>
<th>Agency</th>
<th>National</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pain Assessment Conducted</td>
<td>85</td>
<td>100%</td>
<td>96%</td>
</tr>
<tr>
<td>Pain Interventions Implemented During Short Term Episodes of Care</td>
<td>63</td>
<td>100%</td>
<td>94%</td>
</tr>
<tr>
<td>Heart Failure Symptoms Addressed During Short Term Episodes of Care</td>
<td>4</td>
<td>100%</td>
<td>97%</td>
</tr>
<tr>
<td>Pressure Ulcer Risk Assessment Conducted</td>
<td>85</td>
<td>99%</td>
<td>95%</td>
</tr>
<tr>
<td>Pressure Ulcer Prevention in Plan of Care</td>
<td>43</td>
<td>100%</td>
<td>88%</td>
</tr>
<tr>
<td>Pressure Ulcer Prevention Implemented During Short Term Episodes of Care</td>
<td>33</td>
<td>100%</td>
<td>86%</td>
</tr>
<tr>
<td>Timely Initiation of Care</td>
<td>85</td>
<td>80%</td>
<td>85%</td>
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<tr>
<td>Multifactor Fall Risk Assessment Conducted for Patients 65 and Over</td>
<td>69</td>
<td>100%</td>
<td>94%</td>
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<tr>
<td>Drug Education on All Medications Provided to PI/Caregiver During Short Term Episodes of Care</td>
<td>82</td>
<td>77%</td>
<td>83%</td>
</tr>
<tr>
<td>Depression Assessment Conducted</td>
<td>85</td>
<td>100%</td>
<td>91%</td>
</tr>
<tr>
<td>Influenza Immunization Received for Current Flu Season</td>
<td>85</td>
<td>31%</td>
<td>67%</td>
</tr>
<tr>
<td>Pneumococcal Polysaccharide Vaccine Ever Received</td>
<td>85</td>
<td>67%</td>
<td>60%</td>
</tr>
<tr>
<td>Diabetic Foot Care &amp; PI/Caregiver Education Implemented During Short Term Episodes of Care</td>
<td>21</td>
<td>95%</td>
<td>83%</td>
</tr>
</tbody>
</table>

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8/16/2011
## Management of Medications Dashboard - Completed Episodes

**June 2011**

### Management of Medications

#### June 2020 Management of Oral Medications SOC

<table>
<thead>
<tr>
<th>Category</th>
<th>N</th>
<th>Pct</th>
<th>N-Hosp</th>
<th>%-Hosp</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - Able to independently take the correct oral medication(s) and proper dosage(s) at the correct times</td>
<td>28</td>
<td>39%</td>
<td>5</td>
<td>28%</td>
</tr>
<tr>
<td>1 - Able to take medication(s) at the correct times if: (a) individual dosages are prepared in advance by another person; OR (b) another person develops a drug diary or chart</td>
<td>14</td>
<td>19%</td>
<td>4</td>
<td>22%</td>
</tr>
<tr>
<td>2 - Able to take medication(s) at the correct times if given reminders by another person at the appropriate times</td>
<td>12</td>
<td>16%</td>
<td>1</td>
<td>6%</td>
</tr>
<tr>
<td>3 - Unable to take medication unless administered by another person</td>
<td>19</td>
<td>25%</td>
<td>7</td>
<td>39%</td>
</tr>
<tr>
<td>NA - No oral medications prescribed</td>
<td>1</td>
<td>1%</td>
<td>1</td>
<td>6%</td>
</tr>
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</table>

#### June 2020 Management of Oral Medications ROC

<table>
<thead>
<tr>
<th>Category</th>
<th>N</th>
<th>Pct</th>
<th>N-Hosp</th>
<th>%-Hosp</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - Able to independently take the correct oral medication(s) and proper dosage(s) at the correct times</td>
<td>3</td>
<td>30%</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>1 - Able to take medication(s) at the correct times if: (a) individual dosages are prepared in advance by another person; OR (b) another person develops a drug diary or chart</td>
<td>1</td>
<td>10%</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>2 - Able to take medication(s) at the correct times if given reminders by another person at the appropriate times</td>
<td>2</td>
<td>20%</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>3 - Unable to take medication unless administered by another person</td>
<td>4</td>
<td>40%</td>
<td>0</td>
<td>0%</td>
</tr>
</tbody>
</table>

#### June 2020 Management of Oral Medications DC

<table>
<thead>
<tr>
<th>Category</th>
<th>N</th>
<th>Pct</th>
<th>N-Hosp</th>
<th>%-Hosp</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - Able to independently take the correct oral medication(s) and proper dosage(s) at the correct times</td>
<td>38</td>
<td>59%</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>1 - Able to take medication(s) at the correct times if: (a) individual dosages are prepared in advance by another person; OR (b) another person develops a drug diary or chart</td>
<td>12</td>
<td>19%</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>2 - Able to take medication(s) at the correct times if given reminders by another person at the appropriate times</td>
<td>6</td>
<td>9%</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>3 - Unable to take medication unless administered by another person</td>
<td>8</td>
<td>13%</td>
<td>0</td>
<td>0%</td>
</tr>
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</table>

#### June 2020 Management of Injectable Medications SOC

<table>
<thead>
<tr>
<th>Category</th>
<th>N</th>
<th>Pct</th>
<th>N-Hosp</th>
<th>%-Hosp</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - Able to independently take the correct medication(s) and proper dosage(s) at the correct times</td>
<td>6</td>
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</tr>
<tr>
<td>1 - Able to take medication(s) at the correct times if: (a) individual dosages are prepared in advance by another person; OR (b) another person develops a drug diary or chart</td>
<td>2</td>
<td>3%</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>2 - Able to take medication(s) at the correct times if given reminders by another person based on the frequency of the injection</td>
<td>1</td>
<td>1%</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>3 - Unable to take medication unless administered by another person</td>
<td>3</td>
<td>4%</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>NA - No Injectable medications prescribed</td>
<td>83</td>
<td>84%</td>
<td>18</td>
<td>100%</td>
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</table>

#### June 2020 Management of Injectable Medications ROC

<table>
<thead>
<tr>
<th>Category</th>
<th>N</th>
<th>Pct</th>
<th>N-Hosp</th>
<th>%-Hosp</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - Able to independently take the correct medication(s) and proper dosage(s) at the correct times</td>
<td>1</td>
<td>1%</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>NA - No Injectable medications prescribed</td>
<td>9</td>
<td>90%</td>
<td>0</td>
<td>0%</td>
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</table>

#### June 2020 Management of Injectable Medications DC

<table>
<thead>
<tr>
<th>Category</th>
<th>N</th>
<th>Pct</th>
<th>N-Hosp</th>
<th>%-Hosp</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - Able to independently take the correct medication(s) and proper dosage(s) at the correct times</td>
<td>8</td>
<td>13%</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>2 - Able to take medication(s) at the correct times if given reminders by another person based on the frequency of the injection</td>
<td>1</td>
<td>2%</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>3 - Unable to take medication unless administered by another person</td>
<td>1</td>
<td>2%</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>NA - No Injectable medications prescribed</td>
<td>54</td>
<td>84%</td>
<td>0</td>
<td>0%</td>
</tr>
</tbody>
</table>
Appendix C

Summary of Focus Group

The agencies and their respective representatives are:

- Buckeye Home Health Care – Lillie Webster
- Blessed at Home – Sheila Salisbury
- Union Hospital Home Health – Deb Albaugh
- Ottawa County Health Dept. – Sandy Walton
- Ohio Valley Home Health – April Burgett
- Otterbein Home Health – Kimberly Neikirk
- Fisher-Titus Medical Center (Home Health Center) – Deb Cullen
- Mount Carmel Home Care – Vickie Bullock
- Signature Health Services (Columbus) – Deb Locke
- Good Nursing Care – Teresa Caudle
- Wilson Hosp. Home Health – Steve Lemmon
- Grand Lake Home Health – Carolyn Lammers
- Comprehensive Health Network – Cindy Scott

Below is a summary of the topics covered in the two hour session and the feedback provided by the participants.

Why are patients going back to the hospital?

**Diagnosis – CHF, COPD, Diabetics, Wounds**

Patients with chronic disease have higher propensity for re-hospitalization; however, better medical management could significantly reduce this.

**Early Hospital Discharges**

Patients are being discharged from the hospital too early and are unprepared for the transition. This is a function of hospitals attempting to control their length of stay metrics.

**Lack of D/C planning from the hospital:**

- Lack of pertinent referral information.
- Send patient home with new scripts for medications that the patient may not be able to obtain or afford.
- Pt being discharged later into the evening.
- No or unprepared/incapable caregiver.
Physicians:

- Increased use of hospitalist with poor communication strategies, resulting in more patients being admitted to the hospital and discharged without primary care physician even being aware of hospitalization.
- Large physician groups are resulting in a decrease in familiarity of the patient by their physician. There is a greater use of NPs and PAs. Physician on call does not “know” the patient and is more likely to send to ED to minimize potential liability issues.
- When calling physician office to report potential issues, there is a significant lag time to obtain a call back, if one is obtained at all, to address the issues before they become urgent and require an ED visit.
- Physician office is unable to schedule patients for follow up visits in a seven day time frame post hospital discharge. The evidence is clear that this reduces re-hospitalization.

Communication Issues:

- General lack of communication at all levels.
- Incomplete referrals from hospital.
- Primary care physician unaware of patient’s hospitalization or treatment.
- Patient unaware of what his/her options are and what he/she should expect from home care.
- Physicians unaware of the purpose and capabilities of home care.
- Disconnect with respect to who is ordering equipment and supplies.
- Lack of interdisciplinary communication within the home care agency.

Use of sub-acute facilities

Perception that there are quality issues that are resulting in patients deteriorating at that level of care

Participant ideas to manage some of these issues:

- Develop relationships with hospital D/C planners and keep in touch with them to help them better prepare the pt for D/C (meds, equipment, caregiver, who will sign orders for home care).
- Use of agency liaison to generate referrals.
- Suggestion that the nurses do or review D/C planning as opposed to MSW.
- Utilize an RN in agency intake office to review referrals.
- Use of a high risk screening tool to identify patients at higher risk of re-hospitalization.
- Front loading of visits.
What roles do clinicians, agencies, and patients have? What should it look like?

Clinicians:
- Need to teach patients how to manage their disease and not just do tasks to them.
- Need to be better able to assess knowledge level of patients.
- Need to understand basic teaching concepts for adults (discussed how adults need to understand the “why” of their treatment, the concept of “non-compliance” and use of the Patient Activation Measure to engage patients, and discussed understanding the need to elicit the patient’s goals and not what our goals are for them).
- Perception that “seasoned nurses” are less likely to implement actions such as front loading visits, increasing frequency after identifying an issue, or delaying a scheduled D/C.

Agencies:
- Develop relationships with assisted living facilities to have the agency notified of resident issues instead of sending them to ED.
- Educate physicians that home care agencies are capable of reducing re-hospitalization.
- Make sure agencies provide on-call nurses with the tools they need and set the expectation that when a patient calls the on-call nurse, they should be going out to see the patient and not just sending them to the ED.
- Provide some level of care paths or standardized treatment and education for nurses to provide to patients.
- Develop tool to allow clinicians to check what the objectives of the plan of care were and make sure they were met before discharge.
- Assure adequate staffing levels to allow for same day nursing visit if needed.
- Provide adequate training to their staff to assure that they can do all of the things listed above.

Patients:
- “Compliance is their co-pay” – in order to receive services, they must follow through with the plan of care developed.
- Empower them:
  - Use disease management zones
  - Instruct them to call the agency before going to ED
  - Implement an emergency plan
Disease Management. What does it mean? What should it look like?

- Use of evidence based practice to improve management of the disease state.
- Having a set disease education protocol to address the major disease state components.
- Teach the patient how to keep a log of daily vitals.
- Regular phone calls to patients to check in.
- Use of telemonitoring.
- Establish what the patient’s goals are for their treatment and what motivates them (PAM).
- Structured case conferencing that occurs regularly on all patients.
- Field visits with clinicians (about 1/3 were doing this).

Fall Prevention

- Identify risk at start of care (some participants thought that nurses were not as good at this as therapists were because they ask patients instead of have patients demonstrate).
- Evaluate need and availability of adaptive equipment.
- Assess proper use of equipment by patients.
- Home environment assessment.
- Make referral for PT or OT if indicated.
- HHA placement.
- OT – HHA joint visit.
- PT answers same functional OASIS questions that nursing did on SOC.
- Medication review.
- Assessment of lighting.
- Caregiver education.
- Personal Emergency Response system.

Medication Management

Issues:

- Affordability.
- Patients don’t understand dosing.
- May not take medications if they don’t feel any different.
Potential solutions:

- The standard practice probably consists of the clinician gathering all of the medications in the home and entering them into the profile.
- Suggested a better process where the clinician has the patient gather all of the medication that they are taking. The clinician should have the patient tell the clinician what each medication they are taking is, what it is for, when they take it, and how often.
- This helps to ensure that the patient understands their medication regimen and will identify if the patient is under or overdosing or taking the wrong medication.
- Every visit the clinician should be asking if the patient has any new or changed medications.
- Can they afford their medications – if not MSW referral.
- Establish relationships with pharmacies that deliver.
- See if pharmacy will pre-fill medications.
- Have nurses count pills to see if the patient is consuming the correct number of pills.
- Use a pill box.
- Use a paper schedule so the patient can check off when they take each medication.
- Use electronic med reconciliation to identify side effects or adverse reactions.
- Compare medication regimen to the Beers medication list.
Appendix D

Practice Recommendations

The Four Pillars of Hospitalization Reduction

Pillar 1: Data Tracking and Analysis

Focus on:

- Hospitalization Rate – monthly/quarterly: Item should be trending downward if your interventions are making the desired difference.
- Respiratory and CHF Percentage of Diagnosis on Transfer: Item will tell you if your programs are achieving the desired outcomes.
- Reason for Emergent Care: Pay special attention to the indicators where you have instituted improvement initiatives.
- OASIS-C Process Measures – Items That Have a Relationship to Increasing Hospitalization Rates:
  - Heart Failure Symptoms Addressed
  - Timely Initiation of Care
  - Fall Assessment Conducted
  - Drug Education on all Medications Provided
  - Pneumococcal Vaccine Received

Pillar 2: Optimal Clinical Structure – The Clinical Model

Interdisciplinary Teams:

- Patient centered approach – includes Nurses, PT, OT, ST, MSW, HHA and Transition Coordinators.
- Provides more knowledge and experience than disciplines operating in isolation.
- Integrate separate discipline approaches into a single Care Plan.
- Identification of Case Manager.

Transition Coordinators:

- Successful completion of approved training.
- Pre-discharge visit to the facility.
- Transition POC developed for each patient at risk for hospitalization.
- TC coordinates with the assigned Case Manager.
Weekly Care Management Team Conferences:

- Weekly meetings of the interdisciplinary team.
- Ensure delivery of standardized outcome based care to patients.
- Ensure cost efficient delivery of care.
- Ensure coordination between and among disciplines and TCs.

Staffing to Assure a Limited Number of Nurses Caring for Patient:

- There is an adequate supply of nurses in home care.
- Review current staffing patterns.
- Determine patterns to fit patient and agency need.
- Options: RN and LPN teamed, employees and per diems teamed, admit nurses, and visit nurses teamed, full time nurses and part time nurses teamed.

Pillar 3: Management Process for Excellence

Timely Initiation of Start of Care:

- Ensure an adequate number of clinicians to meet patient SOC needs in a timely manner.
- Evaluate the pattern of referral receipt vis à vis certain days, and trend over time. Staff accordingly.
- Schedule a slot for admits for Case Managers as patterns dictate.
- Assure staff call into agency daily with cancelled visits.

Increase Management’s Support of Initiative throughout Entire Organization:

- Develop teams/groups to provide input for plans for Hospitalization Initiatives.
- Educate all staff on initiatives developed.
- Create “Champions” in each department.
- Report and celebrate successes with all staff.

Front Loading Visits:

- Develop a comprehensive and interdisciplinary tool to identify patients at elevated risk of hospitalization and protocols for providing frequent patient visits.
- Establish protocols where patients with higher medical acuity receive a corresponding higher frequency of nursing visits during the initial weeks of service.
- Ensure that patients with higher functional deficits have therapy services initiated within 1-2 days also with a frequency of higher intensity during the initial weeks of service.
- Utilize phone calls to patients or telehealth if available.
Improve Management of Referral/Physician Relationships:

- Differentiate your agency by building collaborative relationships with physician practices and hospital discharge planners.
- Take outcome data to decision makers to present case on how you can improve financial and quality outcome of facility.
- Develop communication and care protocols for specific physician contacts.
- Assign nurses to work with MDs.
- Teach nurses SBAR Communication.

Implement Disease Management Programs:

- For your top one or two chronic diseases, establish standardized protocols focused on:
  - Patient education regarding their disease and how they can better manage it (medication management, understanding and monitoring their symptoms more effectively, and to changing behavior)
  - Actively monitor patients’ clinical symptoms and treatment plans, following evidence-based guidelines
  - Coordinate care for the disease among all providers within and outside the agency

Audit All Hospitalizations:

- The auditor can evaluate if best practice care was provided and if appropriate referrals/interventions were made for the subject hospitalized patient. Identify if hospitalization was appropriate.
- Aggregate the data by categories and by clinician.
- Identified clinician trends should result in individual coaching for performance. Agency trends should be addressed at least monthly with clinicians/supervisors to address areas of deficiency with specific plan to improve scores.
- Identified trends should be communicated to all and addressed in case conferences.
- Following education, track and trend results.

Pillar 4: Clinical Practices for Excellence

Address and Monitor Respiratory Disease and Infection:

- Offer and provide patients with data to encourage them to receive the Pneumococcal vaccine as well as the flu vaccine.
- Encourage patients and have resources available to assist them to quit smoking.
- Teach the importance of proper hand hygiene.
- Promote the importance of oxygen use if prescribed.
- Instruct on medication management.
- Medication management program in place.
Address and Monitor Signs and Symptoms of Heart Failure (CHF):

- Establish standardized teaching tools to provide to patients to educate them on the disease process.
- Red/Yellow/Green tool or similar tool to instruct patients what they should be doing to manage their condition based on how they feel.
- Telemonitoring.
- Diet education.
- Utilize therapy to teach energy-saving techniques.

Implement a Fall Prevention Program:

- Establish risk factor assessment with written protocols as to when and what additional disciplines or changes to POC should be added to mitigate risk.
- Provide patients with written recommendations on home safety and promote implementation.
- Perform comprehensive medication review.
- Comprehensive assessment of strength, ROM, vestibular, assistive device, etc.

Educate Patients on Whom to Call When They are Concerned About Their Status:

- Make the agency phone number available in numerous places in the home.
- Encourage patients to call the agency at any time to address concerns.
- Provide on-call nurse with sufficient information to include patient history and MD contact to allow intervention PRN.
- Track and trend on-call logs by clinician, patient, Dx, MD. Include time of call and interventions.
- Mystery Calling PRN.

Improve Medication Management:

- At SOC, patients to gather all medications and do a teach-back to clinician that includes what, when, and why they take each medication.
- Review all medications for high-level adverse reactions. Review Beers list for inappropriate medications for seniors.
- Clinician to check for new meds at each visit.
- Utilize pill boxes or med reminders.
- Institute a “Med Management” program in conjunction with M.D.s and local pharmacist.
Appendix E
Agency Improvement Identification Form

Agency Name: _____________________________________________________________

Project Lead: ____________________________________________________________

E-mail: __________________________________________________________________

Phone: __________________________________________________________________

Please rank each Practice Recommendation from A (always or most often do this) to B (sometimes do this) to C (rarely or never do this) for your specific agency for each of these practices. You will be developing plans directed at improving your practices in your three areas that have the most opportunity for improvement.

<table>
<thead>
<tr>
<th>Management Process and Clinical Practice Recommendations</th>
<th>A – B – C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Management Process Recommendation 1: Timely Initiation of Care</td>
<td></td>
</tr>
<tr>
<td>Management Process Recommendation 2: Increase Management’s Support of Hospitalization Initiative Throughout Entire Organization</td>
<td></td>
</tr>
<tr>
<td>Management Process Recommendation 3: Front Loading Visits</td>
<td></td>
</tr>
<tr>
<td>Management Process Recommendation 4: Improve Management of Referral/Physician Relationships</td>
<td></td>
</tr>
<tr>
<td>Management Process Recommendation 5: Implement Disease Management Programs</td>
<td></td>
</tr>
<tr>
<td>Management Process Recommendation 6: Audit All Hospitalizations</td>
<td></td>
</tr>
<tr>
<td>Clinical Practice Recommendation 1: Address and Monitor Respiratory Disease and Infection</td>
<td></td>
</tr>
<tr>
<td>Clinical Practice Recommendation 2: Address and Monitor Signs and Symptoms of Heart Failure (CHF)</td>
<td></td>
</tr>
<tr>
<td>Clinical Practice Recommendation 3: Implement a Fall Prevention Program</td>
<td></td>
</tr>
<tr>
<td>Clinical Practice Recommendation 4: Educate Patients to Call Agency First</td>
<td></td>
</tr>
<tr>
<td>Clinical Practice Recommendation 5: Improve Medication Management</td>
<td></td>
</tr>
</tbody>
</table>
Appendix F
Implementation Accountability Form

The success or failure of each agency’s Move to Improve Campaign is based on the skill and accountability of the leaders of the campaign and of the various initiatives. Please list the leader of each of the following initiatives. We will periodically email them information on their area and will be available to them for guidance and advice. Note: “Lead” means the person responsible for managing and ensuring the success of a specific activity. They own it!

Agency: __________________________________________________________

Director: __________________________________________________________

Director Email: ____________________________________________________

Data Tracking and Analysis Lead: _____________________________________

Tracking and Analysis Lead Email: _____________________________________

Clinical Model Lead: ________________________________________________

Clinical Model Lead Email: ___________________________________________

Management Process Lead: ___________________________________________

Management Process Lead Email: _______________________________________

Clinical Practice Lead: ______________________________________________

Clinical Practice Lead Email: _________________________________________
# Appendix G
## ER Visit/Unplanned Hospitalization Audit Tool

<table>
<thead>
<tr>
<th>SOC/ROC OASIS Assessment</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>SOC/ROC conducted within 48 hrs or per agency policy?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>M1800-1890 ADL/IADL Response ≥3 for ≥3 functional tasks</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>M2020-2030 Medication Management Response = 3</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Patient has a Personal Emergency Plan (PEP) - who to call for what reason and how**

- Teach back for PEP obtained > 1 time in the first week of care at SOC
- Teach back obtained by each discipline within the first 2 weeks of care
- Teach back obtained > 1 time in the first week of care at ROC
- Teach back obtained by each discipline within the first week

**Plan of Care**

- Interventions identified for each area of risk identified in M1032 Hospitalization
- Interventions identified for each area of risk identified in M1910 Falls Risk Assessment
- Interventions identified for each area of risk identified in M1300 Pressure Ulcer Risk
- Obtained parameters for reporting vital signs
- Obtained parameters for reporting lab values
- Obtained parameters for reporting clinical symptoms related to disease/condition

**Medications**

- Does the medication profile contain any high level adverse reactions or medications on the Beers List?
- Did the patient teach back the purpose and dosage of each medication?
- Did the patient teach back medication administration (retrieved from storage, open container, read label, set it up, take it, etc.)?

**Implementation**

- All interventions above were implemented during the 60 day episode
- Teach back obtained for all interventions listed above
- Repeat teach back obtained at discharge from discipline
- Repeat teach back obtained at discharge from agency

**Documentation**

- Rationale for clinical action(s) includes “reducing ER visit/hospitalization” (cleared pathways to reduce risk of falls and ER visit; reviewed meds with pharmacist/MD to reduce number taken to reduce risk for ER visit/hospitalization, etc.)
<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
</table>

**Care Coordination**

- Team meeting identifies high risk patients
- Abnormal findings reported to physician
- Abnormal findings reported to team of care providers
- Regular communication within a discipline
- Regular communication between disciplines
- Summary communication with each discipline when discipline transfers out of case

**Visits**

- Initial visits/patient contacts ensure patient safety and based on risk for rehospitalization
- Visited by ≥ 4 clinicians of the same service within the episode
- Visited by ≥ 3 clinicians of the same service within the first week of care
- Missed visits are rescheduled
- More than 1 missed visit in an episode
- Was the visit frequency appropriate for the clinical acuity of the patient?

**ER Visit/Unplanned Hospitalization**

- Directed to the ER/hospital at the time of the visit
- Actions appropriate
- Directed to the ER/hospital based on call from patient/caregiver
- Actions appropriate
- Agency unaware of the ER visit/hospitalization until after event

**Evaluation**

- ER visit/unplanned hospitalization was **unavoidable**
- Additional actions could have been taken to delay/avoid event

**Comments**

Identify specific actions which could have delayed or prevented ER visit/hospitalization:

---

**Move to Improve Final Report**

**Page 57**
# Appendix H

## Revision Tools

### Monthly Accountability & Planning Meeting

**Meeting Date:** ______________________________

**Attendees:** ________________________________________________________________

<table>
<thead>
<tr>
<th>Date</th>
<th>Accountable Lead:</th>
</tr>
</thead>
<tbody>
<tr>
<td>OASIS data was uploaded to Fazzi no later than tenth day following previous month.</td>
<td></td>
</tr>
<tr>
<td>Hospitalization Management Dashboards printed, analyzed, and distributed to team prior to meeting. Summary provided.</td>
<td></td>
</tr>
<tr>
<td>Hospitalized patients had chart audits completed within two days.</td>
<td></td>
</tr>
<tr>
<td>Report generated identifying trended issues from audit tool.</td>
<td></td>
</tr>
</tbody>
</table>

**Action plan and person responsible for follow up:**

**Review of previous month's focused intervention - what was done and how is it being monitored?**

**Based on audits, identify area of focus for current month/quarter. Develop plan for a targeted objective. What is the goal? How will clinicians be informed/educated? How will it be monitored?**

---

MOVE TO IMPROVE FINAL REPORT PAGE 58
Organizational Structure

- Responsible for directing overall activities related to reducing hospitalization
- Conducts monthly meeting of Leads to review data, identify deficits, establish action plans, and review progress on previous plans

**PROJECT LEAD**
CEO/COO

**Data Coordination Lead**
(Quality/PI Director)
- Pulls Tracker Dashboard
- Evaluates Hospitalization Management Dashboard
- Compiles hospitalized patient audits and identifies areas of deficiency
- Presents tracking and trending reports at monthly MAP Meetings

**Real Time Hospitalization Lead**
(Clinical Director)
- Conducts Hospitalization Audit within 2 days of hospitalization and interviews/coaches clinicians as needed
- Presents completed audit to Data Coordination Lead for compilation

**Clinical Practice Lead**
(Clinical Director)
- Responsible for implementation of clinical best practice and protocol
- Assures clinicians receive required training
Leadership Structure

**Project Lead: (preferably CEO or COO)**

Name: ____________________________________________

Email: ____________________________________________

**Data Coordination Lead: (preferably quality director)**

Name: ____________________________________________

Email: ____________________________________________

**Real Time Hospitalization Lead: (preferably clinical director)**

Name: ____________________________________________

Email: ____________________________________________

**Practice Lead: (preferably clinical director)**

Name: ____________________________________________

Email: ____________________________________________
## ER Visit/Unplanned Hospitalization Audit Tool

<table>
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### Patient has a Personal Emergency Plan (PEP) - who to call for what reason and how

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### Plan of Care

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- Interventions identified for each area of risk identified in M1910 Falls Risk Assessment
- Interventions identified for each area of risk identified in M1300 Pressure Ulcer Risk
- Obtained parameters for reporting vital signs and lab values and symptoms to report

### Medications

- Does the medication profile contain any high level adverse reactions or medications on the Beers List?
- Did the patient teach back the purpose, dosage, and frequency of each medication?

### Implementation

- All interventions on POC were implemented during the 60 day episode
- Teach back obtained for all interventions listed above
- Repeat teach back obtained at discharge from agency

### Care Coordination

- Team meeting or alternate communication identifies high risk patients to all clinicians
- Abnormal findings reported to physician timely
- Regular communication within and between disciplines

### Visits

- Initial visits ensure patient safety and based on risk for rehospitalization
- Visited by ≥ 4 clinicians of the same service within the episode
- Missed visits are rescheduled
- Was the visit frequency appropriate for the clinical acuity of the patient?
- Patient was appropriate for telemonitor, received unit, and results impacted POC?

### Evaluation

- ER visit/unplanned hospitalization was unavoidable

### What was the cause of the hospitalization?

### What could have been done to avoid it?
Appendix I

Revised Hospitalization Dashboard Report

Current Hospitalization Results

<table>
<thead>
<tr>
<th>Number of Patients Hospitalized</th>
<th>Percent of Patients Hospitalized</th>
</tr>
</thead>
<tbody>
<tr>
<td>15</td>
<td>30 %</td>
</tr>
</tbody>
</table>

Reporting period is based on every 50 patients discharged or transferred.

Hospitalization Trend

Hospitalization Improvement Chart

To obtain a lower percentage you need to reduce the number of patients hospitalized.

<table>
<thead>
<tr>
<th>Agency Current Results</th>
<th>State Avg</th>
<th>Nat’l Avg</th>
<th>Targets Top 33%</th>
<th>Targets Top 20%</th>
</tr>
</thead>
<tbody>
<tr>
<td>30 % Percent of Patients Hospitalized</td>
<td>29 %</td>
<td>27 %</td>
<td>21 %</td>
<td>24 %</td>
</tr>
<tr>
<td>Reduce Patients Hospitalized by:*</td>
<td>1</td>
<td>2</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>15 Goal for Number of Patients Hospitalized</td>
<td>14</td>
<td>13</td>
<td>10</td>
<td>12</td>
</tr>
</tbody>
</table>

*Numbers are rounded off to next highest number.
Source for National and State Averages, including Target percentages. CMS Home Health Compare

Your Next Goal

<table>
<thead>
<tr>
<th>Number of Patients Hospitalized</th>
<th>Percent of Patients Hospitalized</th>
</tr>
</thead>
<tbody>
<tr>
<td>13</td>
<td>27 %</td>
</tr>
</tbody>
</table>

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3/20/2012