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

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The Institute for Healthcare Improvement (IHI) is an independent not-for-profit organization helping to lead the improvement of health care throughout the world. Founded in 1991 and based in Cambridge, Massachusetts, IHI works to accelerate improvement by building the will for change, cultivating promising concepts for improving patient care, and helping health care systems put those ideas into action.

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I. Introduction

Delivering high-quality, patient-centered health care requires crucial contributions from many parts of the care continuum, including the effective coordination of transitions between providers and care settings. Poor coordination of care across settings results in rehospitalizations, many of which are avoidable. Importantly, working to reduce avoidable rehospitalizations is one tangible step toward achieving broader delivery system transformation.

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

In 2009, IHI began a strategic partnership with the American College of Cardiology to launch the Hospital to Home (H2H) initiative. The goal is to reduce all-cause readmission rates among patients discharged with heart failure or acute myocardial infarction by 20 percent by December 2012. H2H leverages an array of national initiatives intended to reduce readmissions and catalyze action to improve patients’ care transitions.

IHI is also leading a groundbreaking multi-state, multi-stakeholder initiative called STate Action on Avoidable Rehospitalizations (STAAR). The aim is to dramatically reduce rehospitalization rates in states or regions by simultaneously supporting quality improvement efforts at the front lines of care while working in parallel with state leaders to initiate systemic reforms to overcome barriers to improvement. Since 2009, STAAR's work in Massachusetts, Michigan, and Washington has been funded through a generous grant provided by The Commonwealth Fund, a private foundation supporting independent research on health policy reform and a high-performance health system. Additionally, the state of Ohio has funded its own participation in STAAR beginning in 2010.
The Case for Creating an Ideal Transition Home and Reducing Avoidable Rehospitalizations

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

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

Interventions to Reduce Rehospitalizations

Opportunities abound for improving care when patients leave the hospital setting. A 2006 survey found that over 60 percent of patients reported that no one in the hospital talked to them about managing their care at home, and the same survey found that over 80 percent of patients who required assistance with basic functional needs failed to have a home care referral.\(^5\) In addition, direct communication between hospital providers and ambulatory providers is poor; in 2007, Kripalani and colleagues found that direct communication occurred infrequently (for 3 to 20 percent of cases), and discharge summaries were available to the ambulatory care provider in only 12 to 34 percent of cases.\(^6\) A 2009 analysis of Medicare rehospitalizations revealed that half of patients who were readmitted within 30 days had not seen a physician between the time of discharge and the day of readmission. The analysis also found that the risk of rehospitalization is highest in the days following discharge, suggesting that follow-up within days, not weeks, should be standard practice.\(^7\)
A large body of research has focused on methods to improve the hospital discharge process and promising post-discharge support interventions. IHI’s comprehensive literature review and scan of current best practices identified the following high-leverage interventions:

- Effective patient and caregiver education and self-management training during hospitalization and following discharge; anticipatory guidance for self-care needs at home post-discharge;\textsuperscript{5,9-11}
- Reliable referrals for home health care visits;\textsuperscript{5}
- Effective management and communication of medication regimens whenever changes occur;\textsuperscript{12,13}
- Timely and clinically meaningful communication (handoffs) between care settings;\textsuperscript{6,14}
- Early post-acute care follow-up (by care coordinator, coach, nurse, or clinician);\textsuperscript{15-17} and
- Proactive discussions of advance care planning and/or end-of-life preferences and reliable communication of those preferences among providers and between care settings.

Evidence suggests specific interventions reduce avoidable rehospitalizations: improving discharge planning and transition processes out of the hospital; improving transitions and care coordination at the interfaces between care settings; enhancing coaching, education, and support for self-management; redesigning primary care; and providing supplemental services for patients at high risk of recurrent hospitalization.\textsuperscript{18-21}

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

Based on the growing body of evidence and IHI’s experience to date in improving transitions in care after a hospitalization and in reducing avoidable rehospitalizations, IHI has developed a conceptual roadmap (Figure 1) that depicts the cumulative effect of key interventions to improve the care of patients throughout the 30 days after patients are discharged from a hospital or post-acute care facility.
The transition from the hospital to post-acute care settings has emerged as an important priority in IHI’s work to reduce avoidable rehospitalizations. Transitions in care after hospitalization involve both an improved transition out of the hospital (and from post-acute care and rehabilitation facilities) as well as an activated and reliable reception into the next setting of care such as a home health care agency, primary care practice, or a skilled nursing facility.7,16,22 “Although the care that prevents rehospitalization occurs largely outside of the hospital, it starts in the hospital.”7

The How-to Guide: Improving Transitions from the Hospital to Home Health Care to Reduce Avoidable Rehospitalizations is designed to support hospital-based teams and their community partners in creating an ideal reception into home health care in the first 48 hours after the patient is discharged from the hospital, a post-acute care setting, or a rehabilitation facility.
IHI provides additional How-to Guides for transitions from the hospital to post-acute care settings, clinical office practices, and skilled nursing facilities. These How-to Guides are designed to assist clinicians and staff in home health care agencies, office practices, and skilled nursing facilities in developing processes that ensure a timely and reliable transition into community care settings.

- **How-to Guide: Improving Transitions from the Hospital to Post-Acute Care Settings to Reduce Avoidable Rehospitalizations**
- **How-to Guide: Improving Transitions from the Hospital to Skilled Nursing Facilities to Reduce Avoidable Rehospitalizations**
- **How-to Guide: Improving Transitions from the Hospital to the Clinical Office Practice to Reduce Avoidable Rehospitalizations**
II. Getting Started

This section lists the initial steps to create an enhanced transition to home health care in the first 48 hours after the patient is discharged from the hospital, a post-acute care setting, or a rehabilitation facility.

Step 1. The Home Health Agency CEO Selects an Executive Sponsor and a Day-to-Day Leader to Lead the Improvement Work in the Agency; the Agency Partners with a Hospital Cross-Continuum Team to Co-Lead the Improvements Across Care Delivery Sites.

The role of the executive sponsor is to link the aims of improving transitions in care and reducing readmissions to the strategic priorities of the organization. The sponsor provides oversight and guidance to his or her improvement teams’ work. Depending on the size and organizational structure of the home health care agency, typical executive sponsors may include chief executive officers, chief operating officers, chief nursing officers, medical directors, or chief quality officers. The executive sponsor should also select a day-to-day leader who will coordinate improvement activities; participate in a cross-continuum team (see Step 2); provide guidance to the front-line improvement team(s) (see Step 4b); and communicate progress to the executive sponsor on a regular basis. The day-to-day leader is often a quality improvement leader, a nurse director, or a director of case management.

When framing the improvement initiative, executive sponsors should ask the following strategic questions for improving transitions and reducing rehospitalizations:

- Is improving transitions in care and reducing the home health care agency’s acute care hospitalization rate a strategic priority for the executive leaders at the agency? Why?
- What are the agency’s acute care hospitalization rates for all patients and for various high-risk populations?
- What is the agency’s understanding of the opportunities to improve transitions and reduce rehospitalizations?
- Has the agency declared improvement goals?
- What will help the agency achieve success in quality improvement initiatives?
- Are there initiatives to reduce readmissions already underway or planned in the
organization and how could they be better aligned?

- How much experience do executive leaders, mid-level managers, and front-line teams have in process improvement? What resources (e.g., expertise in quality improvement, data analysis) are available to support improvement efforts?

- How will oversight be provided for the improvement projects in order to learn from the work and spread successes?

- Who are the key stakeholders who need to be involved in a project to improve transitions and reduce acute care hospitalizations within 30 days of a hospital discharge?

- Has the financial impact of the initiative been considered?

The executive sponsor will provide guidance for the quality improvement initiative to achieve breakthrough levels of performance. A proposed system for a strategic quality improvement initiative, as outlined in IHI’s white paper *Execution of Strategic Improvement Initiatives to Produce System-Level Results*, contains four components:23

1. Setting priorities and breakthrough performance goals;

2. Developing a portfolio of projects to support the goals;

3. Deploying resources to the projects that are appropriate for the aim; and

4. Establishing an oversight and learning system to increase the chance of producing the desired change.23

**Step 2. The Executive Sponsor Convenes and Participates in a Cross-Continuum Improvement Team**

A multistakeholder team with representatives from across the care continuum, including patients and family members, provides leadership and oversight for the portfolio of projects to improve transitions in care after discharge from the hospital. By understanding the mutual interdependencies and identifying customer and supplier relationships for each step of the patient journey across the care continuum, the team will codesign processes to improve transitions in care. Collectively, team members will explore the ideal flow of information and patient encounters from one setting to the next. This team can be a large or a small group who regularly work together. In home health care agencies that do not yet have a collaborative relationship with a hospital, the CEO can reach out to a community hospital and explore the
creation of a team to improve care processes between the agency and hospital.

Recommendations for cross-continuum team members include:

- Patients and family members (ideally these are not retired health care professionals)
- Representatives from home health care such as nurses, nurse managers, nurse practitioners, clinical directors, quality improvement staff, and palliative care or hospice nurses and staff
- Representative hospital staff such as nurse managers, nurse educators, staff nurses, hospital physicians or hospitalists, case managers, pharmacists, discharge planners, and quality improvement leaders
- Staff from skilled nursing facilities such as nursing leaders or physician leaders
- Clinicians and staff from office practice settings such as primary care physicians and specialists, nurses or nurse practitioners, and practice administrators
- Community pharmacists
- Staff from community social services agencies such as case managers or staff from elder services

At its first meeting, the cross-continuum team should discuss the purpose and goals of the improvement initiative and the role of the team in providing oversight for its improvement work. A suggested initial activity for the cross-continuum team includes participation in an in-depth review of the last five rehospitalizations (see Step 3). Patients and families bring invaluable contributions to the cross-continuum team.\textsuperscript{24,25} For more information on including patients and families in your cross-continuum team, please refer to the following resources:


Step 3. The Team Identifies Opportunities for Improvement

Step 3a. Perform a Diagnostic Review: Conduct an in-depth review of the last five rehospitalizations to identify opportunities for improvement. In addition, home health care agencies should review acute care hospitalizations within 30 days of a hospital discharge. Home health care agencies will want to do a review of their own cases to identify failures specific to their agency.

- Conduct chart reviews of the last five patients receiving home health care services who were rehospitalized, transcribing key information onto Part 1 of the Diagnostic Worksheet (Figure 2).

Figure 2: **Diagnostic Worksheet (Part 1)** (How-to Guide Resources, page 45)

<table>
<thead>
<tr>
<th>Question</th>
<th>Patient #1</th>
<th>Patient #2</th>
<th>Patient #3</th>
<th>Patient #4</th>
<th>Patient #5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of days between the last discharge and this acute care hospitalization date?</td>
<td>___ days</td>
<td>___ days</td>
<td>___ days</td>
<td>___ days</td>
<td>___ days</td>
</tr>
<tr>
<td>Was the follow-up physician</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Conduct interviews with patients who were recently rehospitalized (ideally, shortly after the rehospitalization) and their family members. If possible, interview the same patients whose charts were reviewed. Next, conduct interviews with inpatient caregivers and clinicians in the community who also know the readmitted patient (e.g., physicians, nurses in the skilled nursing facility, home health nurses, etc.) to identify problem areas from their perspective. Transcribe information from these interviews onto Part 2 of the Diagnostic Worksheet (Figure 3).

Figure 3: **Diagnostic Worksheet (Part 2)** (How-to Guide Resources, page 47)

**Step 3b. Review patient experience data regarding communications and discharge preparations.**

Evaluate trends in the scores of your patient experience survey for the last year. Use the Home Health Consumer Assessment of Healthcare Providers and Systems (HHCAHPS) or equivalent survey questions. Refer to www.hcahpsonline.org/home.aspx for the complete list of HHCAHPS questions. Display this trending data on a run chart that depicts the data for the entire agency, by month, for the last 12 months (Figure 4).

Please reference Patient Experience Measures (Data Reporting Guidelines, How-to Guide Resources, page 51)

**Figure 4: Sample Display of Baseline HHCAHPS Data**

![](HHCAHPS_Baseline_Data_Q5_Medications.png)

**Step 3c. Review OASIS Data.**

Collect historical data (from OASIS) and display monthly (see example in Figure 5):

- Acute care hospitalizations: If possible, include acute care hospitalizations within 30 days of last day of hospital stay.

- Emergency department use: If possible, include emergency department use with hospitalizations within 30 days of last day of hospital stay, and emergency department use without hospitalizations

- Discharged to community measures
Consider segmenting the patient population by chronic illnesses such as heart failure.

Please reference Data Reporting Guidelines (How-to Guide Resources, page 50)

- Acute care hospitalization and, if possible, acute care hospitalizations within 30 days of last day of hospital stay for a specific chronic illness or condition like heart failure or COPD

Figure 5: Sample Display of Baseline Acute Care Hospitalizations

<table>
<thead>
<tr>
<th>Percentage Acute Care Hospitalizations</th>
</tr>
</thead>
<tbody>
<tr>
<td>%</td>
</tr>
<tr>
<td>20%</td>
</tr>
<tr>
<td>15%</td>
</tr>
<tr>
<td>10%</td>
</tr>
<tr>
<td>5%</td>
</tr>
<tr>
<td>0%</td>
</tr>
</tbody>
</table>

Step 4. Develop an Aim Statement

Step 4a. Report findings from Step 3 to the entire cross-continuum team.

In the report, include:

- Summary of chart reviews for acute care hospitalized patients (Diagnostic Worksheet Part 1, How-to Guide Resources, page 45)

- Summary of interviews with readmitted patients, their families, and clinicians in the community (Diagnostic Worksheet Part 2, How-to Guide Resources, page 47)

- Patient stories (summation of what was learned from the Diagnostic Review in Step 3a): Share the stories of the patients and families and their experience navigating transitions in care between participating facilities and services. Such stories will resonate more deeply than the statistics and will engage the “hearts and minds” of front-line clinicians and staff.
• Trending data of patient experience with communication and transition preparations (HHCAPHS)

• Trending data for acute care hospitalization rates as well as counts of the number of patients who have an acute hospitalization

**Step 4b. Select one or two home health care nurses or teams or a pilot population to test changes.**

Improvement involves testing changes to processes and learning from those tests of change. A front-line improvement team will be responsible for performing these tests of change; they should select a segment of patients on whom to test the changes. If there is a particular patient population that accounts for a large percent of the acute care hospitalizations (e.g., heart failure patients) then the team may want to focus its testing initially on this patient segment. Process improvements can then be further tested and implemented for all patients.

The composition of the front-line improvement team(s) will vary from agency to agency. These teams are most successful when they include staff who participate in care on a regular basis, as each staff role brings a unique perspective to the work. A typical front-line improvement team for home health care includes:

• A day-to-day leader for the team;

• Patients and family caregivers;

• Home health nurses;

• Home health aides;

• Pharmacists (on the home health agency staff) or community pharmacists;

• Social worker;

• Therapists (physical therapy, occupational therapy, speech therapy);

• Palliative care representative or hospice representative;

• Clinicians and staff from community settings; and

• A nurse or clinician with quality improvement experience, when possible, to assist with development of the aim statement and facilitate the improvement work.
Step 4c. Write an aim statement.

Aim statements communicate to all stakeholders the magnitude of change and the time by which the change will happen. Aim statements help teams commit to the improvement work.

The cross-continuum team develops a clear aim statement for reducing readmissions in the agency. Effective aim statements include five pieces of information:

- What to improve for patients and families;
- Who will test and implement the improvements (specific nurse or home health care team);
- For which patients;
- By when (date-specific deadline); and
- A measurable goal.

Sample aim statements:

1) The Best Homehealth Agency will improve transitions home for all patients as measured by a decrease in their acute care hospitalization rate within 30 days of the last day of the hospital stay by 30 percent within 24 months. We will start with patients being cared for by Teams A and B and will expect to see a decrease in readmissions for patients being care for by those teams of at least 15 percent within 12 months.

2) The Best Homehealth Agency will improve transitions between the hospital and their home health care agency by improving the handover and focusing on medication management during the first week of service so that within the next 12 months we will reduce emergency department visits by 50 percent and acute care hospitalizations within 30 days of discharge by 20 percent. OASIS data will show improvement in medication management and medication stabilization by 15 percent or more.

For more on setting aims, please refer to:

www.ihi.org/knowledge/Pages/HowtoImprove/ScienceofImprovementSettingAims.aspx.
III. Key Changes

The How-to Guide: Improving Transitions from the Hospital to Home Health Care to Reduce Avoidable Rehospitalizations outlines three key recommendations for improving the patient’s transition from a hospital or post-acute care facility to a home health care agency in the first 48 hours after discharge, or by the first post-discharge home care visit (Figure 6).  

Figure 6: Key Changes to Improve the Patient’s Transition from a Hospital or Post-Acute Care Facility to a Home Health Care Agency

<table>
<thead>
<tr>
<th>1. Meet the Patient, Family Caregiver(s), and Inpatient Caregiver(s) in the Hospital and Review the Transition Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A.</strong> Whenever possible, the home health care nurse or liaison meets the patient, family caregivers, and at least one inpatient caregiver (e.g., nurse, hospitalist, social worker, discharge case manager) in the hospital and reviews the transition plan. It is important to identify and collaborate with the appropriate responsible caregiver(s) whenever possible.</td>
</tr>
<tr>
<td><strong>B.</strong> Reinforce to patient, family caregiver(s), and inpatient caregiver(s) the importance of scheduling a follow-up appointment before hospital discharge to ensure timely follow-up after hospitalization with the primary care or managing clinician.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. Assess the Patient, Initiate the Plan of Care, and Reinforce Patient Self-Management at First Post-Discharge Home Health Care Visit</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A.</strong> Re-evaluate the patient’s clinical status since leaving the hospital.</td>
</tr>
<tr>
<td><strong>B.</strong> Reconcile all medications, including all medications in the home.</td>
</tr>
<tr>
<td><strong>C.</strong> Use Teach Back to assess, reinforce, and improve the patient and family caregiver’s understanding and ability to manage medications and self-care.</td>
</tr>
<tr>
<td><strong>D.</strong> Initiate treatments as ordered (e.g., dressing changes, oxygen saturation, wound care).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3. Engage, Coordinate, and Communicate with the Entire Clinical Team</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A.</strong> Ensure that there is proactive, consistent, real-time consultation with the primary care provider or other managing clinician(s).</td>
</tr>
<tr>
<td><strong>B.</strong> Use a patient-centered health record to communicate patient information to all caregivers.</td>
</tr>
<tr>
<td><strong>C.</strong> Advocate as necessary to ensure referrals are completed and needed services are received.</td>
</tr>
</tbody>
</table>
1. Meet the Patient, Family Caregiver(s), and Inpatient Caregiver(s) in the Hospital and Review the Transition Plan

Recommended Changes:

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

1B. Reinforce to the patient, family caregiver(s), and inpatient caregiver(s) the importance of scheduling a follow-up appointment before hospital discharge to ensure timely follow-up after hospitalization with the primary care or managing clinician.

A proactive approach to receiving patients into home health care has been identified as a key strategy to improve transitions in care. There may be staffing constraints to this approach; however, many home health care agencies are finding ways to partner with hospitals to make this possible by working with their cross-continuum teams.

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

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

- Review the findings from Step 3 in Getting Started with Front-Line Improvement Team(s). Periodically repeat Step 3 to continually learn about opportunities for improvement.

- Observe your current process for assisting in the transition from hospital to home health care and for completing the admission assessment. What did you learn?

Recommended Changes

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

- Review clinical information, including diagnosis, medications, depression screening results from PHQ2 or PHQ-9, and home treatments needed.

- Ask what the patient’s and family caregiver’s primary concerns are about going home.

- Identify potential barriers to a successful transition to home health care. Illicit potential problems by describing typical problems patients and caregivers encounter when going home; work to uncover and discover undetected or unarticulated problems and engage the patient and family caregiver in problem solving.

- Use Teach Back to assess the patient’s and family caregiver’s ability to manage medications and self-care. (Teach Back involves asking the patient or family caregiver to recall and restate in their own words what they thought they heard during education or other instructions.)

- Create a list or use a discharge list of personalized “red flags” or symptoms to indicate a deteriorating condition.

- Review the transition plan with the patient, family caregivers, and inpatient caregivers. Identify and include the patient and family caregiver goals for care and identified challenges, such as unsuccessful Teach Back, resource constraints, or cognitive issues.
For more information on proactive activities for patients, family caregivers, and inpatient caregivers to enhance handoffs to home health care, please see the following resources:


*Resident/Patient Continuum of Care Transfer Form.* Colorado Foundation for Medical Care. Available at [www.cfmc.org/caretransitions/files/toolkit/intervention/QIO%20Developed%20Tools/GA_Con tinuum%20of%20Care%20Transfer%20Form.pdf](http://www.cfmc.org/caretransitions/files/toolkit/intervention/QIO%20Developed%20Tools/GA_C ontinuum%20of%20Care%20Transfer%20Form.pdf).

1B. **Reinforce to patient, family caregiver(s), and inpatient caregiver(s) the importance of scheduling a follow-up appointment before hospital discharge to ensure timely follow-up after hospitalization with the primary care or managing clinician.**

- Ensure the follow-up visit with the primary care physician is scheduled according to the patient’s risk for hospitalization. See Figure 7 below for a risk assessment rubric and Figure 8 for a recommended follow-up schedule after hospital discharge.
- Consider providing more home health care visits and/or follow-up phone calls soon after the patient comes home rather than spacing them out evenly.

**Figure 7: Categories of a Patient’s Risk of Acute Care Hospitalization**

<table>
<thead>
<tr>
<th>High-Risk Patients</th>
<th>Moderate-Risk Patients</th>
<th>Low-Risk Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Patient has been admitted to the hospital two or more times in the past year.</td>
<td>• Patient has been admitted to the hospital once in the past year.</td>
<td>• Patient has had no other hospital admissions in the past year.</td>
</tr>
<tr>
<td>• Patient is unable to Teach Back or the patient or family caregiver has a low degree of confidence to carry out self-care at home.</td>
<td>• Based on Teach Back results, patient or family caregiver has moderate degree of confidence to carry out care at home.</td>
<td>• Patient or family caregiver has high degree of confidence and can Teach Back how to carry out self-care at home.</td>
</tr>
</tbody>
</table>
Figure 8: Follow-Up Schedule after Hospital Discharge

<table>
<thead>
<tr>
<th>High-Risk Patients</th>
<th>Moderate-Risk Patients</th>
<th>Low-Risk Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior to discharge:</td>
<td>Prior to discharge:</td>
<td>Prior to discharge:</td>
</tr>
<tr>
<td>• Schedule a face-to-face</td>
<td>• Schedule a follow-up phone call within</td>
<td>• Schedule a physician office</td>
</tr>
<tr>
<td>follow-up visit within 48 hours</td>
<td>48 hours of discharge and schedule a</td>
<td>visit as ordered by the</td>
</tr>
<tr>
<td>of discharge. Care teams should</td>
<td>physician office within 5 to 7 days</td>
<td>attending physician.</td>
</tr>
<tr>
<td>assess whether a physician office</td>
<td>after discharge. Consult with the patient’s</td>
<td>• Ensure the patient and</td>
</tr>
<tr>
<td>visit or home health care visit</td>
<td>physician to identify whether a home</td>
<td>family have the phone</td>
</tr>
<tr>
<td>is the best option for the</td>
<td>health care visit is needed.</td>
<td>number for whom to contact</td>
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<tr>
<td>patient.</td>
<td></td>
<td>with questions and concerns.</td>
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<tr>
<td>• If a home health care visit is</td>
<td></td>
<td>• Initiate a referral to social</td>
</tr>
<tr>
<td>scheduled in the first 48 hours,</td>
<td></td>
<td>services and community resources</td>
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<tr>
<td>a physician office visit must</td>
<td></td>
<td>as needed.</td>
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<tr>
<td>also be scheduled within the first</td>
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<tr>
<td>3 to 5 days after discharge.</td>
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<tr>
<td>• Initiate intensive care</td>
<td></td>
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<tr>
<td>management programs as indicated.</td>
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<tr>
<td>• Initiate a referral to social</td>
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<td>services and community resources</td>
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<tr>
<td>as needed.</td>
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</table>

For more information on timely follow-up after discharge, please see the following resources:


**Recommended Measures (Data Reporting Guidelines, How-to Guide Resources, page 54)**

Use these measures to guide your improvement to ensure timely connection with the managing clinician(s) and to ensure families and patients are included in defining needs prior to the transition to home health care.

- Percent of patients admitted to a home health care agency who required a follow-up visit scheduled in accordance with their risk assessment
- Percent of home health care agency admissions where patients and family caregivers were included in assessing home health care needs prior to hospital discharge
2. Assess the Patient, Initiate the Plan of Care, and Reinforce Patient Self-Management at First Post-Discharge Home Health Care Visit

**Recommended Changes:**

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

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

2C. Use Teach Back to assess, reinforce, and improve the patient’s and family caregiver’s understanding and ability to manage medications and self-care.

2D. Initiate treatments as ordered (e.g., dressing changes, oxygen saturation, wound care).

Excellent and proactive intervention by home health care agency staff at the point of a transition for a patient into home health care is a significant strategy to reduce avoidable rehospitalizations. It is at this point that new problems and undetected issues for patients and family caregivers may arise from the handoff to the managing clinicians in the next setting of care. Many cross-continuum teams discover that, when doing a diagnostic assessment of patients who are rehospitalized, many patients are readmitted in the first seven days. Home health care executives and nurses state that patients who are transferred from inpatient settings have a higher acuity and require a higher level of clinical skill to manage. Patients who struggle with self-management often have complex chronic conditions and complex medication regimes that create problems with self-care.

Home health care agencies are in an ideal position to assist patients, family caregivers, and the cross-continuum team in a successful transition out of the hospital that achieves clinical stability and improves patient outcomes. Home health care clinical teams are able to assess and address patient’s and family caregiver’s barriers, challenges, and opportunities in the context of the patient’s home, which provides unique insight into the strengths and struggles for the patient and their ability to follow the transition plan of care. Patients and caregivers receive direct problem-solving and patient-centered support to address issues, barriers, and challenges related to their chronic disease management and care continuum.
Typical failures found in assessing and initiating the plan of care, and reinforcing patient self-management at the first post-discharge home health care visit include the following:

- Inadequate completion of comprehensive assessment, problem identification, and care plan development;
- Lack of timely and thorough medication reconciliation and proactive medication management; and
- The patient and family caregiver are unable to overcome challenges (cognitive and functional challenges, financial constraints, problem solving) to successfully manage self-care and medications.

What are your typical failures and opportunities for improvement?

- Review the findings from Step 3 in Getting Started with Front-Line Improvement Team(s). Periodically repeat Step 3 to continually learn about opportunities for improvement.
- Collect data on common medication reconciliation errors for patients in the first 24 to 48 hours.

Recommended Changes

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

- Review the hospital discharge summary and instructions.
- Perform a comprehensive physical, functional, and cognitive assessment of the patient.
- Follow up on outstanding test results or orders from the hospital.
- Identify and report possible medication-related complications.
- Verify that the patient is taking medications correctly, assess adverse side effects, medication effectiveness, drug/drug interactions, therapeutic duplication, and non-adherence.
2B. Reconcile all medications, including all medications in the home.\textsuperscript{16,22,27,28}

- Within 24 hours of discharge, reconcile medications with discharge instructions.
  - Verify that the patient has the needed medications and family caregivers are able to reliably obtain the medications.
  - Check all medications and include herbal remedies, trial medications, over-the-counter medications, old medications, and physician-administered medications such as injections. Determine which are on the current medication list and which the patient should not take.
  - Use a patient-friendly and easily updatable medication list. Write in pencil so the list can be easily updated. Educate the patient and family caregiver how to keep the list updated and the importance of having the list available at each medical encounter so it can be updated in real time.

- Look for ways to simplify the medication regime.
  - Check for potentially inappropriate medications.
  - Identify medication schedules that are unrealistic in a home setting and propose a more realistic schedule. For example, if the insulin prescribed is sliding scale insulin, consider recommending different insulin; or identify an easier schedule for medications prescribed every 6 hours.

For more information on managing medications, please refer to the following resources:


*Medication Reconciliation Toolkit.* American Society of Hospital Pharmacists. Available at [www.ashp.org/Import/PRACTICEANDPOLICY/PracticeResourceCenters/PatientSafety/ASHPMedicationReconciliationToolkit_1.aspx](http://www.ashp.org/Import/PRACTICEANDPOLICY/PracticeResourceCenters/PatientSafety/ASHPMedicationReconciliationToolkit_1.aspx). This online resource center provides tools, references, recommendations, innovative ideas, and examples of success stories and lessons learned.

*My Medicine List™: Information for Health Professionals.* American Society of Health-System Pharmacists. Available at
www.ashpfoundation.org/MainMenuCategories/PracticeTools/MyMedicineList/InformationforHealthProfessionals.aspx.


**2C. Use Teach Back to assess, reinforce, and improve the patient’s and family caregiver’s understanding and ability to manage medications and self-care.**¹⁶,¹⁷,²²,²⁶,²⁷

- Identify key learners and caregivers and discuss their goals for the transition and first 30 days at home.

- Engage patients and family caregivers in early symptom identification and actions to take if needed, including whom to call.

- Using Teach Back, verify the patient’s and family caregivers’ understanding of: the current medication list, what medication has been stopped, adverse drug side effects to report, what happens when new medications are prescribed or changed, and when medications need to be taken and by what route.

- Assist the patient and family caregivers in problem solving any barriers to obtaining and taking the medications as prescribed.

- Provide supplemental education to the patient and caregivers to enable them to successfully follow the plan of care.

- Prepare the patient and family for their first physician office follow-up appointment by helping them identify their questions and ensuring that the medication list is current.
Resources such as Ask Me 3™ (available at www.npsf.org/askme3) are useful in helping to structure the conversations.

For more information on supporting self-care and the use of Teach Back, please refer to the following resources:

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


**2D. Initiate treatments as ordered (e.g., dressing changes, oxygen saturation, wound care).**

**Recommended Measures (Data Reporting Guidelines, How-to Guide Resources, page 54)**

Use these measures to determine whether patients and family caregivers are prepared to engage in self-care or whether they require additional support.

- Percent of Teach Back sessions documented by nurse to assess understanding of patient or other identified learner on identification of signs and symptoms and what to do next

- Percentage of times the two motivational interviewing questions (How important is it to you? How confident are you that you will do this?) are used on admission to assess the patient’s and family caregivers’ confidence in their ability to manage self-care tasks
Use these measures to determine if patient and family caregiver can manage medications in the home:

- Percent of Teach Back sessions documented by nurse to assess understanding of patient or other identified learner to manage medications

- Percent of patients who can Teach Back 75 percent or more of what they are taught when content is broken into easy-to-learn segments
3. Engage, Coordinate, and Communicate with the Entire Clinical Team

**Recommended Changes:**

- 3A. Ensure early, consistent, real-time consultation with the primary care provider or other managing clinician(s).
- 3B. Use a patient-centered health record to communicate patient information to all caregivers.
- 3C. Advocate as necessary to ensure referrals are completed and needed services are received.

The challenges for home health care agencies in collaborating with the numerous, and geographically separated, primary and specialty care physicians, as well as the many community agencies that might be involved in a patient’s home health care, are daunting. However, the function of communicating and coordinating care, in real time, is one of the most important changes that can be made to improve the process of patients successfully transitioning to home health care. A robust cross-continuum team — with good representation from office practices, hospitals, and community agencies — is invaluable to testing the codesign of care processes across sites and learning efficient ways to accomplish this.

In all improvement work, we recommend that home health care agencies start small and work with partners who are willing to help improve communication and coordination. As processes are successfully redesigned, the more efficient processes can be spread to other practices and agencies. Choose physicians and agencies that do a high volume of work with the home health care agency, or other enthusiastic partners who are willing to test changes.

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

- Lack of a shared understanding of the patient’s current status, situation, and comprehensive care plan;
- Lack of a clear, designated clinician to coordinate needed care and care decisions;
When the primary care physician is designated as the lead clinician, often they are not current on hospitalization, discharge instructions, and current status;

- Financial and other patient constraints are a barrier to receiving needed services;
- Inadequate care plan development and implementation due to incomplete understanding of the whole patient context; and
- Too many post-discharge “care managers,” which can be confusing and overwhelming to the patient and family caregivers.

What are your typical failures and opportunities for improvement?

- Review the findings from Step 3 in Getting Started with Front-Line Improvement Team(s). Periodically repeat Step 3 to continually learn about opportunities for improvement.

**Recommended Changes**

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

- Within 24 hours after first home health care visit, contact the managing clinician with any significant clinical findings or medication issues and obtain physician parameters for managing symptoms in the home.

- When available, send the following information to the primary care physician and other caregivers, as appropriate: assessment of the clinical status and plan of care; patient’s ability to manage self-care; and cognitive, functional, and other barriers to following self-care instructions.

- Coordinate other needed therapies through the home health care agency, for example, wound care, diabetes management, rehabilitation services, and social services.

- Use evidenced-based care guidelines when providing care and managing symptoms of home health care patients such as the American Cardiology Association, American Diabetic Association, and Global Obstructive Lung Disease.

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

- Assist the patient and family caregivers in creating a clear, concise, and customized patient health record, with an initial focus on a clear, patient-friendly and updatable medication list.

- Help the patient and family caregivers understand the importance of keeping an updated medication list and the importance of taking their list to all medical appointments and having it updated in real time.

For more information on patient-centered health records, please refer to the following resources:


3C. Advocate as necessary to ensure referrals are completed and needed services are received.

- Establish relationships with care team members in the community and hospital with whom the agency frequently liaises to make communication easier.

- Use the SBAR communication model (Situation, Background, Assessment, and Recommendation) as an efficient and effective communication strategy around patient issues.

- Work with community partners to establish efficient and effective means to communicate, especially in critical situations (e.g., a private telephone number used to quickly reach a primary care physicians’ nurse).

For more information on SBAR communications, please refer to the following resources:


Recommended Measures (Data Reporting Guidelines, How-to Guide Resources, page 54)

Use this measure to determine adequate communication between home health professionals in the home health care agency and the managing clinician in the community:

- Percentage of time the managing clinician is contacted within 24 hours of a home health care agency admission because of significant clinical findings or medication issues

IV. Testing, Implementing, and Spreading Changes

Step 1. Based on your learning from the Getting Started activities (in Section II), select a place to start and identify the opportunities or failures in your current processes.

All three key changes (outlined in Section III) are strongly recommended for improving a patient’s transition to home health care in the first 48 hours after discharge from the hospital. These three changes are depicted in the flowchart below (Figure 9). Many teams start with improving the enhanced transition to home health care or with medication reconciliation, but there are merits to allowing the front-line team’s interests to determine where to start improvement. If there are two pilot improvement teams, they may want to begin testing different process improvements and share what they are learning to accelerate overall progress.

Tips for Fixing Problems from The High Velocity Edge, by Steve Spear

- “Start small. Find a process or system that is reasonably tightly bounded so that the number of people learning together is relatively small. That way the chance for shared reflection will be relatively high.”
- “Solve a problem that really matters…When you start to score gains, you want people to sit up and take notice.”
- “Don’t think too much but do a lot. That’s where the real learning takes place. Start with a small footprint but a long leg. Although you should start with a fairly small group and a fairly well-defined problem…make sure that every layer of management is involved. After all, what you are trying to master is a fundamentally different set of roles and relationships.”
- “Don’t wait.”
Each key change to improve transitions to home health care contains several processes. Choose which processes you want to investigate and use observation or self-audit to gain a deeper understanding of the current processes and to assess your own local opportunities for improvement. Many quality improvement and innovation strategies include observation as an essential foundation to inform process improvements.  

For example, processes related to Key Change 2 (Assess the Patient, Initiate the Plan of Care, and Reinforce Patient Self-Management at First Post-Discharge Home Health Care Visit) include an observation or self-audit of how staff do the following:

- **2A.** Re-evaluate the patient’s clinical status since discharge leaving the hospital.
- **2B.** Using Teach Back, assess, reinforce, and improve the patient’s and family caregiver’s understanding and ability to manage medications and self-care.

**Step 2. Use the Model for Improvement; test changes.**

Developed by Associates in Process Improvement, the Model for Improvement (Figure 10) is a simple yet powerful tool for accelerating improvement that has been used successfully by hundreds of health care organizations to improve many different health care processes and outcomes.

The model has two parts:

- Three fundamental questions guide improvement teams to 1) set clear aims, 2) establish measures that will tell if changes are leading to improvement, and 3) identify changes that are likely to lead to improvement.
- The Plan-Do-Study-Act (PDSA) cycle, developed by W. Edwards Deming, supports testing small-scale change in real work settings — by planning a test, trying it,
observing the results, and acting on what is learned. This is a pragmatic version of the scientific method used for action-oriented process improvement.
First Test of Change: A first test of change should involve a very small sample size (typically one nurse or one patient) and should be described ahead of time in a Plan-Do-Study-Act (PDSA) format so that the improvement team can easily predict what they think will happen, observe the results, learn from them, and continue to the next test.

Use iterative PDSA cycles to design and redesign processes to make them effective and reliable.

Use the PDSA worksheet (Figure 11) that outlines guidance for each of the steps: Plan, Do, Study, Act. Figure 12 shows an example ocompleted PDSA Worksheet for patient education.

**Figure 11:** [PDSA Worksheet](How-to Guide Resources, page 56)
Example: Series of PDSA Cycles

- **Cycle 1**: One nurse, on one day, tests whether using Teach Back with one patient who has heart failure (HF) helps the patient learn the reasons to call the physician for help now that they are at home. The nurse learned that patient teaching materials were confusing to the patient.

- **Cycle 2**: Nurse adapts the materials to better meet the patient’s needs by circling key information. Nurse uses Teach Back for all HF patients she is visiting that day. One patient is asked to include her daughter in the teaching. Nurse learned that patient’s daughter could Teach Back all the circled information and that the patient could Teach Back two of the three selected items.

- **Cycle 3**: Nurse expands use of Teach Back with all patients and checks with each patient to find out if there is a family caregiver they want included in the teaching.

- **Cycle 4**: Nurse starts to train her colleagues in the Teach Back method, making time to observe or role-play and give feedback to each trainee.

- **Cycle 5**: A Teach Back educational module and competency assessment are developed and tested on one group of nurses.

- **Cycle 6**: Module adapted and rolled-out agency-wide, including plan for new staff orientation.
Step 3. Increase the reliability of your processes.

The Planning step (P) of each PDSA cycle should include a high level of detail on the change being tested: who, what, when, where, and the specifics of how. Adapt and clarify this detail as you conduct iterative PDSA cycles and learn about what works in your organization. The aim is to end up with a process that can be executed as designed, every time, for every appropriate patient, with the desired results.

Teach Back example: When redesigning your patient education processes in order to better teach patients about home care instructions (as described in the example PDSA cycles above), work with staff who conduct the tests to precisely describe the work, including information regarding:

- **Who will do it** (be specific — e.g., include the name of the nurse assigned to the patient)?

- **What will they do** (e.g., use Ask Me 3 framework to organize teaching for all patients and each patient is asked [in a non-shaming way] to describe in their own words what was learned)? Learning is documented in the patient’s record so that details on the patient’s ability to Teach Back the key points can be shared with other caregivers.

- **When will they do it** (e.g., during beginning of the first home health care visit while patient is not overly tired)?
• Where will they do it?

• How do they do it (include tools that are used such as Teach Back documentation tool)?

• How often will they do it (e.g., at each visit, by each care team member)?

• Why should they do it (e.g., to enhance learning and identify patients who are at risk for problems while caring for themselves post-transition)?

Continue to test the process under a variety of conditions (e.g., different nurses, different kinds of patients). Adapt the change until it optimally meets the needs of both patients and staff.

When testing a change, you will learn from your failures as well as from your successes. Understanding common failures (situations when a process is not executed as expected) helps the team to (re)design the new processes to eliminate those failures.

Here is an example of a team learning from a failed test and applying that learning to improve the process:

• The process being tested required nurses to use the Ask Me 3 framework for all patients. During testing, a nurse assigned to a patient with heart failure and chronic depression was unsure about the relevant Ask Me 3 questions to assist her with patient education; nurses and social workers met to delineate the relevant Ask Me 3 questions for common mental health conditions and the training was redesigned to cover this information.

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

**Step 4. Use data, displayed over time, to assess progress.**

The Getting Started activities (in Section II) include collecting baseline data on acute care hospitalizations within 30 days of hospital discharge and patient experience, and displaying those data in run charts or time series graphs. Continue to collect and display this data in order to see whether your changes result in improvement for your patients. We recommend looking at data both for your pilot population(s) and your home health care agency as a whole. Augment
this quantitative data with information you gather from asking readmitted patients about their experience (consider using the Diagnostic Worksheet, How-to Guide Resources, page 45). Annotate run charts to indicate when specific changes were implemented.

In addition to the outcome measures for acute hospitalizations within 30 days of hospital discharge and patient experience, it is necessary to track whether your new and improved processes are being executed as expected. These process measures tell us whether the specific changes we make are working as planned and they provide information on the relationship between our theory (the changes we are making) and the outcomes for our patients. Plotting process measure data over time uncovers signals of improvement (increased reliability of the process) or opportunities (problems with the execution of the process). These signals show us when to investigate and apply the resulting learning to redesign the process to make it work better.

Figure 13 shows an example of an annotated run chart or time series graph for a process measure for Key Change 2 (Assess Patient, Initiate the Plan of Care, and Reinforce Patient Self-Management at the First Post-Transition Home Health Care Visit), specifically the change to use Teach Back to assess and improve the patient’s and family member’s understanding and ability to manage self-care. The annotations on the run chart show when specific changes were tested or implemented.

**Figure 13: Example Time Series Graph for Process Measure**
Example: When we start to test Teach Back as a new teaching strategy, we need a way to understand if patients are being taught as we want them to be taught. This is difficult to assess without direct observation that is best done during a home health care visit. This assessment may be done as a self-audit by the nurse. We recommend that a sample of teaching opportunities are observed or self-audited each week or month to determine if the intervention (Teach Back) is being executed as planned. Note that this means that a clearly documented set of expectations for what Teach Back should look like is needed to determine if the teaching matches those expectations. Consider using the Observation or Self-Audit Guide: Current Processes for Patient Teaching (Figure 14).

Figure 14: Observation or Self Audit Guide: Current Processes for Patient Teaching (How-to Guide Resources, page 59)

When the data suggest we are not performing a process reliably, we want to go to the people who should be executing the process and ask them what barriers they face. Use the data to identify opportunities to make the new processes easier to execute, not to blame staff. Assume the problem is the design of the process or the system in which it is embedded and work with your team to fix it. For example, if the team observes that nurses or care team members are not using Teach Back, the team should consider how to improve the training process by getting input about what barriers were encountered with the process.

Collecting and reviewing data, over time, through implementation, helps you see when new problems arise with the execution of your desired interventions. Note, for example, how the data in the graph in Figure 13 enables the team to see when performance declined so they could test

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1 Sampling is an important strategy for collecting data for process measures since this kind of data is often not available through automated systems. In the example (Figure 13), ten observations were conducted each month (two each week) in order to collect just enough data on the process to inform the team’s understanding of what was happening.
new interventions to improve the reliability of the process. Share data with agency staff, physicians, community partners, and senior leaders. Reflect on lessons learned from both successful and unsuccessful tests of change. Develop the habit of challenging assumptions.

Figure 15 lists examples of process measures that can help evaluate the successful implementation of each of the recommended key changes.

**Figure 15: Recommended Process Measures for Each Key Change**

<table>
<thead>
<tr>
<th>Key Change</th>
<th>Process Measures</th>
</tr>
</thead>
</table>
| 1. Meet the Patient, Family Caregiver(s), and Inpatient Caregiver(s) in the Hospital and Review the Transition Plan | • Percent of patients admitted to a home health care agency who required a follow-up visit scheduled in accordance with their risk assessment  
• Percent of home health care agency admissions where patients and family caregivers were included in assessing home health care needs prior to hospital discharge |
| 2. Assess the Patient, Initiate the Plan of Care, and Reinforce Patient Self-Management at the First Post-Discharge Home Health Care Visit | • Percent of Teach Back sessions documented by nurse to assess understanding of patient or other identified learner on identification of signs and symptoms and what to do next  
• Percentage of times the two motivational interviewing questions (How important is this to you? How confident are you that you can do this?) are used on admission to assess patient and family caregiver’s confidence and how important it is to manage self-care tasks.  
• Percent of Teach Back sessions documented by nurse to assess understanding of patient or other identified learner to manage medications  
• Percent of patients who can Teach Back 75 percent or more of what they are taught when content is broken into easy-to-learn segments |
| 3. Engage, Coordinate, and Communicate with the Entire Clinical Team | • Percentage of time the managing clinician is contacted within 24 hours of a home health care agency admission because of significant clinical findings or medication issues |
Step 5. Implement and spread successful practices.

Implementation

After testing a change on a small scale, learning from each test, and refining the change through several PDSA cycles, the team can implement the change on a broader scale — for example, for an entire pilot population (patients with heart failure). Implementation is the process of making an improvement a part of the day-to-day operation of the system in your pilot population or for all patients assigned to a particular nurse or care team.

Unlike the testing that you’ve done to develop your new processes, implementation is a permanent change to the way work is done and, as such, involves building the change into the organization. It may affect written policies, hiring, training, compensation, equipment, and other aspects of the organization's infrastructure that are not heavily engaged in the testing phase.

Attention should be given to communication (i.e., publicizing the benefits of the change), documenting improvement, as well as keeping in contact with the pilot team so that they are supported during the implementation phase. PDSA cycles can and should be used to enhance learning and accelerate the process of hardwiring the changes so they become an integral part of the system.

Example: During the testing process, a few nurses may be trained in the redesigned patient education processes that use Teach Back with the identified learners. Once the processes and support materials have been adapted so that these nurses are able to teach the identified learner effectively over 90 percent of the time, those processes should be implemented more broadly. Making these processes the default system (i.e., the way the work is done rather than the way a few nurses do the work from time to time) requires a training system for all current nurses and changes to orientation programs for new nurses; it might also require changes to an IT system where information about education is documented and shared. Communication to all staff about the revised expectations for teaching and learning might be developed to start to generate interest in implementing the redesigned process in other service lines or with all disciplines in preparation for spread.

During implementation, attend to the social aspects of the change as well as the technical infrastructure. Leaders need to communicate the why as well as the how of the change, and to address questions and concerns. It is common for processes that seem to be working well (i.e.,
being executed reliably) during testing to get less reliable, temporarily, when you move to implementation. During implementation, a larger group, some unfamiliar or unsympathetic with the purpose, are now expected to make the change and there may be resistance, or simply confusion. It may take some cycles of testing to put in place an effective infrastructure to support the change(s). Continue to monitor whether your processes are being executed as planned and to act on that information to adapt the processes and the related infrastructure to support the change. Make it easy to do the right thing, and hard to do the wrong thing.

### Tips for Sustaining Improvements

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

### Spreading Changes

Leaders should begin making plans for spreading the improvement developed in the pilot population or pilot team during the early stages of the initiative. After successful implementation of a change or package of changes for a pilot population or for all patients under your care, leaders will be prepared to lead the spread of the changes to other parts of the agency or to other agencies. Even though the changes have been tested and implemented, spread efforts will benefit from testing and adaptation (using PDSA cycles) in the new patient populations or with additional care teams. Those adopting the change may need to adapt it to their own setting and to build confidence that the change will result in the predicted improvement.

Some considerations for leaders as they plan for spread of the changes to improve transitions to home health care include the following:

- If the initial population of focus was a specific patient population (e.g., patients with a particular disease type like heart failure), consider adaptations to the process that may be necessary for spread to all patients. For example, if you developed a teaching strategy and materials for heart failure patients, what tools and strategies will your nurses need to apply the teaching method to all patients?
If the initial population of focus was a particular nurse or care team, what do you need to do to spread to others? What adaptations might be needed? Who are the stakeholders who need to be engaged in the process? How might you involve them early on to build will and excitement in the staff to whom the change will be spread?

Successful spread of reliable processes requires that leadership take responsibility for spread and commit sufficient resources to support spread. Pilot staff also play an important role in spread activities by 1) making the case that the changes contribute to better transitions for patients and reduced acute care rehospitalizations, and 2) generating information and materials that leaders can package to make it easier for others to adapt the changes they made. They may also be involved in teaching and mentoring others, although the responsibility for developing the overall training and support system lies with leadership.

An important consideration for leaders in preparing for spread is whether staff outside of the pilot group or those caring for the pilot population will have the time and resources to make the same changes that have been made at the pilot level. In other words, are the changes developed at the pilot level scalable to the rest of the organization? For example, completing an enhanced transition to home health care services, using Teach Back for all patients, or ensuring that follow-up appointments for patients after discharge have been made within a defined time period may mean that nurses and other staff will need to rethink and redesign their activities and responsibilities to free up time to reliably carry out these as well as the other steps needed for an ideal transition.

One way that leaders can work together with nurses in the home health care agency to begin the redesign effort is to use structured observation or self-audit methods to evaluate current workflows and processes, identify areas of waste (i.e., time spent looking for supplies, medications, information, etc.), and then test new ways of carrying out work more efficiently so they have more time to spend with patients (providing care and supporting the patient and family caregivers in their transition into the home). Information about how to engage front-line staff in the redesign of patient care can be found in the IHI materials on Transforming Care at the Bedside (see the web resources list below).

A key responsibility of leaders is to develop a plan and timetable for spread of changes and then to measure and monitor progress as the spread unfolds. This oversight process involves two parts: 1) measuring and monitoring the rate of spread of the changes, and 2) tracking improvement in outcomes (e.g., reductions in acute care hospitalization rates within 30 days of
Institute for Healthcare Improvement
How-to Guide: Improving Transitions from the Hospital to Home Health Care to Reduce Avoidable Rehospitalizations

(a hospital discharge). Figure 16 shows an example of a tool that leaders can use to monitor the spread of a package of changes (the changes are listed in rows, and the areas designated for spread are listed in columns). This tool allows a leader to understand the progress of the spread of each change and the spread of changes across the locations designated for spread (in this example, among nurses and other disciplines in the home health care agency, but it could also be service lines or multiple agencies within a larger system). Use Spread Tracker Template (Figure 17) as a template to monitor spread.

Figure 16: Tool to Monitor Spread

![Spread Plan Diagram]

Data about acute care hospitalization rates or other outcome measures as identified by the leaders can be used in conjunction with information about the rate of adoption of the changes.

Figure 17: Spread Tracker Template (How-to Guide Resources, page 61)
For example, if a care team sees no reduction in acute care hospitalizations then a leader could check their progress in implementing each of the recommended changes. Leaders would want to determine if further guidance and support is needed to accelerate progress and results. It is recommended that outcome measures are reported and tracked at the home health care agency or system level as well as at the care team level in order to provide leaders, care team managers, and front-line staff with regular feedback on their progress.

**Recommended Resources on Quality Improvement**

Books and articles:


Web tools and resources:

*Spreading Changes.* Institute for Healthcare Improvement. Available at [www.ihi.org/knowledge/Pages/HowtoImprove/ScienceofImprovementSpreadingChanges.aspx](http://www.ihi.org/knowledge/Pages/HowtoImprove/ScienceofImprovementSpreadingChanges.aspx).

*On Demand Presentation: An Introduction to the Model for Improvement.* Institute for Healthcare Improvement. Available at [www.ihi.org/offerings/VirtualPrograms/OnDemand/ImprovementModelIntro/Pages/default.aspx](http://www.ihi.org/offerings/VirtualPrograms/OnDemand/ImprovementModelIntro/Pages/default.aspx).

*Transforming Care at the Bedside (TCAB).* Institute for Healthcare Improvement. Available at [www.ihi.org/offerings/Initiatives/PastStrategicInitiatives/TCAB/Pages/default.aspx](http://www.ihi.org/offerings/Initiatives/PastStrategicInitiatives/TCAB/Pages/default.aspx).


*How to Improve.* Institute for Healthcare Improvement. Available at [www.ihi.org/knowledge/Pages/HowtoImprove/default.aspx](http://www.ihi.org/knowledge/Pages/HowtoImprove/default.aspx).

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

Diagnostic Worksheet
   Part 1 p. 45 p. 35
   Part 2 p. 45 p. 9, 11

Data Reporting Guidelines
   Outcome Measures: Acute Care Hospitalizations and ED Visits p. 50 p. 11
   Outcome Measures: Patient Experience p. 51 p. 10
   Process Measures p. 54 p. 18, 23, 28

PDSA Worksheet p. 57 p. 31

Example Completed PDSA Worksheet p. 58 p. 32

Observation or Self-Audit Guide: Current Processes for Patient Teaching p. 60 p. 36

Spread Tracker Template p. 62 p. 41
Diagnostic Worksheet: In-depth Review of Patients with an Acute Care Hospitalization within 30 days of a Hospital Discharge

Part 1: Chart Review

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

<table>
<thead>
<tr>
<th>Question</th>
<th>Patient #1</th>
<th>Patient #2</th>
<th>Patient #3</th>
<th>Patient #4</th>
<th>Patient #5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of days between the last discharge and this acute care hospitalization date?</td>
<td>_____ days</td>
<td>_____ days</td>
<td>_____ days</td>
<td>_____ days</td>
<td>_____ days</td>
</tr>
<tr>
<td>Was the follow-up physician visit scheduled prior to discharge based on risk assessment of patient?</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>If yes, was the patient able to attend the office visit?</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Were there any urgent clinic/ED visits before this acute care hospitalization?</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Functional status of the patient on admission?</td>
<td>Comments:</td>
<td>Comments:</td>
<td>Comments:</td>
<td>Comments:</td>
<td>Comments:</td>
</tr>
<tr>
<td>Was a clear discharge plan documented?</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Was evidence of Teach Back documented?</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>List any documented reason(s) for the acute care hospitalization.</td>
<td>Comments:</td>
<td>Comments:</td>
<td>Comments:</td>
<td>Comments:</td>
<td>Comments:</td>
</tr>
<tr>
<td>Did any social conditions (transportation, lack of money for medication, lack of housing) contribute to the rehospitalization?</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Diagnostic Worksheet: In-depth Review of Patients with an Acute Care Hospitalization within 30 days of a Hospital Discharge

Part 1: Reflective Summary of Chart Review Findings

What did you learn?

What themes emerged?

What, if anything, surprised you?

What new questions do you have?

What are you curious about?

What do you think you should do next?

What assumptions about rehospitalizations that you held previously are now challenged?
## Diagnostic Interview Worksheet: In-depth Review of Patients with an Acute Hospitalization within 30 days of Hospital Discharge

### Part 2: Interview with Patient, Family Caregivers, and Care Team Members in the Community

If possible, conduct the interviews on the same patients from the chart review (Part 1). Use a separate worksheet for each interview.

**Ask Patient and Family Caregivers:**

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

<table>
<thead>
<tr>
<th>Did you see your doctor or the doctor’s nurse in the office before you came back to the hospital?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
</tr>
</tbody>
</table>

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

Has anything gotten in the way of taking your medicines?

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

Describe your typical meals since you got home.

**Ask Care Team Members in the Community:**

What do you think caused this patient to be readmitted to the hospital?

*After talking to the care team members about why they think the patient was readmitted, write a brief story about the patient’s circumstances that contributed to the readmission.*
Diagnostic Worksheet: In-depth Review of Patients with an Acute Hospitalization within 30 days of Hospital Discharge
Part 2: Summary of Interview Findings

What did you learn?

What themes emerged?

What, if anything, surprised you?

What new questions do you have?

What are you curious about?

What do you think you should do next?

What assumptions about rehospitalizations that you held previously are now challenged?
Typical failures associated with patient assessment:
- Failure to actively include the patient and family caregivers in identifying needs, resources, and planning for care;
- Unrealistic optimism of patient and family to manage at home;
- Failure to recognize worsening clinical status;
- Lack of understanding of the patient’s physical and cognitive functional health status resulted in a transfer to a care venue that does not meet the patient’s needs;
- Not addressing whole patient (underlying depression, etc.);
- No advance directive or planning beyond Do Not Resuscitate (DNR) status;
- Medication errors, duplicate medications, medication interactions, or adverse drug events; and
- Multiple drugs exceed patient’s ability to manage.

Typical failures found in patient and family caregiver education:
- Assumption that the patient is the key learner;
- Written discharge instructions that are confusing, contradictory to other instructions, or not tailored to a patient’s level of health literacy or current health status;
- Failure to ask clarifying questions on instructions and plan of care; and
- Non-adherent patient’s lack of compliance with self-care, diet, medications, therapies, daily weights, follow-up and testing; or lack of adherence due to patient and/or family caregiver confusion.

Typical failures in handover communication:
- Poor hospital care (evidence-based care missing or incomplete) or premature discharge;
- Medication discrepancies;
- Discharge plan not communicated in a timely fashion or adequately conveying important anticipated next steps;
- Poor communication of the care plan to the home health care team, primary care physician, or family caregiver;
- Current and baseline functional status of patient rarely described, making it difficult to assess progress and prognosis;
- Discharge instructions missing, inadequate, incomplete, or illegible;
- Patient returning home without essential equipment (e.g., scale, supplemental oxygen, or equipment used to suction respiratory secretions);
- Having the care provided by the facility unravel as the patient begins home care (e.g., poorly understood cognition issues emerge); and
- Poor understanding that social support is lacking.

Typical failures following discharge from the hospital:
- Medication errors;
- Discharge instructions that are confusing, contradictory to other instructions, or are not tailored to a patient’s level of health literacy;
- No follow-up appointment or follow-up needed with additional physician expertise;
- Follow-up too long after hospitalization;
- Follow-up is the responsibility of the patient;
- Inability to keep follow-up appointments because of illness or transportation issues;
- Lack of an emergency plan with number the patient should call first;
- Multiple care providers, patient believes someone is in charge;
- Lack of social support; and
- Patient lack of adherence to self-care (e.g., medications, therapies, daily weights, or wound care) because of poor understanding or confusion about needed care, transportation, how to get appointments, or how to access or pay for medications.
## Data Reporting Guidelines

<table>
<thead>
<tr>
<th>Measure</th>
<th>Description</th>
<th>Numerator</th>
<th>Denominator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute care hospitalizations within 30 days of hospital discharge</td>
<td>Percent of acute care hospitalizations within 30 days of hospital discharge</td>
<td>Number of acute care hospitalizations within 30 days of hospital discharge</td>
<td>The number of patients on service who were discharged from a hospital in the last 30 days</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Exclusion: Planned readmissions (e.g., chemotherapy schedule, rehab, planned surgery)</td>
<td></td>
</tr>
<tr>
<td>Count of acute care hospitalizations within 30 days of hospital discharge</td>
<td>Number of acute hospitalizations within 30 days of hospital discharge (same as numerator from the percent of acute care hospitalizations within 30 days of hospital discharge [above])</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Emergency department use with hospitalization</td>
<td>Use OASIS Data</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discharged to community</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute care hospitalizations within 30 days of hospital discharge for a specific clinical condition (optional measure)</td>
<td>Count of acute care hospitalizations within 30 days of hospital discharge with a specific clinical condition who were hospitalized for any cause within 30 days of discharge</td>
<td>Number of patients on service with a specific clinical condition hospitalized for any cause within 30 days of a hospital discharge</td>
<td>N/A</td>
</tr>
<tr>
<td>Measure</td>
<td>Description</td>
<td>Numerator</td>
<td>Denominator</td>
</tr>
<tr>
<td>---------</td>
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<td>-------------</td>
</tr>
<tr>
<td>HHCAHPS Communication Question 5</td>
<td>When you started getting home health care from this agency, did someone from the agency ask to see all the prescription and over-the-counter medicines you were taking?</td>
<td>Number of patients surveyed in the month who answered “Yes”</td>
<td>Number of surveys completed in the month with an answer for this question</td>
</tr>
<tr>
<td>HHCAHPS Communication Question 4</td>
<td>When you started getting home health care from this agency, did someone from the agency talk with you about all the prescription and over-the-counter medicines you were taking?</td>
<td>Number of patients surveyed in the month who answered “Yes”</td>
<td>Number of surveys completed in the month with an answer for this question</td>
</tr>
<tr>
<td>HHCAHPS Discharge Question 10</td>
<td>In the last 2 months of care, did you and a home health provider from this agency talk about pain?</td>
<td>Number of patients surveyed in the month who answered “Yes”</td>
<td>Number of surveys completed in the month with an answer for this question</td>
</tr>
<tr>
<td>HHCAHPS Discharge Question 12</td>
<td>In the last 2 months of care, did home health providers from this agency talk with you about the purpose for taking your new or changed prescription medicines?</td>
<td>Number of patients surveyed in the month who answered “Yes” Exclusions: Those patients who did not take any new prescriptions or have any medication changes</td>
<td>Number of surveys completed in the month with an answer for this question</td>
</tr>
<tr>
<td>HHCAHPS Discharge Question 13</td>
<td>In the last 2 months of care, did home health providers from this agency talk with you about when to take these medicines?</td>
<td>Number of patients surveyed in the month who answered “Yes” Exclusions: Those patients who did not take any new prescriptions or have any medication changes</td>
<td>Number of surveys completed in the month with an answer for this question</td>
</tr>
<tr>
<td>HHCAHPS Discharge Question 14</td>
<td>In the last 2 months of care, did home health providers from this agency talk with you about the side effects of these medicines?</td>
<td>Number of patients surveyed in the month who answered “Yes”</td>
<td>Number of surveys completed in the month with an answer for this question</td>
</tr>
<tr>
<td>------------------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>Exclusions: Those patients who did not take any new prescriptions or have any medication changes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HHCAHPS Discharge Question 17</td>
<td>In the last 2 months of care, how often did home health providers from this agency explain things in a way that was easy to understand?</td>
<td>Number of patients surveyed in the month who answered “Always”</td>
<td>Number of surveys completed in the month with an answer for this question</td>
</tr>
<tr>
<td>HHCAHPS Discharge Question 18</td>
<td>In the last 2 months of care, how often did home health providers from this agency listen carefully to you?</td>
<td>Number of patients surveyed in the month who answered “Always”</td>
<td>Number of surveys completed in the month with an answer for this question</td>
</tr>
<tr>
<td>Patients are asked to rate their level of agreement with the following three items:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• The home health staff took my preferences and those of my family or caregiver into account in deciding what my health care needs would be when I left the hospital.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• When I left the hospital, I had a good understanding of the things I was responsible for in managing my health.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• When I started home health, I clearly understood the purpose for taking each of my medications</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Calculate the sum of responses across the three items</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Responses are scored:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strongly Disagree =1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disagree =2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agree =3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strongly Agree =4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of questions answered across all patients asked</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Collect data on routine follow-up phone calls</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sample 20 patients: If you have less than 20 admits per month, report 100 percent</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Response options: Strongly Disagree, Disagree, Agree, Strongly Agree, or Don't Know/Don't Remember/Not Applicable</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do not count in your denominator questions where the patient responded Don't Know/Remember/Not Applicable</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If response is Disagree or Strongly Disagree, ask about and document their concerns</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Process Measures

<table>
<thead>
<tr>
<th>Measure</th>
<th>Description</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Data Collection Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Follow-up visit scheduled</strong></td>
<td>Percent of patients admitted to home health care who required a follow-up visit scheduled in accordance with their risk assessment</td>
<td>Number of patients admitted to home health care that required a follow-up visit scheduled with their provider in accordance with their risk assessment</td>
<td>Number of admissions to a home health care agency in the sample</td>
<td>Review charts of 10 to 20 patients admitted to home health. Look for evidence of risk assessment and a scheduled follow-up visit with provider. Enter data monthly</td>
</tr>
<tr>
<td><strong>Patients and family included in identifying home health care needs prior to hospital discharge</strong></td>
<td>Percent of home health care agency admissions where patients and family caregivers were included in assessing home health care needs prior to hospital discharge</td>
<td>Number of home health care agency admissions where patient and family caregiver were included in assessing home health care needs prior to hospital discharge and home health care agency admission</td>
<td>Number of patients admitted to a home health care agency after a hospital stay in the sample</td>
<td>Sample 20 per month Enter data monthly</td>
</tr>
<tr>
<td><strong>Motivational interview</strong></td>
<td>Percentage of times the two motivational interviewing (How important is this to you? How confident are you that you can do this?) questions are used on admission to a home health care agency to assess patient and caregiver’s confidence in their ability to manage self-care tasks</td>
<td>Number of times the patient and caregiver are asked, “How important is this (educational component of self-care) to you?” and “How confident are you that you can do this?”</td>
<td>Number of patients and caregivers who are asked the motivational interviewing questions</td>
<td>Both questions have a response variable of 1 to 10, where 10 is highest level and 1 is lowest level. If answers are lower than 7, it signals patient or caregiver need more support or may not be able to execute self-care.</td>
</tr>
<tr>
<td>Measure</td>
<td>Description</td>
<td>Numerator</td>
<td>Denominator</td>
<td>Data Collection Strategy</td>
</tr>
<tr>
<td>---------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Medication management</strong></td>
<td>Percent of Teach Back sessions documented by nurse to assess understanding of patient or other identified learner to manage medications&lt;br&gt;Often patients are not able to learn enough to Teach Back due to cognitive issues. Ensure that the nurse is best supporting the patient by teaching the appropriate person who will support the patient’s self-management.</td>
<td>Number of documented sessions in which nurses used Teach Back with patient or identified learner to assess understanding of medication management</td>
<td>Number of documented sessions in which nurse is teaching about medication management</td>
<td>Observe 10 to 20 teaching opportunities or request nursing or care team members to conduct a self-audit&lt;br&gt;Enter data monthly</td>
</tr>
<tr>
<td><strong>Effectiveness of patient education for transition instructions</strong></td>
<td>Percent of patients or designated learners who can Teach Back 75 percent or more of what they are taught when content is broken into easy-to-learn segments &lt;br&gt;Assess the effectiveness of your teaching and your content design by tracking which elements patients or designated learners can Teach Back. Define three or four “vital few” elements for the transition instructions, medications, and/or self-care needs.</td>
<td>Number of patients or designated learners in your sample who were able to Teach Back 3 out 3 or 3 out of 4 content elements by the time of transition</td>
<td>Number of patients or designated learners in the sample for whom Teach Back is used</td>
<td>At the last teaching opportunity (preferably at transition), document which of the 3 or 4 key elements of the transition instructions the patient or designated learner is able to Teach Back</td>
</tr>
<tr>
<td><strong>Contact managing clinician</strong></td>
<td>Percentage of time the managing physician or clinician is contacted within 24 hours of home health care agency admission because of significant clinical findings or medication issues</td>
<td>Number of times the managing physician or clinician is contacted within 24 hours of admission to the home health care agency due to significant clinical finding or medication issue</td>
<td>Number of new admissions to a home health care agency</td>
<td>Sample 20 charts per month&lt;br&gt;Consider segmenting patients based on a chronic condition (like heart failure)</td>
</tr>
</tbody>
</table>
PDSA Worksheet

DATE __________

Change or idea evaluated: ____________________________

Objective for this PDSA Cycle: ______________________

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

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

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

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

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

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

Act:
What changes are to be made? Plan for the next cycle.
Example Completed PDSA Worksheet  

DATE : 8/10/2010

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

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

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

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

Plan:

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

Emily will talk to Jane (a nurse we know is interested in this project) and ask her to try the change
An hf patient with sufficient cognitive ability (Jane will decide) will be identified on Aug 10
Jane will use hf zone handout example from St. Luke’s as teaching tool
Jane will ask four St. Luke’s sample questions:
  • What is the name of your water pill?
  • What weight gain should you report to your doctor?
  • What foods should you avoid?
  • Do you know what symptoms to report to your doctor?

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

Jane will write down which answers pts were able to teach back successfully and which they had trouble with and come to the next team meeting on the 11th and report on her experience

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

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

Do:

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

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

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

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

Act:
What changes are to be made? Plan for the next cycle
Find one or more patients willing to work with Jane on redesigning patient materials and continue to test the teach back technique – Jane will try on more patients and try to recruit another nurse to test with her. Will report back at next meeting. Jane will create a paper tool that will help her keep track of which items the patients teach back so that she can continue to collect the data.
Observation or Self-Audit Guide: Current Processes for Patient Teaching

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

What do you predict you will observe?

<table>
<thead>
<tr>
<th>Did you or the care team member(s)….</th>
<th>Patient # 1</th>
<th>Patient # 2</th>
<th>Patient # 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use simple language and terminology?</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Use patient-friendly teaching materials?</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Request the patient Teach Back what was understood in the patient’s own words?</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Use non-shaming language in the Teach Back request?</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Display a warm attitude?</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Use a friendly tone of voice?</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Display comfortable body language?</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Ask “Do you understand?” or “Do you have any questions?” (“Avoid using this language)</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Use teaching materials in the patient’s language of choice?</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>

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

What did you learn?
Observation or Self-Audit Guide: Current Processes for Patient Teaching

How did your findings compare to the predictions?

What, if anything, surprised you?

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

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

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

1.

2.

3.

4.

5.
### Spread Tracker Template

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

<table>
<thead>
<tr>
<th>Change</th>
<th>Pilot Care Team 1</th>
<th>Pilot Care Team 2</th>
<th>Spread Team 1</th>
<th>Spread Team 2</th>
<th>Spread Team 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
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<td>C</td>
<td>A</td>
<td>B</td>
<td>C</td>
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<tr>
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<td>C</td>
</tr>
<tr>
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<td>D</td>
<td>C</td>
<td>A</td>
<td>A</td>
<td>C</td>
</tr>
<tr>
<td>4</td>
<td>D</td>
<td>C</td>
<td>B</td>
<td>A</td>
<td>B</td>
</tr>
<tr>
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<td>C</td>
<td>C</td>
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</tr>
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<td>C</td>
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<td>C</td>
<td>D</td>
<td>A</td>
<td>C</td>
<td>A</td>
</tr>
</tbody>
</table>
VII. References


