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SUPERIOR HEALTH
Quality Alliance

Call Us First Toolkit for Home Health Organizations

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SUPERIOR HEALTH QUALITY ALLIANCE

Call Us First - Toolkit for Home Health Organizations

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OVERVIEW

Superior Health Quality Alliance (Superior Health) is dedicated to reducing preventable emergency department (ED) overutilization and hospital readmissions. Home health agency (HHA) interventions for patients' post-hospital discharge have been shown to reduce readmissions. This toolkit provides interventions that can be implemented by HHAs to decrease hospital readmissions and ED utilization. It includes the following topic areas: client risk assessment tools; home care engagement readmission prevention tools; nursing care plans and emergency action plans; diagnosis-specific action plans, or zone tools; community and educational resources and information for caregivers and professional staff; competency training on high-risk conditions for direct care and professional staff internal workflow processes tools; and links to home care quality measures.

CLIENT RISK ASSESSMENT

Risk Assessment

Risk Assessment: Risk assessments identify potential problems your patient may have so that actions can be implemented to prevent these risks from occurring. For example, if you determine that your patient is at risk of falls, you can put into place a plan of care to reduce their risk of falling.

1. Patients with a **High-Risk Diagnosis** are more likely to utilize the ED. The following diagnoses are identified as high-risk:
    a. **Sepsis:** urinary, respiratory, wound or surgery
    b. **Congestive Heart Failure (CHF)** and other cardiac
    c. **Chronic Obstructive Pulmonary Disease (COPD)** and other respiratory
    d. **Undiagnosed Mental Health Condition**

Resource	Link	Description
Assessment Tool	Home Health Documentation Checklist | CGSMedicare	This is a home health documentation checklist.
The 8P Screening Tool	The 8P Screening Tool - Identifying Your Patient's Risk for Adverse Events After Discharge | Society of Hospital Medicine	This tool helps screen patients for specific risk factors known to be associated with adverse post-discharge events, initiate risk-specific interventions to reduce risk and communicate risk and ongoing interventions to subsequent care providers.

2. **Comorbidities:** A comorbidity is any preexisting health condition. Patients who have the following comorbidities are at high risk for an ED visit:
   a. **Medications:** Patients taking more than five medications.
   b. **Physical deficits:** A decrease in vision, balance or gait impairments.
   c. **Cognitive deficits:** A decline in memory, attention, learning and judgment.
   d. **Knowledge deficits:** Refers to a lack of cognitive or psychomotor abilities necessary for health restoration, preservation or promotion.
   e. **Frequent ED visits, i.e., three visits within the past three months.** Most patients seen in the ED are treated and then discharged without hospital admission. However, this may reflect problems with community access to and availability of primary and preventive care, lack of a regular healthcare provider or limited health insurance coverage.
   f. **Recent hospitalization:** 20 percent of hospitalizations in the United States are rehospitalizations within 30 days of discharge.

Resource	Link	Description
Medications	The Dangers of Polypharmacy and the Case for Deprescribing in Older Adults | National Institute on Aging	An article by the National Institute on Aging about the dangers of polypharmacy in older adults.
Physical Deficits	Risk for Falls: Nursing Diagnosis and Care Plan Guide | Nurseslab	A comprehensive nursing care plan and management guide to effectively prevent falls among patients.
Cognitive Deficits	Disturbed Thought Process: Nursing Diagnosis Care Plan Guide | Nurseslab	Care plan focused on patients with impaired thought process or cognitive impairment.
Knowledge Deficits	Knowledge Deficit and Patient Education: Nursing Diagnosis and Care Plan Guide | Nurseslab	Care plan focused on lack of cognitive or psychomotor abilities necessary for health restoration, preservation or promotion.
Frequent ED Visits (i.e., three within the past three months)	Most Frequent Reasons for ED Visits | Agency for Healthcare Research and Quality	This article provides information about reasons for ED visits.

Recent hospitalization	How-to Guide: Improving Transitions from the Hospital to Home Health Care to Reduce Avoidable Rehospitalizations | Institute for Healthcare Improvement	A How-to Guide designed to support home health care to ensure that patients who have been discharged from the hospital have an effective transition into home health care.

3. **Non-Clinical Aspects:** Social Determinants of Health (SDOH) can affect health outcomes. SDOH are the conditions in the environments where people are born, live, learn, work, play, worship and age.
   a. Z codes (Z00–Z99) are diagnosis codes used for situations where patients don't have a known disorder, which could arise in two ways:
      i. When a person, who may or may not be sick, encounters health services for some specific purpose, such as to receive limited care or service for a current condition or to discuss a problem that is not a disease or injury.
      ii. When some circumstance or problem is present that influences the person's health status but does not have a diagnosis consistent with a current disease or injury.

Resource	Link	Description
Social Determinants of Health Z Code Resource	Utilization of Z Codes for Social Determinants of Health among Medicare Fee for Service Beneficiaries | CMS	Article about how Z codes capture standardized information on SDOH.
Social Determinants of Health Z Code Documentation Guide	Social Determinants of Health Z Code Documentation Guide | Superior Health	Z coding and documentation for social determinants of health.

TIP

A best practice is to set up timely and front loaded (i.e., more visits in the first weeks) home visits.

Emergency Department Readmission Prevention Plan (EDRePP)

An EDRePP aims to prevent avoidable readmissions or trips to the emergency room. An EDRePP will contain relevant information about a patient's diagnosis, treatment goals and an evaluation plan for ED readmission prevention.

1. **Home Care Acceptance and Initiation:** Discharge from hospital to home requires successfully transferring information from clinicians to the patient and family to reduce adverse events and prevent readmissions. Engaging patients and families in the discharge planning process helps make this transition in care safe and effective.

Resource	Link	Description
ED Readmission Plan Resources	Resources and Tools to Improve Discharge and Transitions of Care and Reduce Readmissions | Agency for Healthcare Research and Quality	This page features links to AHRQ's resources and tools - based on this research. It is for clinicians, patients and researchers.
Homecare Intake Scripting Tool (HIS Tool)	Script to Assist in Patient Acceptance of Homecare Services | Superior Health	Scripting tool to assist in Patient's acceptance of homecare services, with six points to cover at the intake call.
Homecare Acceptance Scripting Tool (HAT Tool)	Homecare Acceptance Tracking Tool | Superior Health Example: Homecare Acceptance Tracking Tool | Superior Health	Six steps to track homecare acceptance rates, with optional practice tool.
Instructional Video for HIS and HAT Tools	Homecare Tools Instructional Video | Superior Health	Instructional video explains how to use the intake scripting and tracking tools.

2. **Individualized Education Plan:** Care planning provides a written document that communicates to all disciplines and can be referred to at any time. It is important that every home visit has a distinct purpose in assisting the patient with reaching their goals, and all disciplines are working together as a team to make this happen.

Resource	Link	Description
Developing an Individualized Plan of Care in Home Health Care	Developing an Interdisciplinary, Individualized Plan of Care in Home Health Care | Relias	A webpage focused on developing a care plan.
Guide to Writing a Nursing Care Plan	Nursing Care Plan: Ultimate Guide and List | Nurseslab	This guide provides a step-by-step approach to correctly completing the parts needed for a care plan.

3. **Comprehensive Emergency Plan:** Comprehensive care plans reflect shared decisions made with patients, caregivers and families about interventions, treatments and other activities needed to achieve care goals.
   a. **The goal of an emergency plan is to have the patient, caregiver or family call the HHA first, before going to the ED.**
   b. Most emergency plans contain information that includes the following 14 symptoms but are customized to the patient:

- Anxiety/Depression
- Bleeding
- Bowel Problem
- Breathing
- Change in Weight/Appetite
- Change in Wound
- Confusion
- Diabetes (High or Low Blood Sugar)
- Dizzy/Fall, Mobility
- Feel Unwell
- Fever/Chills
- Pain
- Upset Stomach
- Urinary Problem
- Other

4. **Diagnosis Specific Action Plans:** Zone Tools are downloadable tools created to assist patients in managing various common health conditions. Better self management can lead to improved overall health and help reduce the chances of hospital readmission. The tools include Green Zone—All Clear; Yellow Zone—Caution; and Red Zone—Medical Alert.

Resource Materials
Asthma Recommended for Home Health Care: English | Spanish Other resources with additional details: • My Asthma Action Plan (American Lung Association) • Asthma Action Plan (NHLB Institute)
COPD English | Spanish
COVID-19 English | Spanish
Diabetes English | Spanish
Heart Failure • Heart Disease: English | Spanish • Heart Failure: English | Spanish • Heart Failure: After You Go Home - Week 1 for Heart Failure Patients
Medication Management • Blood Thinners: English | Spanish • Medications: English | Spanish
Mental Health English | Spanish

Musculoskeletal

- Hip (Total): English | Spanish
- Knee (Total): English | Spanish

Neurological (Stroke)

English | Spanish

Pain Control

English | Spanish

Sepsis Prevention

- Pneumonia: English | Spanish
- Sepsis: English | Spanish
- Urinary: English | Spanish

Wound Care

Wound Care: Zones for Self-Management | Mountain-Pacific Quality Health

Please note that not all zone tools are designed to call home care first. Use your agency protocols and discretion to determine how you would like to have home care called first. We are not responsible for any customizations of these tools.

These downloadable tools were created to assist patients in managing a number of common health conditions. Better self-management can lead to improved overall health and help reduce the chances of hospital readmission.

This information is intended for educational purposes only. Health Services Advisory Group (HSAG) does not represent or guarantee that this information is applicable to any specific patient's care or treatment. This content does not constitute medical advice from a physician and is not to be used as a substitute for treatment or advice from a practicing physician or other healthcare provider.

EDUCATE CAREGIVERS, FACILITIES AND PROFESSIONAL STAFF

Educate Caregivers and Families

It is essential for caregivers and facilities, such as an assisted living facility, to understand home health services clearly. To educate caregivers and facilities about home health services, you may want to:

1. Provide education about home health services such as skilled nursing care, physical therapy, occupational therapy, speech therapy, personal care, homemaker services and medical equipment and supplies.
2. Explain the benefits of home health services for recipients, such as improving their quality of life, reducing hospitalizations and preventing long-term nursing home stays.
3. Inform them about the eligibility criteria and coverage options for home health services such as Medicare, Medicaid, private insurance or out-of-pocket payments.

Resource	Link	Description
What's Homecare?	What's home health care? | Medicare	This document provides an overview of what Medicare covers.
All About Home Health Services	All About Home Health Care Services | AgingInPlace	This document provides an overview of the benefits of using Homecare Services.
Homecare Acceptance Tracking (HAT) Tool	See link on page six.	Tracking tool to track homecare acceptance rates.

4. Offer training and support on providing or coordinating home health services for their care recipients.
5. Encourage caregivers to take care of their health and well-being.
6. Recommendations:
   a. Provide a refrigerator magnet with the HHA phone number and care instructions customized to the care recipient.
   b. Provide a resource list of community-based services.
   c. Offer frequent reminders to improve communication with caregivers, facilities and care recipients.

Resource	Link	Description
Caregiver Resources and Long-Term Care	Caregiver Resources and Long-term Care | HHS	This website offers a list of resources for caregivers to support older adults living in their homes and communities.
Caregiving for Family and Friends	Caregiving for Family and Friends – A Public Health Issue | CDC	Provides an overview of the need to support family and friends in a caregiving role.
Community Resource List: FindHelp.org	Search and Connect to Social Care | FindHelp	This website locates support by zip code for services related to financial assistance, food pantries, medical care and other free or reduced cost help.
Community Resource List: Call211.org	Call 211 for Essential Community Services | United Way	Call 2-1-1 or visit their website to access a comprehensive source of information about local resources and services in the country.
Community Health Information Exchange	Health Information Exchange | HealthIT.gov	Provides information about how health care professionals and patients can appropriately access and securely share a patient's medical information electronically.
Home Health Quality Measures	Medicare Quality Measures: Home Health Quality Measures | CMS	Quality measures that are reportable to CMS.

COMPETENCY TRAINING FOR PROFESSIONAL STAFF

Competencies

A formal process of determining that direct care personnel can provide care within the scope of practice. Competencies includes both theoretical and practical knowledge. It is:

- Validation of skills specific to each employee's role and responsibilities that are attained via various methods, including clinical observation, skills lab review, knowledge-based tests and case studies.
- Self-assessment, ongoing training and education, in-services, observation of duty and/or supervisory visits.
- An ongoing process. Competencies are not only performed at hire (initial competency) and annually but when a new task or skill is identified, e.g., before a staff member is assigned to a new task.

Resource	Link	Description
Superior Health Front Line Forces (FLF) Modules	Click on a subject to explore the training modules and resources. More modules are available on the Superior Health website. • Change in Condition • Clostridioides difficile (C.Diff) • Preventing Falls and Falls with Injury • Sepsis • Substance Use Disorder (SUD) • Vaccinations	FLF training modules and resources cover topics developed with the direct care staff in mind and created for those working in long term care and other health care settings. These short on-demand learning modules and resources fit seamlessly into the day's routine without causing lengthy interruptions. FLF modules • Empower and engage direct care staff in their work by building the confidence and skills they need to support quality care and a resident centered approach; • Build on current knowledge; and • Promote best practices.
Diagnosis Specific Action Plans	• Asthma • COPD • Diabetes • Heart Failure • Medication Management • Mental Health • Pain Control • Wound Care	Diagnosis Specific Action Plans, or other training materials, can be used to assess competencies.

INTERNAL WORKFLOW PROCESS

An internal workflow process in home health care is a series of steps that involve different team members and tasks to deliver care to patients at home. Workflow processes are agency specific. Below are examples of what workflows to develop or review, and what step can be included in an internal workflow process:

1. **Clinical Decision Support:** These systems are computer programs that organize patient data into helpful information to make evidence-based treatment planning decisions. Flags and hard stops within the programs assist with the following patient interventions:
    a. High-risk diagnoses
    b. Complex patients
    c. Polypharmacy
    d. Fall risk
    e. Positive screenings: mental health, substance use disorder (SUD), abnormal Review of Systems (ROS) and exam, Social Determinants of Health (SDOH)
    f. Frequent ED visits, i.e., three within the past three months
    g. Recent hospitalization
2. **Agency-Specific Actions:** Specific **diagnosis zone tools** for when encountering a patient in the Yellow or Red zones.
    a. Neurological: stroke, confusion, loss of function
    b. Cardiac: myocardial infraction, congestive heart failure, chest pain, shortness of breath, dizziness, syncope
    c. Respiratory: pneumonia, COPD, upper respiratory infection
    d. Pain control: surgery, chronic or acute pain
    e. Infection risk: fever or chills, risk factors, respiratory, skin, urinary
    f. Gastrointestinal: stomach, bowels, nausea, vomiting
    g. Endocrine: diabetes mellitus
3. **Track Your Numbers:** Home Care Acceptance Rate
    a. Home Care Acceptance Rate (HAT Tool)
    b. ED utilization rate
    c. Hospital readmission rate

If you would like more information on any of the above resources, please let us know.

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