



## Home Health Agency Change Package

Provider Name: \_\_\_\_\_ Date: \_\_\_\_\_

Provider Number: \_\_\_\_\_ Name of Provider Contact Person: \_\_\_\_\_

Please Check One or More	Interventions	Targeted Population (Ex: Heart Failure, PN, or AMI Patients)	Planned Start Date	Actual Start Date
<b>1. Patient/Caregiver Education</b>				
	<p><b>1a.</b> Promote improvement in oral medication (OM) management by patient/caregiver.</p> <ul style="list-style-type: none"> <li>• Utilize tools from Medication Management Best Practice Intervention Package (BPIP) to ensure consistent and comprehensive assessment of patient's/caregiver's ability to safely manage the prescribe medication regime, providing educational interventions based on clinical assessment               <ul style="list-style-type: none"> <li>– Medication Reconciliation</li> <li>– Medication Simplification</li> <li>– Medication Non-adherence</li> <li>– Medication Documentation. Complete medication list and give to patient/caregiver in the home</li> </ul> </li> </ul>			
	<p><b>1b.</b> Promote utilization of Emergency Care Plan (ECP) from BPIP: Patient Emergency Plan.</p>			
	<p><b>1c.</b> Promote patient- and family-centered care; involve the patient and caregiver in the development of a Plan of Care and in subsequent updating of the Plan of Care.</p>			



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	<b>1d.</b> Educate patient, caregiver, and families to the importance of improving care transitions between provider settings and the community-wide CT Initiative and the ability to reduce unnecessary re-hospitalizations.			
	<b>1e.</b> Educate patients and families on progressive stages of chronic disease and care options available for the treatment of the exacerbations of chronic diseases.			
	<b>2. Post-hospital Discharge/Admission to Home Health</b>			
	<b>2a.</b> Promote utilization of assessment tools from OM BPIP <ul style="list-style-type: none"> <li>• Medication Reconciliation</li> <li>• “Be Safe and Take”</li> </ul>			
	<b>2b.</b> Promote utilization of a Hospital Risk Assessment (HRA) Tool to identify patients at risk for unnecessary re-hospitalization; develop a Plan of Care and visit frequency based on assessment findings.			
	<b>2c.</b> Promote utilization of a Falls Risk Assessment (FRA) Tool to identify patients at risk for re-hospitalization due to injuries from a fall. <ul style="list-style-type: none"> <li>• Promote assessment tool, “Timed Up and Go”</li> <li>• Identify opportunities for and encourage referrals to physical therapy for balance and strengthening interventions</li> </ul>			
	<b>2d.</b> Promote reporting and review of unobserved patient falls.			
	<b>3. Advance Care Planning</b>			
	<b>3a.</b> Investigate opportunities to institute a Palliative Care Program.			
	<b>3b.</b> Educate patients/caregivers/families on care options available to the patient for exacerbation of chronic illness.			
	<b>3c.</b> Educate patients/caregivers to care options such as Palliative Care and/or Hospice Care; increase percentage of patients with Advance Directives.			

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	3d. Encourage support staff to assist patients and caregivers in advance care planning.			
<b>4. Disease Management</b>				
	4a. Promote improvement in oral medication (OM) management by patient/caregiver as noted above.			
	4b. Promote utilization of Emergency Care Plan (ECP) from BPIP: Patient Emergency Plan, as noted above.			
	4c. Promote utilization of standardized protocols or care paths for HF, COPD.			
	<p>4d. Review utilization of Telehealth program to maximize its effectiveness or consider opportunities to initiate a Telehealth Program; review BPIP: Telehealth.</p> <ul style="list-style-type: none"> <li>• Implement use of INTERACT tool kit and the Unplanned Transfer Review Tool. Both are interventions designed to reduce acute care transfers among nursing home residents and can be found at <a href="http://www.qualitynet.org">www.qualitynet.org</a>. Click on the MedQIC tab and type “INTERACT” in the search box</li> <li>• Improve interdisciplinary communication between clinicians and between clinicians and physicians through utilization of the Situation, Background, Assessment, Recommendation (SBAR) communication format</li> <li>• Investigate opportunities to implement Planned Phone Monitoring: BPIP Phone Monitoring and Frontloading Visits</li> </ul>			
<b>5. Discharge Planning</b> (from home health services – “Discharged to the Community”)				
	<p>5a. Foster patient/caregiver/family self-management.</p> <ul style="list-style-type: none"> <li>• Review BPIP: Patient Self-Management</li> <li>• Pilot utilization of Patient Self-Management Tools, Confidence Scale, Patient SBAR, My Action Plan</li> <li>• Promote use of PHR</li> </ul>			
	5b. Provide medication list at discharge to patient/caregiver, with a copy to patient’s physician.			
	5c. Educate patient/caregiver/family re: “red flags.”			

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<b>6. Multidisciplinary Staff Education</b>				
	<b>6a.</b> Introduce all staff to Care Transitions.			
	<b>6b.</b> Educate clinicians on the identification of patients at risk of re-hospitalization; implement an HRA tool.			
	<b>6c.</b> Provide skills update for nurses; utilize “Polish Your Practice Series” of educational programs for HF and other chronic diseases.			
	<b>6d.</b> Provide communications update for clinicians; implement or optimize use of SBAR.			
	<b>6e.</b> Review utilization of Telehealth; update in-service opportunities as needed.			
<b>7. Physician and Cross-provider Education</b>				
	<b>7a.</b> Educate physicians and other providers re: HH care (opportunities, criteria for hospital discharge to home care, barriers, concerns, commonalities).			
	<b>7b.</b> Educate and promote utilization of evidence-based communication tools such as SBAR.			
	<b>7c.</b> Educate clinicians re: transition from patient education to self-management support in preparation for patient’s discharge from home health care.			
	<b>7d.</b> Educate re: goals of Telehealth Program; collaborative opportunities to reduce avoidable re-hospitalizations, as well as support for disease management and patient/family self-management.			

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<b>8. Home Health Quality Improvement</b>				
	<b>8a.</b> Ongoing review of Publicly Reported Quality Measures and reasons for re-hospitalization.			
	<b>8b.</b> Review QI process and team participation in support of agency and staff in implementation of selected CT transitions.			
	<b>8c.</b> Review and revise (as needed) the agency’s process of monitoring the implementation of best practices.			
	<b>8d.</b> Utilize a Best Practice Monitoring Tool (BPMT) or standard tracking form.			
<b>9. Other Facility-chosen Interventions</b>				