Quality Improvement Series: Briefing Card Compendium

Expanded Home Health Value-Based Purchasing (HHVBP) Model

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Overview

- The briefing cards provide strategies that a home health agency (HHA) might consider for Quality Assurance and Performance Improvement (QAPI) plans.
- Each card follows an SBAR (situation, background, assessment, and recommendation) format. See the *First Performance Year Quick Guide recording* and *Strategies for Success Self-Assessment Tool* for more information on SBAR.
- Strategies are drawn from sources such as health service research, home health nursing standards of practice, Medicare Home Health Conditions of Participation (CoP), and the Medicare Benefits Policy Manual.
- Updates will occur on a quarterly basis when new briefing cards are available.
- Additional resources designed to support HHAs' quality and performance improvement efforts are available on the Expanded HHVBP Model webpage, under "Quality Improvement."

Organization

Briefing cards are categorized by an aspect of care delivery, as shown in the table below, and numbered sequentially within the category.

	Assessment
	Care Planning
	Monitoring
	Patient Engagement
	Maintenance Coverage

ASSESSMENT

1. Clinical assessments include appropriate observation of patients' functional abilities.

***S**ituation*	Clinicians new to home health care, charged with completing assessment data collection, may be over-reliant on patient reported data and fail to systematically and reliably collect data based on direct observation of patient functional abilities or incorporate such data into their assessment.
***B**ackground*	Comprehensive patient assessment, providing a complete picture of the patient's status and abilities is an essential home health function, necessary for care planning.
***A**ssessment*	Over reliance on patient reported data can significantly and negatively impact patient outcomes and HHA operations.
***R**ecommendation*	HHAs should establish procedures to ensure patient assessments include direct observation of functional abilities, as appropriate. Staff should be supported in the use of this strategy, including: • Allocating the time required to complete assessments • Monitoring performance • Providing positive feedback on desired performance

2. Clinical assessment involves all required disciplines.

HHA has established procedures for initiating request for orders for needed nursing or rehabilitation therapy assessment when not included in physician referral.

***S**ituation*	Patients may have needs for skilled care beyond those included in their care plan that are either not identified by home health clinicians or not accessed through care coordination efforts with the referring physician.
***B**ackground*	Through interactions with patients in their homes, home health clinicians gain a unique perspective on the patient's health and care needs. Home health clinicians – including nurses and therapists – are in an ideal position to identify potential needs for skilled care from other disciplines beyond those included in the original physician referral.
***A**ssessment*	Unmet skilled care needs can significantly and negatively impact patient outcomes and HHA operations.
***R**ecommendation*	HHAs should establish procedures to ensure that initial and ongoing patient assessments identify needs for skilled care beyond those included in the current care plan. This should include: • Interdisciplinary orientation and education that promotes understanding the roles and functions of other clinical disciplines. • Assessment procedures that include identification of potential unmet skilled care needs. • Care coordination procedures to effectively communicate assessment findings to referring physicians to approve additions or modifications to the care plan.

3. Medication review strategies and procedures reliably identify potential adverse effects and drug reactions for all patients.

***S**ituation*	Medication review for home health patients may not reliably identify potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, and duplicate drug therapy.
***B**ackground*	HHA patients, including those with multiple chronic conditions and complex care needs, who may be under the care of multiple prescribing clinicians, and who experience frequent care transitions are at significant risk for adverse drug effects (ADEs). In this population, ADEs are a common cause of emergency department visits, hospitalization, and treatment failures.
***A**ssessment*	Failure to identify potential ADEs can significantly and negatively impact patient outcomes and HHA operations. With the modern pharmacopeia, identifying potential ADEs in this patient population is an exceptionally challenging cognitive task – even for experienced HHA nurses.
***R**ecommendation*	HHAs should establish procedures to ensure that, during medication review, the HHA nurse considers the potential for ADEs of each medication the patient is taking and for their medication regimen as a whole. This review for potential ADEs should be documented in the clinical record. Medication review procedures should include or consider: • Orientation and education on the standards and expectations for medication review. • Tools and decision aids to support HHA nurses in this task. • Care coordination procedures to effectively communicate medication review findings of potential ADEs to referring physicians.

4. Patients who want and continue to require HHA services that can be provided safely are not discharged until measurable outcomes and goals set forth in their plan of care have been achieved.

***S**ituation*	Home health care patients may be discharged from care even though they want home health services, remain homebound, have a qualifying skilled need, and the measurable outcomes and goals set forth in their plan of care have not been achieved.
***B**ackground*	A patient's overall medical condition, without regard to whether the illness or injury is acute, chronic, terminal, or expected to extend over a long period of time, is to be considered in deciding whether skilled services are needed. Unless there is some other specific justification for discharge, discharge is only appropriate when the physician who is responsible for the home health plan of care and the HHA agree that the measurable outcomes and goals set forth in the plan of care have been achieved, and the HHA and the physician who is responsible for the home health plan of care agree that the patient no longer needs the HHA's services.
***A**ssessment*	The discharge of eligible patients from home health care can deny patients benefits to which they are entitled and significantly and negatively impact patient experience, post-discharge outcomes, and HHA operations.
***R**ecommendation*	HHAs should establish procedures to ensure that eligible patients who have not met the measurable outcomes and goals set forth in their plan of care are not discharged from care. This would include: • Orientation and education on the standards for home health care discharge. • Assessment procedures with documentation of plan of care goals and progress toward those goals. • Care coordination procedures to effectively communicate assessment findings and continuing care needs to referring physicians.

CARE PLANNING

1. HHA has established clinical protocols or pathways for conditions common to the HHAs patient population.

***S**ituation*	Reliable individual and interdisciplinary team performance, and improved patient and caregiver communication can be achieved though standardization of common tasks and clinical activities.
***B**ackground*	While every patient's care needs are unique, an HHA's patient population will have common conditions, with aspects of care that can be standardized.
***A**ssessment*	Failure to use clinical protocols or pathways can negatively impact patient outcomes, patient experience, and HHA operations.
***R**ecommendation*	HHAs should incorporate clinical protocols or pathways for conditions seen in their patient population and institutionalize their use. This would include: • Development or adoption of clinical protocols or pathways. • Orientation and education on clinical protocols or pathways and expectations for their use. • Incorporation of clinical protocols or pathways into procedures, tools, and patient education and training resources.

MONITORING

1. HHA has established protocols for monitoring for and responding to signs of deterioration in clinical status, including monitoring outside of in-person visits.

***S**ituation*	Home health patients may experience delays in care because signs of deterioration in clinical status are not detected or because monitoring occurs at times of limited availability of care resources.
***B**ackground*	Home health patients are at risk for emergency department visits and hospitalization due to, for example, their underlying and recognized health conditions, fragmentation of care and care transitions, exacerbation of previously well-managed conditions, and even new diagnoses that can arise. Responding to signs of deterioration in clinical status may involve coordination of care with other providers. Care plans must include interventions, such as monitoring, that address these underlying risk factors. Monitoring scheduling should consider patient-specific risk and the availability of other care providers.
***A**ssessment*	Failure to establish and use protocols for monitoring for and responding to signs of deterioration in clinical status or pathways can negatively impact patient outcomes, patient experience, HHA operations, and increase risk for emergency department visits and hospitalizations.
***R**ecommendation*	HHAs should establish protocols for monitoring for and responding to signs of deterioration in clinical status. This would include: • Development or adoption of monitoring protocols. • Orientation and education on monitoring protocols and expectations for their use. • Ensuring that responsible staff have the time to perform expected monitoring activities, according to schedules provided in protocols. • Incorporating monitoring protocols into procedures, tools, and patient education and training resources. • Performance monitoring and feedback.

PATIENT ENGAGEMENT

2. Assessment protocols ask patients to identify their own strengths and independently identify the patient's strengths

***S**ituation*	Assessment processes that focus exclusively on functional limitations and care needs or that don't include an opportunity for a patient to affirm their own strengths can leave patients feeling un-empowered to take an active role in their own care. Patients who are un-empowered may experience anxiety, negative affect, and dissatisfaction with home care services; the effectiveness of health promotion teaching can be negatively impacted for such patients; they may be less likely to participate in self-care activities; and more likely to experience negative outcomes of care.
***B**ackground*	Consistent with the principles of patient-centered care, the intent in identifying patient strengths is to empower the patient to take an active role in his or her care. To promote a sense that the patient is respected as an active partner in the delivery of care, the HHA should ask the patient to identify her or his own strengths and independently identify the patient's strengths to inform the plan of care and to set patient goals and measurable outcomes.
***A**ssessment*	Failure to consistently identify patient strengths, and have those strengths affirmed by the patient themselves, can negatively impact patient outcomes, patient experience, and HHA operations.
***R**ecommendation*	HHAs should establish protocols identifying patient strengths and documenting those strengths in their comprehensive assessment. The interdisciplinary team should consider patient strengths in care plan development. Implementation of patient strengths identification protocols would include: • Identification of effective strengths identification methods and tools. • Orientation and education on strengths identification protocols and expectations for their use. • Ensuring that responsible staff have the time to perform strengths identification interventions. • Incorporating strengths identification protocols into procedures, tools, and patient education and training resources. • Performance monitoring and feedback.

3. Care delivery promotes patient and family/caregiver engagement (PFE) consistent with patient goals

***S**ituation*	Home health care processes and care practices should promote patient/person and family/caregiver engagement (PFE), consistent with patient values, preferences, and goals, in all aspects of care, decision-making, and self-care. These processes and care practices, however, can present barriers if the patient/person is not at the center of care.
***B**ackground*	PFE is a desired result or output of health care processes. Barriers to PFE in home care include previous adverse experiences with health care; interactions with the home health agency (HHA) and staff that are not perceived by patients and family/caregivers to be respectful, supportive, nurturing, and responsive to what is important to and for them; gaps in incorporating patient and family/caregiver education and training needs into care planning; and gaps in monitoring the effects of education and training interventions and adapting care plans accordingly.
***A**ssessment*	Engagement of patients and family/caregivers supports the home health plan of care, goal accomplishment, positive patient outcomes and the patient and family/caregiver experience during the delivery of home health care.
***R**ecommendation*	Home health care processes should anticipate and identify barriers to PFE. HHA staff training and education should include strategies to promote PFE. HHAs should establish procedures that promote PFE, including: • Recognition of PFE as an organizational and leadership priority. • Identification of methods and techniques for patient and family/caregiver education and training that are effective in promoting PFE across the range of needs found in the population served by the HHA. Examples include: ▪ Motivational Interviewing and other patient communication approaches, Outreach Calls during times of risk for hospitalization or ED Use, Self-Management Tools, Remote Patient Monitoring, Decision Making Aids such as “Important To” and “Important For,” and Teach-back. • Staff orientation, education, and training on PFE processes and methods. • Ensuring responsible staff have the time to perform PFE activities and interventions. • Incorporating PFE activities and methods into procedures, tools, and patient education and training resources. • Performance monitoring and feedback for staff.

MAINTENANCE

1. HHA has established clinical protocols or pathways for eligible patients needing skilled care to maintain function or prevent or slow decline in function.

***S**ituation*	Home health providers and clinical staff may believe that the Home Health Benefit of the Medicare program covers nursing and therapy services only when a beneficiary is expected to improve. This is not always true. HHAs may not have established clinical protocols or care pathways that guide goals in the plan of care, decision making, documentation, care coordination, and appropriate discharge.
***B**ackground*	The Home Health Benefit of the Medicare program is not based on the presence or absence of a beneficiary's potential for improvement, but rather (when all other coverage criteria are met) on their need for skilled care.
***A**ssessment*	Establishing clinical protocols or care pathways for home health patients with maintenance goals can potentially positively impact beneficiary access to care, patient outcomes, patient experience, and HHA operations.
***R**ecommendation*	HHAs should incorporate clinical protocols or care pathways for eligible patients needing skilled care to maintain function or prevent or slow decline or deterioration and institutionalize their use. This would include: • Development or adoption of clinical protocols or pathways. • Orientation and education on clinical protocols or pathways and expectations for their use. • Incorporation of clinical protocols or pathways into procedures, tools, and patient education and training resources. • Care coordination procedures to effectively communicate assessment findings and care plans for patients with maintenance goals to referring physicians.