

Strategies to reduce acute care hospitalization

Just as the cause of acute care hospitalizations is multi-dimensional, the solution is also multi-dimensional and will involve patient, caregiver, health care provider and health system factors. Actions taken by home health providers are not the entire solution, but home health agencies can improve their care processes and influence and lead improvements in transitions and coordination across settings.

CREATE A QUALITY CULTURE

- ▲ Secure commitment of senior leaders to address the issue of reducing hospitalization
- ▲ Work collaboratively with hospitals to establish a joint hospital/HHA quality agenda
- ▲ Establish an organizational quality improvement plan of action and allocate resources to implement and monitor it
- ▲ Integrate and sustain organizational changes demonstrated to achieve positive improvement

PROMOTE PATIENT SELF-MANAGEMENT

- ▲ Engage patients and caregivers in the determination of whether home care is the right option
- ▲ Provide patients and caregivers with information and options to address immediate/urgent care needs
- ▲ Establish patient and caregiver expectations and assess their capacity to engage in self-management
- ▲ Prepare patient and caregiver expectations and assess their capacity to engage in self-management
- ▲ Prepare patient and caregiver to identify and manage problems that may arise after discharge from home care
- ▲ Prepare patient and/or caregiver to maintain and convey key health and treatment information

IMPROVE CARE DELIVERY SYSTEMS AND MOBILIZE COMMUNITY RESOURCES

- ▲ Collaborate with hospitals to establish key criteria for safe, appropriate discharge from the hospital to home care
- ▲ Establish transition protocol for transfers from hospital or other facility (e.g., SNF) to home care
- ▲ Organize care teams to promote consistency and continuity
- ▲ Match intensity of clinical resources and services to patient risks/conditions/problems as identified by risk assessment at individual patient level and staff caseload/population level
- ▲ Coordinate with primary care providers and specialists to promote continuity of outpatient/in-home care

IMPLEMENT EVIDENCE-BASED PRACTICES AND GUIDELINES

- ▲ Use evidence-based guidelines to assess clinical readiness for hospital
- ▲ Use evidence-based risk assessment tools to identify high-risk patients and incorporate risk factors into individualized patient care plans

- ▲ Use evidence-based condition-specific/problem-specific interventions e.g., heart failure, diabetes, chronic lung disease, pressure ulcer, pain management, fall prevention
- ▲ Screen patients for depression and refer for treatment when appropriate

USE SYSTEMS AND TECHNOLOGY TO PROMOTE EFFECTIVENESS AND EFFICIENCY

- ▲ Increase home health agency organizational capacity to screen patients for safe/appropriate admission
- ▲ Implement systems to identify and track patients at increased risk for hospitalization and related problems
- ▲ Use systems to enhance effective internal and external communication and continuity of care
- ▲ Use decision support tools that prompt clinicians to implement evidence-based practices
- ▲ Use telehealth/telemonitoring systems to supplement care of patients at risk of hospitalization
- ▲ Implement systems to track patients who go to the emergency department