Tracking Home Care Acceptance Rates After Implementing an Intake Scripting Tool, Helping to Prevent Readmission and Emergency Department (ED) Overutilization

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Objectives

- Discuss the importance of the timeliness of care and how it relates to reducing ED overutilization and unnecessary hospital readmissions.
- Identify and implement a Home Care Intake Scripting (HIS) Tool and intervention within your agency's intake process.

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Meet the Audience

- Home Care Administrator or Manager
- Home Care Provider and/or Nurse
- Quality Improvement and/or Compliance
- Ancillary: Therapy, Behavioral Health, Social Worker
- Other?

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Rational of Scripting Intervention and Tracking Home Care Acceptance Rates

- Nearly 20% of patients 65+ discharged from hospitals are readmitted within 30 days, costing over $1.9 billion annually.
- Research shows readmission rates decrease with improved health care.
  - Quality of care during the initial admission.
  - Improvement in communication (patients, caregivers, clinicians).
  - Patient education.
  - Predischarge assessment.
  - Coordination of care after discharge.
    - Home health agency (HHA) services and visiting providers.
  - Hospital care management programs.
  - Addressing social determinants of health (SDOH) issues.
    - NQF's All-Cause Readmissions Project, National Quality Forum
    - Potentially avoidable hospitalizations of nursing home residents: frequency, causes and costs, PubMed

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Improving Transitions from the Hospital to Home Health Care to Reduce Avoidable Rehospitalizations

- STate Action on Avoidable Rehospitalizations (STAAR) aims to improve the transition home in the first 24 to 48 hours:
  - Meet the patient, family caregiver(s) and inpatient caregiver(s) in the hospital and review the transition home plan.
  - Assess the patient, initiate the plan of care and reinforce patient self-management at the first post-discharge home health care visit.
  - Engage, coordinate and communicate with the full clinical team.
    - Sevin C, Evdokimoff M, Sobolewski S, Taylor J, Rutherford P, Coleman EA. How-to Guide: Improving Transitions from the Hospital to Home Health Care to Reduce Avoidable Rehospitalizations. Cambridge, MA: Institute for Healthcare Improvement; June 2013. Available at www.IHI.org.

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Preventing Rehospitalization in the Home Health Patient

- **Obtain and review:** H&P, Problem, Allergy, Med List, labs, procedure and surgical notes.
- **Assess:** Support system, knowledge of disease, medications and economic status.
- **Individualize plan of care:** Frontload visits and decrease with time for intensive teaching and assessment.
- **Do med reconciliation:** after admission and routinely thereafter.
- **Coordinate care:** Between clinical and therapy staff, family/ caregivers, agency managers, clinicians and specialists.
  - Preventing Re-hospitalization in the Home Health Patient, Axxess

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Preventing Re-hospitalization in the Home Health Patient (cont.)

- **Implement a "know when to call your nurse" symptom list.**
  - Do PRN visits for early interventions to prevent ER visits.
    - "Call Us First" toolkit
- **Assure the patient has a follow-up appointment and transportation ASAP.**
  - Within a week following hospital discharge
    - Social Drivers of Health Z-Code Resource Guide
- **If the patient goes to the hospital, communicate with the hospital staff.**
  - **Call ER and send documentation**: 485, problem list, med list and summary.
- **Call daily to check on the hospitalized patient's status**.
- **Visit ASAP after hospital discharge and increase visit frequency for a couple of weeks.**
  - Reconcile medications and involve caregiver(s).
  - Focus teaching on medication changes and the reason for hospitalization.
    - Preventing Re-hospitalization in the Home Health Patient, Axxess

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Workgroup Aims to Improve Home Care Timeliness of Care and Acceptance Rates to Reduce Readmissions

- **Superior Health Care Coordination Team** convened over 30 Home Health Care Agencies from Minnesota, Wisconsin and Michigan.
- **Identified gaps.**
  - Timeliness: Readmissions increase if not accessing home care promptly.
  - Access: COVID-19, staffing, family and patient reasons.
  - **Developed Home Care Intake Scripting tool (HIS Tool).**
  - Knowledge gap: Decline or delay in initiating home care.
  - Provides cues for intake workers to address reasons for decline.
- **Developed Home Care Acceptance Tracking Tool (HAT Tool).**
  - Monitors training and use of HIS Tool.
  - Monitors acceptance rates and reasons for declining home care.

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WHEN YOU CALL PATIENTS TO SET UP THE INITIAL VISIT, WHAT RESPONSES ARE YOU GETTING?

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HIS TOOL

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Script to Assist in Patient Acceptance of Homecare Services

Six Points to Cover at the Intake Call

Introduction: "Hello, my name is [NAME]. I'm [ROLE] calling from [AGENCY NAME]. Your doctor asked us to check on you at your home after your recent hospital stay."

- Pause to answer questions at any time during the call.

"Your doctor feels it is important to have a home visit done within [X DAYS/TOMORROW/etc.]."

- "Homecare visits can help you get better faster and may prevent you from returning to the hospital."
  - Options for responding to the patient:
    - "This is especially true if you are not feeling well or are having difficulty at home, and we can come to you."
    - "I want to make sure you are okay."
    - "What isn't feeling good today? Let's work together to help you feel better so you can stay at home."

"Medicare frequently pays for home care services when needed (medically necessary)."

- "There is no charge for the assessment."
- "Frequency of visits can vary based on your needs and the assessment."
- "We usually schedule visits or calls about two to three times a week for the first couple of weeks."
- "Visits decrease as you improve or increase if needed."

"At the assessment visit, the nurse will…"

- "Determine any urgent needs you may have."
- "Review your medication and treatments."
- "Help you understand your discharge instructions and treatment plan."
- "Talk to you about which services you need and qualify for."
- "Notify your doctor if there are any concerns."

"Our nurse is available at [TIME] or [TIME] tomorrow. Which time works for you?"

- "Okay – the nurse will be there at [TIME]."
- "Please call us if you need to reschedule this appointment. Our phone number is [PHONE NUMBER]."

"Have you made a follow-up appointment with your doctor yet?"

- If yes… "That's great!"
  - "When is it, and with which doctor?"
  - "Do you need help getting to your appointment?
- If no… "Do you need help making your appointment?"
  - If yes… "I will let the nurse know you need help with that."
  - If no… "Please make your follow-up appointment as soon as possible or call us back if you need help."

HAT TOOL

Baseline Data:

- Intake Scripting Inservice/Education
- Prior Home Care Acceptance Rates

	Home Care Acceptance Tracker				Fill in cells highlighted in yellow.				Green cells auto-populate.	
	Intake Scripting Inservice and First month				Fill in cells highlighted in light gold (optional).				Gray cells - ignore.	
	Intervention - Intake Scripting					Data Collection				
	Inservice Date	Number of Staff Attended	Number of Staff to be Trained	Percent of Staff Traine	Implementation Date	Data Collection End Date	Number of Patient Intakes	Home Care Services Accepted	Home Care Services Declined	Acceptance Rate
Baseline					5/8/2023	5/7/2023	100	47	53	47%
Inservice 1	5/7/2023	4	10	40%	5/15/2023	5/14/2023	16	7	8	44%
Inservice 2	5/14/2023	4	10	80%	5/22/2023	5/21/2023	18	11	7	61%
Inservice 3	5/21/2023	2	10	100%	5/31/2023	5/30/2023	18	12	6	67%
Inservice 4	5/30/2023	1	11	100%		end of month	17	12	5	71%
	Enter data in yellow fields.	11	11	100%	Defaults to day after inservice.	Defaults to day of inservice (or end of month).	69	42	26	61%

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Home Care Acceptance Tracker: Weekly and Monthly Data

HAT TOOL

Acceptance Rates by Total Number of Intake Calls and Use of Scripting

	Total Number of Intakes	No Scripting Used	Scripting Used	Accepted Home Care Services	Declined Home Care Services	Overall Acceptance Rate (Post)	Scripting Use Rate
Baseline	100	100	0	47	53	47%	0%
Week 1	**16**	**4**	**12**	**7**	**8**	**44%**	75%
Week 2	**18**	**3**	**15**	**11**	**7**	**61%**	83%
Week 3	**18**	3	15	12	6	67%	83%
Week 4	**17**	2	15	12	5	71%	88%
Total	**69**	**12**	**57**	**42**	**26**	61%	83%

	Number of Patient Intakes	Scripting Used	Scripting Use Rate	Home Care Services Accepted	Home Care Services Declined	Acceptance Rate
Month	100		0%	47	53	47%
May-23	69	57	83%	42	26	61%
Jun-23	79	68	86%	59	20	75%
Jul-23	77	71	92%	62	15	81%
Aug-23	0	0	#DIV/0!	0	0	#DIV/0!
Sep-23	0	0	#DIV/0!	0	0	#DIV/0!
Oct-23	0	0	#DIV/0!	0	0	#DIV/0!
Nov-23	0	0	#DIV/0!	0	0	#DIV/0!
Dec-23	0	0	#DIV/0!	0	0	#DIV/0!
Jan-24	0	0	#DIV/0!	0	0	#DIV/0!
Feb-24	0	0	#DIV/0!	0	0	#DIV/0!
Mar-24	0	0	#DIV/0!	0	0	#DIV/0!
Apr-24	0	0	#DIV/0!	0	0	#DIV/0!
	225	**196**	**87%**	**163**	**61**	**72%**

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Scripting Intervention: Assess

- Who to train on **scripting** and **use of intake tracker:**
  - Intake Staff (scripting, tracker):
    - New staff and backup staff.
  - Assessment Staff (scripting, tracker optional) :
    - First contact with the patient.
    - Ideas and feedback.
    - Consistent messaging.

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Scripting Intervention: Plan

Assign Project Lead and team.

- Assign roles (project lead, data submission and data analysis).
- **Who** and **how** to decide if changes are needed.

Determine implementation date(s).

- Provide access to training video .
- Baseline data collection ends the day the video is viewed.
- Begin using the HAT Tool the day after viewing the video.

Submit data to HATTool@superiorhealthqa.org

- Submit baseline data within ten days.
- Monthly: before the 10th of every month.

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Scripting Intervention: Implementation and Evaluation

IMPLEMENT

Use the HAT Tool for every intake.

Day after in-service, document:

- If scripting was used.
- Acceptance of home visit.
- If no visit is done, why?

Gather feedback from staff

- Document feedback and ideas.
- What works and what doesn't.

MONITOR AND EVALUATE

Monitor:

- Acceptance rates
- Use of scripting.

Evaluate:

- Trends
- Issues
- Generate ideas and improvements.
- Plan-Do-Study-Act (PDSA): Decide if/when to implement changes.

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STEP 1: IMPLEMENT HOME CARE INTAKE SCRIPTING INTERVENTION

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How many people in your organization do intake calls and/or follow-up on referrals?

- Two or less.
- Three to five.
- Six or more.

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Home Care Intake Scripting Intervention

- Provide accurate and helpful information to individuals at risk for hospital readmissions.
- The scripting tool offers six talking points:
  - Use your own words and language;
  - Offer a rationale for Home Care and effect on health and well-being, in particular decreasing readmission;
  - Address client questions and improve trust;
  - Dispel myths about Home Care that can lead to reluctance;
  - Provide consistent and accurate communication by all staff; and
  - Normalize Home Care services as a component of health care.

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Scripting for Intake Workers to Improve Patient's Acceptance of Home Care Services

Introduction: "Hello my name is [NAME]. I'm a [ROLE] calling from [AGENCY NAME]. Your doctor asked us to check on you at your home after your recent hospital stay."

- Pause to answer questions any time during the call.

"Your doctor feels it is important to have a home visit done within [X DAYS/TOMORROW/etc.]."

- Options for responding to the patient:
  - "We want to make sure you are okay."
  - "Home care visits can help you get better faster - and may prevent you from going back to the hospital."
  - "This is especially true if you are not feeling well or having difficulty at home, and we can come to you."
  - "What is not feeling well today? Let's work together to help you feel better so you can stay at home."

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Scripting for Intake Workers to Improve Patient's Acceptance of Home Care Services (cont.)

- **"Medicare frequently pays for home care services when needed (medically necessary)."**
  - "There is no charge for the assessment. "
  - "The frequency of visits can vary based on your needs and the assessment."
  - "We usually schedule visits or calls about two to three times a week for the first couple of weeks."
  - "Visits decrease as you improve or increase if needed."
- **"At the assessment visit, the nurse will…"**
  - "Determine any urgent needs you may have."
  - "Review your medications and treatments."
  - "Help you understand your discharge instructions and treatment plan."
  - "Talk to you about which services you need and qualify for."
  - "Notify your doctor if there are any concerns."

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Scripting for Intake Workers to Improve Patient's Acceptance of Home Care Services (cont.)

"Our nurse is available at [TIME] or [TIME] tomorrow. Which time works best for you?"

- "Okay – the nurse will be there at [TIME]."
- "Please call us if you need to reschedule this appointment. Our phone number is [PHONE NUMBER]."

"Have you made a follow-up appointment with your doctor yet?"

- If yes... "That's great!
  - "When is it, and with which doctor?"
  - "Do you need help getting to your appointment?"
- If no… "Do you need help making your appointment?"
  - If yes… "I will let the nurse know you need help with that."
  - If no… "Please make your follow-up appointment as soon as possible or call us back if you need any help."

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Home Health Intake Scripting Role Play

- **HAT and HIS Tools to Help Prevent Readmissions**

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STEP 2: ENTER BASELINE DATA

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ARE YOU CURRENTLY TRACKING NUMBER OF REFERRALS AND NUMBER OF THOSE WHO HAVE ACCEPTED SERVICES?

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Enter Baseline Data for Home Care Acceptance and Staff Training (cont.)

	Home Care Acceptance Tracker				Fill in cells highlighted in yellow.					Green cells auto-populate.
	Intake Scripting Inservice and First month				Fill in cells highlighted in light gold (optional).					Gray cells - ignore.
	Intervention - Intake Scripting					Data Collection				
	Inservice Date	Number of Staff Attended	Number of Staff to be Trained	Percent of Staff Traine	Implementation Date	Data Collection End Date	Number of Patient Intakes	Home Care Services Accepted	Home Care Services Declined	Acceptance Rate
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Inservice 3	5/21/2023	2	10	100%	5/31/2023	5/30/2023	18	12	6	67%
Inservice 4	5/30/2023	1	11	100%		end of month	17	12	5	71%
	Enter data in yellow fields.	11	11	100%	Defaults to day after inservice.	Defaults to day of inservice (or end of month).	69	42	26	61%

Example of a completed form

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STEP 3: BEGIN DATA ENTRY DURING INTAKE CALLS

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HAT Tool for HIS Intervention

	Home Care Acceptance Tracker		Month 1	Enter month.			Manually enter data in yellow fields.		
	Fill in columns B-K and Month Started in G1								
	Date and Patient Data		Post-intervention (Scripting)				Reasons Home Care Services Declined		Intake and Staff Feedback
	Date	Patient ID or Initial	No Scrip	Scripting Used	Accepted Home Care Services	Declined Home Care Services	Reason Home Care Services Declined	Other Reasons	Staff Feedback	Suggested Changes
1	Week 1 start date									
2										
3										
4										
5										
6										
7										
8										
9										

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HAT Tool Example

Date and Patient Data		Post-intervention (Scripting)			
Date	Patient ID or Initial	No Scrip	Scripting Used	Accepted Home Care Services	Declined Home Care Services
5/8/2023	aa	x			
5/8/2023	ab		x	x	
5/9/2023	ac		x		x
5/9/2023	ad		x	x	
5/9/2023	ae	x			x
5/9/2023	af		x		x
5/10/2023	ag		x	x	
5/10/2023	ah		x	x	
5/11/2023	ai		x		x
5/11/2023	aj	x			x
5/11/2023	ak		x	x	
5/12/2023	al		x	x	
5/12/2023	am		x		x
5/12/2023	an		x		x
5/13/2023	ao		x		x
5/13/2023	ap	x		x	

Reason Home Care Services Declined	Other Reasons	Staff Feedback	Suggested Changes
Other	Went to SNF	Script did not feel natural when talking to	
Wrong contact information unable to reach patient.		Not trained in scripting	
Reports doing well, did not need service.		Patient redirected conversation	
Reports not feeling well enough to have visit		Script too long	
No reason given			
		Script worked well and helped to engage	
Date and time did not work for them			
Cost/ not covered by Medicare/insurance		Script too short	
Other	Staying with family		

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Enter Intake Data Daily

Reasons declined
Date and time did not work for them
Wrong contact information unable to reach patient.
Reports doing well, did not need service.
Reports not feeling well enough to have visit
Cost/ not covered by Medicare/insurance
No reason given
Other

Staff feedback
Script too long.
Script too short.
Patient redirected conversation.
Script did not feel natural when talking to patient.
Script worked well and helped to engage patient.
Other comments.
Not trained in scripting.

Reasons Home Care Services Declined		Intake and Staff Feedback	
Reason Home Care Services Declined	Other Reasons	Staff Feedback	Suggested Changes
Other	Went to SNF	Script did not feel natural when talking to	
Wrong contact information unable to reach patient.		Not trained in scripting	
Reports doing well, did not need service.		Patient redirected conversation	
Reports not feeling well enough to have visit		Script too long	
No reason given		Script too short	

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STEP 4: MONITOR USE OF THE SCRIPTING TOOL AND HOME CARE ACCEPTANCE RATES

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How many referrals does your agency receive per week?

- Less than five.
- Five to 14.
- 15 to 29.
- 30 or more.

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HAT Tool Weekly Data

	Date	Patient ID or Initial	No Scrip	Scripting Used	Accepted Home Care Services	Declined Home Care Services
1	Week 1 start date					
2						
1	Week 2 start date					
2						
1	Week 3 start date					
2						
40						
1	Week 4 start date					
2						

Acceptance Rates by Total Number of Intake Calls and Use of Scripting

	Total Number of Intakes	No Scripting used	Scripting Used	Accepted Home Care Services	Declined Home Care Services
Baseline	0	0	0	0	0
Week 1	0	0	0	0	0
Week 2	0	0	0	0	0
Week 3	0	0	0	0	0
Week 4	0	0	0	0	0
Total	0	0	0	0	0

(Optional) Manually enter data in yellow fields.

To compare acceptance rates between use of scripting and no scripting, count and manually

	Total Number of Intakes	No Scripting Used	Scripting Used: Number Accepted	Scripting Used	Scripting Used: Number accepted
Week 1	0	0		0	
Week 2	0	0		0	
Week 3	0	0		0	
Week 4	0	0		0	
Total	0	0	0	0	0

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HAT Tool Weekly Data (cont.)

Acceptance Rates by Total Number of Intake Calls and Use of Scripting

	Total Number of Intakes	No Scripting Used	Scripting Used	Accepted Home Care Services	Declined Home Care Services
Baseline	100	100	0	47	53
Week 1	16	4	12	7	8
Week 2	18	3	15	11	7
Week 3	18	3	15	12	6
Week 4	17	2	15	12	5
Total	69	12	57	42	26

Overall Acceptance Rate (Post)	Scripting Use Rate
47%	0%
44%	75%
61%	83%
67%	83%
71%	88%
61%	83%

(Optional) Manually enter data in yellow fields.

To compare acceptance rates between use of scripting and no scripting, count and manually enter number accepted for each week or only total.

	Total Number of Intakes	No Scripting Used	Scripting Used: Number Accepted	Scripting Used	Scripting Used: Number Accepted
Week 1	16	4	1	12	6
Week 2	18	3	1	15	10
Week 3	18	3	1	15	11
Week 4	17	2	0	15	12
Total	69	12	3	57	39

Acceptance Rate With Scripting	Acceptance Rate Without Scripting
50%	25%
67%	33%
73%	33%
80%	0%
68%	25%

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Monthly HAT Data Tracker

	Number of Patient Intakes	Scripting Used	Scripting Use Rate	Home Care Services Accepted	Home Care Services Declined	Acceptance Rate
Month	100		0%	47	53	47%
May-23	69	57	83%	42	26	61%
Jun-23	79	68	86%	59	20	75%
Jul-23	77	71	92%	62	15	81%
Aug-23	0	0	#DIV/0!	0	0	#DIV/0!
Sep-23	0	0	#DIV/0!	0	0	#DIV/0!
Oct-23	0	0	#DIV/0!	0	0	#DIV/0!
Nov-23	0	0	#DIV/0!	0	0	#DIV/0!
Dec-23	0	0	#DIV/0!	0	0	#DIV/0!
Jan-24	0	0	#DIV/0!	0	0	#DIV/0!
Feb-24	0	0	#DIV/0!	0	0	#DIV/0!
Mar-24	0	0	#DIV/0!	0	0	#DIV/0!
Apr-24	0	0	#DIV/0!	0	0	#DIV/0!
	225	196	87%	163	61	72%

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STEP 5: EVALUATE FEEDBACK, BARRIERS AND STAFF SUGGESTIONS FOR IMPROVEMENT

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Compare and Discuss Progress Root Cause Analysis

Group discussions and problem-solving (Plan-Do-Study-Act or PDSA) at Monthly Home Care meetings to consider:

- Scripting
- Staff feedback
- Barriers to care

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Evaluate Staff and Customer Feedback

- Use staff and customer feedback.
  - Bring to large group meetings.
  - Use data internally.
  - Use PDSA cycles to improve interventions.
- Track time from referral to first visit (not in this tool).
- Involve staff and customers.
  - Inform staff of process and results. Share lessons learned.
- Celebrate data and wins, even if not as expected.
  - Reward staff for efforts.
- Learn and have fun.

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WHAT IS YOUR AVERAGE NUMBER OF DAYS FROM REFERRAL (OR DISCHARGE DATE) UNTIL START OF CARE?

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STEP 6: SUBMIT DATA TO SUPERIOR HEALTH

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Voluntary Data Submission with Benefits

We welcome anyone who uses the tool to submit data to Superior Health and to join our workgroup calls.

- Practice-based evidence in real time.
  - Obtain (de-identified) aggregate data.
  - Compare and contrast what works.

How to submit:

- Email your agency information and contact person/info.
- Baseline data due within 10 days of implementation.
- Monthly data due by the 10th of each month for the previous month.
- Submit Excel files to HATTool@superiorhealthqa.org.

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HIS AND HAT TOOLS IN ACTION

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Horizon Health Home Care and Hospice

PLAN: August 4
Reviewed videos, HIS and HAT Tools

DO

- Enter Baseline data.
  - Home Care Acceptance rates to date.
- **IMPLEMENT**
  - Staff Training/video
  - Use the HIS Tool.
- Data Entry during intake calls.
  - Use HAT Tool during intake calls.

STUDY

- **MONITOR** weekly and monthly:
  - Rates of Scripting Use.
  - Home Care Acceptance.
- Submit monthly data to HATTool@superiorhealthqa.org.

ACT

- **EVALUATE** rates, feedback, barriers and suggestions.
  - Feedback, barriers and staff suggestions.
  - Track time to start of care.
  - Discuss and compare.
  - Celebrate wins, efforts and lessons learned.

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Discoveries

- Organizations felt the training and tools were easy to use and implement.
- Home care tools improve the uptick of services, increase patient satisfaction and improve the quality of care.
- **Barriers:**
  - Getting started.
  - Competing priorities.
  - Getting baseline data.
  - Learning the script.
  - Turnover of staff and leaders within organizations.
  - Not everyone fits the mold of using scripting or brief calls.
  - Caregiver/family arranging appointments.
  - Referrals are not always appropriate or known.

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Links to HIS and HAT Tools

- Home Care Intake Script (HIS) Tool
- Home Care Acceptance Tracker (HAT) Tool
- HAT Tool Example
- Instructional Video

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Questions?

Are you interested in joining our meetings or submitting and receiving aggregate data?

- If yes, contact Superior Health's Care Coordination Team: HATTool@superiorhealthqa.org

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Want to Join the Superior Health Home Health Workgroup or Another Superior Health Initiative?

- Join Superior Health's member organizations in contributing locally to the national health quality goals through the following improvement initiatives:
  - End Stage Renal Disease (ESRD) Network.
  - Hospital Associations.
  - Quality Innovation Network – Quality Improvement Organization. (QIN-QIO)
- To learn about Superior Health's current Medicare Quality Initiatives in Michigan, Minnesota and Wisconsin, visit our website.

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Additional Resource

- Call Us First Toolkit for Home Health Organizations, Superior Health
- Toolkit provides resources to support patients contacting home care before going to the ED.
  - Launched December 2023.

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Continue the Conversation in Superior Health Connect

- Connect is a shared learning environment for Superior Health participants to come together to foster and promote an all-teach-all-learn climate that provides the framework to improve and sustain mutual health care quality improvement initiatives locally, regionally, and nationally.
  - https://bit.ly/3BhfHc1

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References

- NQF's All-Cause Readmissions Project, National Quality Forum
- Potentially avoidable hospitalizations of nursing home residents: frequency, causes and costs, PubMed
- How-to Guide: Improving Transitions from the Hospital to Home Health Care to Reduce Avoidable Rehospitalizations, Institute for Healthcare Improvement
- Preventing Re-hospitalization in the Home Health Patient, Axxess

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The End

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