

Improving the Home Health Patient Experience

The following summaries of recent peer-reviewed articles describe the benefits of improving the patient experience and reducing suffering in home health settings. Citations are linked to full-text articles [*] when available.

Study	Objective	Conclusion
Panozzo, G. L., Rossetti, J., & Hess, K. (2017). The home healthcare universal best practice protocol . <i>Home Healthcare Now</i> , 35(7), 378-385.	To develop a best practice protocol that helps to decrease rehospitalization rates and emergency department visit rates for home health patients.	<ul style="list-style-type: none"> Rehospitalizations and emergency department visits during a home health care episode result in quality and financial repercussions for home health care agencies, hospitals, and patients. The Home Health Universal Best Practice Protocol is effective in decreasing rehospitalization and emergency department rates and improving home health care agency referral rates. Interventions include risk assessment for rehospitalization, initiation of telehealth, utilization of teach-back method, and timely documentation. When best practice guidelines such as telehealth, SBAR charting, performing high-risk assessments, and wellness phone calls are used comprehensively by home health care clinicians, patients can be kept safe in their homes.
[*] Landers, S., Madigan, E., Leff, B., Rosati, R. J., McCann, B. A., Hornbake, R., ... Breese, E. (2016). The future of home health care: A strategic framework for optimizing value . <i>Home Health Care Management & Practice</i> , 28(4), 262-278.	To articulate a vision for home-based care and recommend a bold framework for the Medicare-certified home health agency of the future.	<ul style="list-style-type: none"> As the home health industry begins to care for patients more broadly, the industry needs to identify what constitutes person-centered home health care and how it is defined and measured. The home health agency of the future must be part of a seamless, connected and coordinated home-based care continuum, as well as being connected with primary care, and facility-based care. With the transition to value-based care, the home health industry must be flexible and responsive to changes in patient population and consistently provide reliable, high-quality care that allows patients to get and remain at home as safely and quickly as possible.
O'Connor, M., Asdornwised, U., Dempsey, M. L., Hufferberger, A., Jost, S., Flynn, D., & Norris, A. (2016). Using telehealth to reduce all-cause 30-day hospital readmissions among heart failure patients receiving skilled home health services . <i>Applied Clinical Informatics</i> , 7(2), 238-247.	To describe the impact on patient outcomes of a telehealth program intended to reduce all-cause 30-day hospital readmissions among heart failure patients receiving skilled home health services.	<ul style="list-style-type: none"> Telehealth is associated with reducing all-cause 30-day readmission among heart failure patients receiving skilled home health services. Vigilant clinicians, efficient processes, and interprofessional communication and collaboration of the patient care team contribute to the success of a telehealth program. Creating an effective team is a best practice that contributes to the success of interventions designed to reduce hospital readmissions.
[*] Ward, L. (2016, November 12). Let the pilot be your guide to a	To describe a study of home health family and friend caregiver	<ul style="list-style-type: none"> Family members or friends who are voluntarily providing home-based care are key to successful paid home care

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<p>systemwide solution. <i>Modern Healthcare</i>.</p>	<p>needs and to identify practices to meet those needs.</p>	<p>services because they ensure patients are well attended to when professionals and aides are not on site.</p> <ul style="list-style-type: none"> ■ Five practices can guide agencies as they develop services to support family and friend caregivers: <ul style="list-style-type: none"> – Ask caregivers about their needs, not symptoms – Foster caregiver networks, connect them with community services, and offer online help – Address the emotional context of providing care by encouraging caregivers to take time for themselves – Provide relevant information such as practical strategies for caring (e.g., showering, toileting) – Remove participation barriers (e.g., arrange respite, provide transportation) ■ Many services can be provided to family and friend caregivers virtually, including: <ul style="list-style-type: none"> – Virtual coaches (e.g., a trained nurse) available 24 hours a day for a 45-minute session – Chat rooms or peer online support forums – A database of local support services – A self-evaluation, showing what services might be useful for the caregiver – A library of articles offering expert advice on how to deal with specific conditions or challenges
<p>Burt, S., Berry, D., & Quackenbush, P. (2015). Implementation of transition in care and relationship based care to reduce preventable rehospitalizations. <i>Home Healthcare Now</i>, 33(7), 390-393.</p>	<p>To describe how a home health care organization implemented a Transitions in Care Program (TCP) in concert with Relationship-Based Care (RBC) to improve the health of its patient population and decrease rehospitalization rates.</p>	<ul style="list-style-type: none"> ■ Working in partnership with patients in their homes, and using RBC principles such as motivational interviewing and appreciative inquiry (AI), nurses can transfer ownership of disease management from provider to patient, improve patient outcomes, and decrease rehospitalization rates. ■ Patients need to be seen as active participants in health care decision-making. It is important to differentiate between providing patients with information and patient engagement. ■ As patient educators, home health care nurses can leverage AI's use of affirmative questions to identify the best in people and situations, which leads to positive patient outcomes.
<p>Moran, K. J., & Burson, R. (2014). Understanding the patient-centered medical home. <i>Home Healthcare Nurse</i>, 32(8), 476-481.</p>	<p>To describe the patient-centered medical home (PCMH) and the role of home health care clinicians in linking the home environment with the primary care-based PCMH.</p>	<ul style="list-style-type: none"> ■ The PCMH's team approach to comprehensive patient care creates partnerships between patients, families, physicians, and other health care team members including home health care nurses. ■ Home health nurses can bring value to the PCMH model by assessing the home and community factors affecting the patient's health. ■ Home health nurses are integral in enhancing care coordination and improving patient transitions across the care delivery continuum.

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<p>Reidt, S. L., Larson, T. A., Hadsall, R. S., Uden, D. L., Blade, M. A., & Branstad, R. (2014). Integrating a pharmacist into a home healthcare agency care model: Impact on hospitalizations and emergency visits. <i>Home Healthcare Nurse</i>, 32(3), 146-152.</p>	<p>To measure the impact of integrating a pharmacist into a model of care at a Medicare-certified home health care agency for clients recently discharged from the hospital.</p>	<ul style="list-style-type: none"> ■ A greater reduction in hospitalization was observed in the "expanded model" group compared to previous studies. ■ The reductions in emergency department visits and hospitalizations observed in this study represent opportunities for cost savings that may be used as evidence supporting this service. ■ Keys to success of this model included access to the health system EHR and collaboration between health care providers, clients, and their caregivers.
<p>Abusalem, S., Myers J. A., & Aljeesh, Y. (2013). Patient satisfaction in home health care. <i>Journal of Clinical Nursing</i>, 22(17-18), 2426-2435.</p>	<p>To assess the current use of patient satisfaction measures in home health care and to examine the reliability and validity of current measures of patient satisfaction in home health care.</p>	<ul style="list-style-type: none"> ■ Home health care agencies need valid and reliable patient satisfaction scales. ■ Frameworks of patient satisfaction are still in their early developmental stage. ■ Only some of the variables related to patient satisfaction are explained by many frameworks.
<p>[*] Fleming, M. O., & Haney T. T. (2013). Improving patient outcomes with better care transitions: The role for home health. <i>Cleveland Clinic Journal of Medicine</i>, 80(E-supplement 1), e-S2-e-S6.</p>	<p>To create and test a care transitions initiative for its impact on patients' quality of life and avoidable rehospitalizations.</p>	<ul style="list-style-type: none"> ■ Reduced hospital readmissions and the home health industry play a critical role in improving patient outcomes and reducing costs. ■ The 12-month average readmission rate (as calculated month by month) in the last six months of the study decreased from 17% to 12%. During this period both patient and physician satisfaction were enhanced. ■ By coordinating care at the time of discharge, some of the fragmentation that has become embedded in our system might be overcome.
<p>Franckhauser, M. (2013). Rural healthcare and the challenges of home healthcare and hospice. <i>Home Healthcare Nurse</i>, 31(4), 227-228.</p>	<p>To describe the challenges of rural home health and hospice (HHH) providers.</p>	<ul style="list-style-type: none"> ■ Rural HHH providers have the challenges of distance, weather, geographic features, and gas prices. ■ Under current Medicare and Medicaid reimbursement, it is difficult to manage productivity sufficient to support serving residents living in remote locations. ■ Although some small hospitals operate home health and hospice services, the critical access hospital reimbursement structure does not include home care as an allowable cost. ■ New regulatory requirements create unique challenges for rural agencies that receive referrals from healthcare specialists in distant urban locations that treat people who return to their rural community for continuing care.
<p>Narayan, M. C. (2013). Using SBAR communications in efforts to prevent patient rehospitalizations. <i>Home Healthcare Nurse</i>, 31(9), 504-515.</p>	<p>To introduce the SBAR communication method, its origins, its features, and evidence that it provides effective and efficient communication,</p>	<ul style="list-style-type: none"> ■ SBAR is particularly effective when hierarchical positions or critical situations (high-stake situations that require quick communication and decision making) make effective communication difficult. ■ SBAR is most effective when combined with excellent physical assessment skills and good clinical judgment and critical-thinking skills.

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	thereby promoting better patient outcomes.	<ul style="list-style-type: none"> SBAR is a communication framework that can promote patient safety and enhance outcomes while helping to control healthcare costs and decrease hospitalizations.
<p>Reidt, S., Morgan, J., Larson, T., & Blade, M. A. (2013). The role of a pharmacist on the home care team: A collaborative model between a college of pharmacy and a visiting nurse agency. <i>Home Healthcare Nurse</i>, 31(2), 80-87.</p>	To describe how one visiting nurse agency successfully partnered with a college of pharmacy to include a pharmacist as a member of their home care team.	<ul style="list-style-type: none"> There is a need for a drug information expert to help with clients' complex medication regimens. Pharmacists visit clients in their homes to identify, resolve, and prevent medication-related problems, allowing clients to stay safely in their homes. The goals are to improve clients' ability to take medications correctly and reduce client emergent care and hospitalizations resulting from inappropriate medication use. Preliminary data show that hospitalizations and emergency room visits decreased by half after a pharmacist's home visit.
<p>Woods, L. W., & Snow, S. W. (2013). The impact of telehealth monitoring on acute care hospitalization rates and emergency department visit rates for patients using home health skilled nursing care. <i>Home Healthcare Nurse</i>, 31(1), 39-46.</p>	To describe the impact of telemonitoring on acute care hospitalization (ACH) and emergency department (ED) visit rates for a Medicare-certified home health agency (HHA).	<ul style="list-style-type: none"> Sociodemographic characteristics did not significantly differ among patients in the baseline, control, and intervention groups. Patients in the telemonitoring group had a statistically lower rate of ACH and ED visit rates. Telemonitoring may be an effective strategy for HHAs to reduce hospitalization and ED visits for patients with cardiac and/or respiratory conditions.
<p>Foust, J. B., Vuckovic, N., & Henriquez, E. (2012). Hospital to home health care transition: Patient, caregiver, and clinician perspectives. <i>Western Journal of Nursing Research</i>, 34(2), 194-212.</p>	To describe the experiences of patients, informal caregivers, and home health clinicians during their post-hospital transition.	<ul style="list-style-type: none"> Discharge instructions are a versatile means of communication. Both informal caregivers and home health care clinicians emphasized the inadequate preparation of caregivers during the discharge process. Patients recalled receiving discharge instructions but with few details and limited information about follow-up actions if they had problems. More attention is needed to proactively engage informal caregivers and involve home health clinicians who can facilitate the implementation of discharge plans to improve patient outcomes.
<p>Markley, J., Sabharwal, K., Wang, Z., Bigbee, C., & Whitmire, L. (2012). A community-wide quality improvement project on patient care transitions reduces 30-day hospital readmissions from home health agencies. <i>Home Healthcare Nurse</i>, 30(3), E1-E11.</p>	To describe the results of a Centers for Medicare & Medicaid Services Care Transitions project that emphasized a community-wide focus on (a) rehospitalizations, (b) improving cross-setting collaboration, (c) access to performance data, and (d) implementation	<ul style="list-style-type: none"> When providers communicated effectively with each other and educated the patient and family members on understanding and managing the patient's chronic illness, providers generally saw readmissions drop. Through discussions with community providers, home health care agencies (HHAs) began to understand ways to contribute to decreasing readmissions (e.g., ensuring medication reconciliation discrepancies are resolved within 24 hours of discharge, coordinating timely physician follow-up appointments, teaching chronically ill

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	<p>of best-practice interventions to reduce avoidable hospitalizations.</p>	<p>patients or their family members techniques for managing the patient's illness).</p> <ul style="list-style-type: none"> ▪ Better communication at the time of transition, collecting and monitoring performance data to gauge improvement, and using evidence-based interventions can help prevent avoidable 30-day hospital readmissions from HHAs.
<p>Watkins, L., Hall, C., & Kring, D. (2012). Hospital to home: A transition program for frail older adults. <i>Professional Case Management</i>, 17(3), 117-123.</p>	<p>To describe a social-worker navigator transitional care model for at-risk seniors being discharged from hospital to home.</p>	<ul style="list-style-type: none"> ▪ The results of this study demonstrate the importance of extending social support and health education into the home after discharge from the hospital. ▪ Access to immediate in-home care services such as transportation, housekeeping, laundry, and light meal preparation allows patients not to experience gaps in care that could result in a readmission. ▪ The assigned navigator reinforces medical management and connects participants to appropriate community resources in order to remain safe at home.