Chapter 11: Discharge & hospitalization

Heed the "Rule of Three" when answering these OASIS questions by digging back three years into a patient's history to determine the patient's true reason for hospitalization. Why? Patients are nearly twice as likely to hospitalize if they have been hospitalized at least once during the last three years, according one benchmark vendor.

📖 ***The OASIS Implementation Manual* says*:** Complete **M0855** when the patient transfers to an inpatient facility -- with or without being discharged from your agency and when the patient is discharged from your agency, but *not* to an inpatient facility.

"Noninstitutional hospice" in **M0870** means the patient is receiving hospice care at home or in a caregiver's home, not in an inpatient hospice facility.

For **M0880**, refer to the list of services and assistance in M0380 as a reference. Include services that your agency may have arranged, or personal care/chore services that your agency may continue to provide after discharge from skilled care services.

3M OASIS Integrity Project* says: Report any impatient admission that lasts 24 hours or longer (for reasons other than diagnostic tests), and occurs while the patient is on service with your agency. A hospital in Response "1" to **M0855 i**ncludes both acute care and long term acute care hospitals and excludes outpatient visits or visits during which the patient was "held for observation" up to 24 hours or more.

If your agency discharges the patient due to a change in payer source, select Response "1" in **M0870.** In this response, "remained in community" includes patients who are discharged due to a change in payer source and patients who now reside in an assisted living facility or "board and care" housing.

Keep in mind that assistance in **M0880** may be paid or unpaid. Response "3" also includes outpatient therapy or assistance that your own agency will provide due to a change in payer source. ❖

Data items collected at inpatient facility admission or agency discharge

(M0855) To which **Inpatient Facility** has the patient been admitted?

1 - Hospital **[Go to *M0903*]**
2 - Rehabilitation facility **[[Go to *M0903*]**
3 - Nursing home **[Go to *M0903*]**
4 - Hospice **[Go to *M0903*]**
NA - No inpatient facility admission

(M0870) Discharge Disposition: Where is the patient after discharge from your agency? **(Choose only one answer.)**

1 - Patient remained in the community (not in hospital, nursing home, or rehab facility)
2 - Patient transferred to a noninstitutional hospice **[Go to *M0903*]**
3 - Unknown because patient moved to a geographic location not served by this agency **[Go to *M0903*]**
UK - Other unknown **[Go to *M0903*]**

(M0880) After discharge, does the patient receive health, personal, or support **Services or Assistance**? **(Mark all that apply.)**

1 - No assistance or services received
2 - Yes, assistance or services provided by family or friends
3 - Yes, assistance or services provided by other community resources (e.g., meals-on-wheels, home health services, homemaker assistance, transportation assistance, assisted living, board and care)
[Go to *M0903*]

You've likely never paid any attention to "discharge to community" (M0870), yet how you answer this question contributes to how good or bad your agency looks.

That's because this outcome score is compared to other home health agencies' on CMS' Home Health Compare Web site. To calculate your score, CMS combines all of the patients for which you noted the following in response to OASIS questions:

- **M0100** (reason for assessment) -- Patients marked "9, discharge from agency" (not to an inpatient facility.)
- **M0870** (discharge disposition) -- Those marked "1, patient remained in the community (not in hospital, nursing home, or rehab facility)."

The response you provide for this OASIS item also affects your agency's acute care hospitalization scores.

Consider this: When Athens, Texas-based Home Health Specialists worked with its quality improvement organization to improve scores for discharge to community, it also boosted its scores for acute care hospitalization by four percentage points, Home Health Specialists Administrator Donna Isabell tells *HCO*.

The agency improved its discharge to community rate to 57.2% for October 2003 to September 2004 from 52.3% for October 2002 to September 2003. It simultaneously decreased the percentage of patients it hospitalized to 36.4% for October 2003 to September 2004.

Your patient population shouldn't hurt you

So now that you know what will go into your discharge to community scores, you're probably concerned about your population of chronically ill patients. The good news: primary and secondary diagnoses are among the nearly 100 risk adjustments CMS makes for the acute hospitalization outcome. Coding all diagnoses that impact the patient's care and outcomes may positively affect your agency's scores.

Quick Q & A

Question: How should OASIS items M0100, M0870, and M0880 be answered in the discharge assessment for a patient who is no longer receiving skilled care but continuing to receive personal care?

Answer from CMS: We encourage HHAs to complete a discharge assessment at a visit when a patient receiving skilled care no longer requires skilled care, but continues to receive unskilled care. While this is not a requirement, conducting a discharge assessment at the point where the patient's skilled need has ended provides a clear endpoint to the patient's episode of care for purposes of the agency's outcome-based quality monitoring (OBQM) and improvement (OBQI) reports.

In this case, OASIS item M0100 (Reason for Assessment) should be marked with Response 9 (Discharge from agency). OASIS item M0870 (Discharge Disposition) should be marked with Response 1 (Patient remained in the community), and item M0880 should be marked with Response 3 (yes, assistance or services provided by other community resources). (If Response 2 also applies to M0880, it should also be marked.)

📖 ***The OASIS Implementation Manual says*:** Responses to this item include the entire period since the last time OASIS data were collected, including current events. A patient has received emergent care if he/she went to the ER and was "held" at the hospital for observation. Outpatient visits for scheduled diagnostic testing are not considered emergent, although a doctor's office visit for an emergent problem, which is scheduled less than 24 hours in advance, is considered an emergent care visit.

For M0840, mark all that apply if more than one reason contributed to the emergent care visit. For example, mark both responses if a patient sought care for a fall at home and was found to have medication side effects. If the reason isn't included in the choices, mark Response "9 - Other than above reasons."

Ask the patient/caregiver to state all the symptoms and reasons for which they sought emergent care. A phone call to the doctor's office or emergency room may be required to clarify the reasons for emergent care.

We realize the wording for M0100 and M0880 is somewhat awkward in this situation; clinicians should note in their documentation that the agency will be continuing to provide only personal care services. ◆

Focus on CHF helps reduce emergent care, acute hospitalizations

You'll have to constantly educate congestive heart failure patients about the importance of nutrition and weight monitoring to prevent them from requiring emergent care.

Chesterfield, Va.-based Freedom Home Health incorporated this and other mandatory practices into its clinical guidelines for CHF patients after finding in a chart audit that more than half of its CHF patients who have experienced "any emergent care" weren't having their weight checked daily. CHF patients represent the agency's highest emergent care population.

Now, a staff of three newly appointed clinical directors make sure the guidelines are followed.

That's just one of several interventions the 250-patient agency made to reduce incidents of "any emergent care" to 18.5% in 2001 and 2002 from 19.5% in 2000, Administrator Deborah Hackman says.

That's good when you consider that the national reference for emergent care has risen, from 19.9% in 2000 to 23.2% in 2002, according to CMS figures.

As you know, "any emergent care" [M0830] and "acute care hospitalization" [M0855] are some of the quality indicators that CMS uses to compare your agency publicly. [Note that the national reference for acute care hospitalization was 28% in 2005.]

Straight from the source

Quick Q & A with CMS

M0870

Q: Do we stop collecting OASIS data for a patient who longer receives skilled care but continues to receive personal care only? If so, how should we answer OASIS items M0100, M0870, and M0880 in the discharge assessment?

A: Correct. While it is not a requirement to complete a discharge assessment at a visit when a patient receiving skilled care no longer requires skilled care, we recommend it. *Conducting a discharge assessment at the point where the patient's skilled need has ended provides a clear endpoint to the patient's episode of care for purposes of the agency's outcome-based quality monitoring (OBQM) and improvement (OBQI) reports.*

In this case, OASIS item M0100 (Reason for Assessment) should be marked with Response 9 (Discharge from agency). OASIS item M0870 (Discharge Disposition) should be marked with Response 1 (Patient remained in the community), and item M0880 should be marked with Response 3 (yes, assistance or services provided by other community resources). (If Response 2 also applies to M0880, it should also be marked.)

We realize the wording for M0100 and M0880 is somewhat awkward in this situation; clinicians should note in their documentation that the agency will be continuing to provide only personal care services. ❖

Low-salt diets monitored 38% of time

To reduce your emergent care numbers, focus first on the diagnosis with the highest percentage of incidents at your HHA.

For Freedom, that was congestive heart failure, responsible for 15 out of 112 instances of emergent care in 2001, more than twice that of most other diseases.

Freedom's senior staff decided to embark on improving its already above-average emergent care outcomes in 2000 because it felt the issue was one of the most important in patient care and obtaining managed care contracts, says Administrator Hackman.

The HHA also discovered that CHF exacerbation was behind 30% of its emergent cares. Falls, wound infections and respiratory failure were other common reasons.

A team of 23 nurses met repeatedly for months to develop best practice guidelines that would ultimately keep CHF patients in their homes and progressing toward their goals. The practices were made part of a new clinical pathway and added to nurses' notes for tracking purposes.

After auditing the charts of patients who had received emergent care in 2001, the clinical audit uncovered how often the following best practices were being observed:

- Assessing edema daily (followed 63% of the time)
- Assessing weight daily (followed 44% of the time)

- Reviewing medication at every visit(followed 25% of the time)
- Monitoring low-salt ADA diet(followed 38% of the time)
- Monitoring dyspnea (followed 74% of the time)
- Calling MD with any abnormal findings (followed 92% of the time).

In addition to making the above practices mandatory and hiring clinical directors to enforce them, Freedom gave the staff nutritional in-service training by a registered dietician on the different cardiac diets available. The HHA also trained its nurses on how to encourage patients in the home care setting to better comply with care.

'Prior hospitalizations' are a must-have indicator

Dig back three years into a patient's history to learn his true risk for hospitalization. Patients are nearly twice as likely to hospitalize if they have been hospitalized at least once during the last three years, according to data compiled from nearly 150,000 patients by Santa Barbara, Calif.-based benchmark vendor Strategic HealthCare Programs.

Of the 17,865 home health patients in Strategic's study who were hospitalized in May or June 2005, 26% were hospitalized at least once more during the previous three years. By comparison, just 15% of the 131,421 home health patients in Strategic's study who were not hospitalized in May or June 2005 were previously hospitalized.

As many as 13% of the patients hospitalized in May or June 2005 were making at least their third trip over the past three years to the acute care facility, while 3% have been hospitalized five or more times.

But beware when you try to identify how many of your current patients are frequent fliers. Strategic was able to pull OASIS data from M0100 (reason for the assessment) and M0855 (inpatient facility) to determine how many of the patients in its database previously were hospitalized, going back as far as June 2002.

There are a few limitations, however. Strategic was not able to detect all hospitalizations for patients who were not on service with an agency that contributed data to the benchmark vendor for the entire three years of the study, says Anthony Harris, director of customer services for Strategic.

In addition, some hospitalizations aren't detected due to errors in patients' social security numbers or OASIS data. As a result, it's likely that the percentage of patients previously hospitalized is even greater

Straight from the source:
Quick Q & A with CMS

M0855

Q: A patient receiving skilled nursing care from an HHA under Medicare is periodically placed in a local hospital under a private pay arrangement for family respite. The hospital describes this bed as a purely private arrangement to house a person with no skilled services. This hospital has acute care, swing bed, and nursing care units. The unit where the patient stays is not Medicare certified. Should the agency do a transfer and resumption of care OASIS? How should the agency respond to M0100 and M0855?

A: If the patient was admitted to an inpatient facility, the agency will need to contact the inpatient facility to verify the type of care that the patient is receiving to determine the appropriate response to M0855. If the patient is using a swing-bed it is necessary to determine whether the patient was occupying a designated hospital bed or a nursing home bed. The hospital utilization department should be able to advise the agency of the type of bed and services the patient utilized.

M0870

Q: For M0855 are 'Rehabilitation Facility' and 'Nursing Home' both considered skilled nursing facilities?

A182. For M0855, response 2, 'rehabilitation facility' is a certified, distinct rehabilitation unit of a nursing home OR a freestanding rehabilitation hospital. For response 3, 'nursing home' includes either a skilled nursing facility or an intermediate care facility. ❖

than presented, Harris adds.

Noncompliance a common trait in repeat hospitalizations

There are a number of reasons why elderly patients who hospitalize are prone to hospitalize again, says Dorothy Vanderburg, quality improvement director for Athens, Texas-based Home Health Specialists.

Her home health agency makes special note of any patients with prior hospitalizations.

Patient noncompliance is a common trait among Home Health Specialists' "frequent fliers," Vanderburg says.

Her agency currently has one patient on service who has been admitted to the hospital six times in the past 12 months. The patient suffers from congestive heart failure, complicated by a case of loneliness that leads to noncompliance with medication and diet regimen whenever she knows that the episode is ending, Vanderburg says.

She's fine when the nurses visit her frequently, but when she stabilizes, signaling the end of the episode, she'll "conveniently" forget to take her Lasix and begin eating high-sodium foods that aggravate her condition, Vanderburg recounts. The patient is married, but she enjoys the company of the home health clinicians, she adds.

Clinicians involved in this case have discussed the patient's unwillingness to comply, and the case manager has instructed nurses to "take a firm stance," Vanderburg says. She's been instructed that her disease could kill her if she doesn't take control of it. But the agency has readmitted the patient as many as six times in the past three year, Vanderburg concedes. The only way the agency will refuse services to this patient is if the she threatens the safety of the clinicians, she says.

M0890 – M0906: Hospitalization, nursing home, death

(M0890) If the patient was admitted to an acute care **Hospital**, for what **Reason** was he/she admitted?

1 - Hospitalization for emergent (unscheduled) care
2 - Hospitalization for urgent (scheduled within 24 hours of admission) care
3 - Hospitalization for elective (scheduled more than 24 hours before admission) care
UK - Unknown

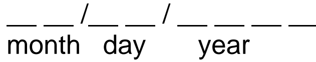
(M0895) Reason for Hospitalization: (Mark all that apply.)

1 - Improper medication administration, medication side effects, toxicity, anaphylaxis
2 - Injury caused by fall or accident at home
3 - Respiratory problems (SOB, infection, obstruction)
4 - Wound or tube site infection, deteriorating wound status, new lesion/ulcer
5 - Hypo/Hyperglycemia, diabetes out of control
6 - GI bleeding, obstruction
7 - Exacerbation of CHF, fluid overload, heart failure
8 - Myocardial infarction, stroke
9 - Chemotherapy
10 - Scheduled surgical procedure
11 - Urinary tract infection
12 - IV catheter-related infection
13 - Deep vein thrombosis, pulmonary embolus
14 - Uncontrolled pain
15 - Psychotic episode
16 - Other than above reasons
[Go to *M0903*]

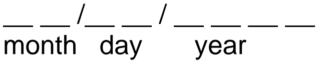
(M0900) For what **Reason(s)** was the patient **Admitted** to a **Nursing Home**? **(Mark all that apply.)**

1 - Therapy services
2 - Respite care
3 - Hospice care
4 - Permanent placement
5 - Unsafe for care at home
6 - Other
UK - Unknown

(M0903) Date of Last (Most Recent) Home Visit:



(M0906) Discharge/Transfer/Death Date: Enter the date of the discharge, transfer, or death (at home) of the patient.



Beware: One of the most common OASIS mistakes occurs when a patient record is updated in the state system because you've incorrectly changed the discharge/transfer/death date field on your OASIS assessment (M0906).

The OASIS Implementation Manual says: Complete **M0890** when the patient transfers to an inpatient facility -- with or without being discharged from your agency -and when the patient is discharged from your agency, but *not* to an inpatient facility. If a family member or medical service provider informs you that the patient has been admitted to an inpatient facility, ask which type of facility it is. If you're still unsure, contact the facility to determine how it is licensed.

3M OASIS Integrity Project says:
Select response "1" in **M0890** for all unscheduled hospital admissions. Select "2" or "3" based on how much time elapsed between the scheduling and the actual admission.
Emergent care in M0890 includes direct admit and is defined differently in M0890 (unscheduled care less than 24 hours in advance), than it is in M0830 (scheduled less than 24 hours in advance).

For **M0895**, interview the patient, family or physician to find out the reason, and note that more than one reason may apply (check all that are applicable).

For **M0900**: If nursing home placement was planned, the medical record must reflect this plan.

The most recent visit in M0903 could be a skilled (SN, PT, SLP, OT) or unskilled HHA visit.

"Death at home" in **M0906** includes death while being transported to an inpatient facility and *before* admission to the facility or treatment in the emergency room. ❖

The resulting error message, "Data not matching previous submissions" (error #81), is among the most common reasons given by states for rejecting OASIS submissions. Similar matching errors also occur in these fields: patient name (M0040), Medicare number (M0063), Social Security number (M0064), Medicaid Number (M0065), birth date (M0066).

Simple typographical errors are usually to blame, according to CMS. And too often, agencies don't give proper credence to patient information data because "they just assume that's going to be right because it's so simple," says one top CMS staffer. "It's not like a wound care question where there's lots of room for ambiguity."

Patient information mistakes also occur because you get incorrect or incomplete information from your referral source, says Pat Sevast, clinical/operations consultant and OASIS education advisor, American Express Tax & Business Inc., Timonium, Md.

But be aware that there are times when you will receive error messages from CMS simply as a warning that records have changed, says the CMS staffer who works with IFMC on record processing. Only error messages flagged as "fatal" require action.

Patient records will be considered correctly updated, for example, when you add information you previously didn't know, such as the Medicare or

Medicaid number. You also will receive error message #81 when you've taken on a new patient that used to be served by a different home health agency or facility.

As you know, OASIS rejections can cost you plenty, delaying payments for weeks. Someone at your HHA needs to correct the record, submit a new file and wait for the state to process the correction before you get the OASIS matching key you need to file your request for anticipated payment and final claim. ◆

'Other' haunts industry attempts to reduce hospitalizations

Agencies have been haunted by the nebulous category "other" that accounts for half of all reasons for hospitalization recorded in M0895. But now we know who they are.

Nearly all of these "others" could have been more appropriately classified under one of the 15 definitive reasons listed in this OASIS item, says Karen Pace, senior research scientist for the Easton, Md.-based Delmarva Foundation.

DecisionHealth analyzed CMS hospital claims data provided by Delmarva and found that congestive heart failure (428.0) was the top diagnosis for the "other" patients. But these patients probably should have been classified under "exacerbation of CHF" in M0895, had clinicians been able to dig a little deeper to obtain their true reason for hospitalization, says Angi Johnson, an 11-year home care veteran who also reviewed the data. Johnson is executive vice president of clinical services for the Visiting Nurse Association, Cincinnati, Ohio.

The hospital claims data show the top ten diagnoses for those home care patients who end up in the hospital with a reason of "other" on the transfer OASIS form. And because CMS doesn't require agencies to document this information for the purposes of answering OASIS, the hospital claims data provides the clearest picture yet of why home health patients are hospitalized, Johnson says.

For example, the data show that pneumonia (486) and obstructive chronic bronchitis (491.21) were two of the most common diagnoses listed for hospitalized patients who were identified as "other" on M0895. But with more information, home health clinicians likely would have identified most of these patients as having "respiratory problems" when answering this OASIS item, Johnson says.

Unless, your agency performs a labor-intense chart review, you'd have no way of knowing what triggers these hospitalizations, Johnson says.

The data were pulled from a total of 95,337 home health episodes, of which 46,726 (49%) had "other" marked as the reason for hospitalization. Note: The data are limited to the hospitalizations that occurred in 2003 in

Straight from the source:
Quick Q & A with CMS

<u>**M0890**</u>

Q: What if M0830 was already answered "yes?" How should I answer this item?

A: Respond appropriately for the situation. M0830 might have been answered "yes" for a separate instance of emergent care, not necessarily relating to this hospitalization. If the patient was hospitalized after having been seen in the emergency room, then M0830 would be answered "yes," and M0890 would most likely be answered with response "1."

<u>**M0903**</u>

Q: What constitutes a "home visit?" Medicaid programs pay for some home health services provided outside of the home. If these patients receive all of their skilled care outside the home, must OASIS data be collected and transmitted? If some of the visits are provided outside of the home should a visit provided outside the home be considered the last visit for M0903, or should M0903 be the last visit at the patient's home?

A: The date of the last (most recent) home visit (for responding to M0903) is the last visit occurring under the plan of treatment. The HHA must conduct the comprehensive assessment and collect and transmit OASIS items for Medicaid patients receiving skilled care.

<u>**M0906**</u>

Q: My patient died at home 12/01 after the last visit of 11/30. I did not learn of her death until 12/04. How do I complete M0903 and M0906? What about M0090?

A: You will complete an agency discharge for the reason of death at home (RFA 8 for M0100). M0090 would be 12/04 -- the date you learned of her death. M0903 (date of last home visit) would be 11/30, and M0906 (death date) would be 12/01. ❖

the five states that piloted the OBQI program: Maryland, Michigan, New York, Rhode Island and Virginia.

Nationally, clinicians chose "other," instead of amore specific reason, for about 51% of all hospitalizations, according to data provided to HCO by Seattle-based benchmark vendor Outcome Concept Systems. At a distant second are respiratory problems, which account for 19% of hospitalizations, according to the data, which include 78,000 hospitalizations that occurred during the second quarter of 2005

3 strategies to uncover "other" reasons

With agencies facing more public pressure than ever to reduce their hospitalization rates, why do so many home health clinicians continue to check off "other" so often?

One reason may be that clinicians who complete the OASIS transfer form usually don't have enough information about the patient to answer this question accurately, Johnson says. An agency is lucky if the patient's family member or caregiver calls to inform it that the patient has been hospitalized, she says.

When they do, the family member or caregiver typically provides scant information to the agency's intake or clerical staff about the reason why, Johnson says. The clerical staff then will notify the nurse who completes the transfer OASIS. Rather than taking additional steps to get more information, the nurse may simply check "other," she says.

But there are a few easy ways to prompt them to gather this information:

1. Add a blank space on the transfer OASIS. This simple step helped Barbour Home Health determine that many of its patients who hospitalize for "other" have chronic diseases that could more appropriately fall under one of the other 15 specific reasons for hospitalizations, says Marsha Smith, director of home health for the Philippi, West Virginia-based agency.

Three blank lines added to the bottom of the agency's transfer OASIS assessment form prompt clinicians to explain the reason for hospitalization. The agency asks this additional information not only for patients who fall into "other," Smith says, but for all patients who end up in the hospital to look for key trends, such as the day of the week when hospitalizations commonly occur, a diagnosis that more commonly relates to hospitalization or a cause for the hospitalizations such as family panic.

2. Call a family member or caregiver. It's worth it to ask the caregiver or family member why the patient was hospitalized, says Carol Elrod, quality manager, Richmond-based A.T. Home Care.

When you ask the patient's daughter, for instance, why her father became short of breath, she might tell you that the doctor said he has CHF, which would help your clinicians answer M0895.

A.T. Home Care also encourages its patients and family members to call the home health agency when the patient enters the hospital. This provides an opportunity for agency staff to find out why, she adds.

3. Ask the discharge planner. Train your intake staff, medical secretaries or anyone else who typically fields calls from hospital discharge planners to ask, "Why did the patient go to the hospital?" It's a simple, yet important question, Johnson says.

Respiratory problems are No. 1 reason why patients are hospitalized

"Respiratory problems," defined as shortness of breath, obstruction, or asthma, are the most common OASIS-specified reason for hospitalization by far, an analysis of 250,000 OASIS records by Outcome Concept Systems, Seattle, shows. (The data is for third quarter 2002.)

It's more than twice as common as "exacerbation of CHF, fluid overload, heart failure" at 8.5%, and "wound infection" at 8.2%, according to data. It's a problem that touches many types of patients. For example, respiratory problems lead to 21.3% of heart attack patient hospitalizations in the first week of home care, OCS data shows.

Another secret revealed in hospitalization data: You may need more visits in week one of care, as well as frank discussions with discharge planners or physicians you suspect are sending patients your

way too early. Why? One of every five home health patients who require hospitalization needed it in the first week of care.

In analysis for CSA, OCS found that 5% of all patients were hospitalized in the first week, while another 4% of patients were hospitalized in the second week and 3% in the third week. What's more, 87% of the 12,500 patients hospitalized during the first week of home health care required emergency services.

Four strategies that lead to better outcomes

1. Pay attention to patients with the primary diagnoses of malignant neoplasm of trachea bronchus and lung (162) and acute myocardial infarction (410). Though they make up a small percentage of all home care patients (1% in OCS's study), nearly one in 10 mal neo trachea/lung patients were hospitalized during the first week of care. Of those 162 patients to require hospitalization, 30.2% did so in the first week.

2. Keep an eye on acute myocardial infarction (heart attack) patients. As many as 8% of these patients were hospitalized in the first week, OCS found. And 16.6% of the study's heart attack patients wound up in the hospital in the first week because of an "exacerbation of CHF." Another 13.7% suffered a stroke or a second heart attack. For the diagnoses most commonly requiring week-one re-hospitalization (see chart, below), it may help to have physician orders for "visits as needed" so that you can increase up-front visits, say consultants.

3. Meet with hospital staff. To keep her affiliated hospital from discharging patients too soon into her HHA's care, Kathy Christiansen, executive director of Rush Home Care Network, Oak Park, Ill., and her liaison manager participate in a one-hour committee meeting each month with staff from the hospital's utilization management and discharge planning units.

The group reviews all patients returned to the hospital within 72 hours. Discussion centers around whether the re-hospitalization could have been anticipated and/or prevented. The group isolates trends and problems that need to be solved.

For example, the group quickly noticed that patients linked with a certain HMO made up more than 5% of all re-hospitalizations. The group suspected that the HMO's case manager might have been responsible and alerted the hospital staff.

Because of the agency's focus on re-hospitalizations, its emergent care rates are consistently lower than the national reference, Christiansen says.

4. Look at your approaches to improving emergent care. See whether your own practices may lead to unnecessary hospitalizations also may improve your outcomes, says Angi Johnson, clinical director of the VNA of Greater Cincinnati and Northern Kentucky. About eighteen months ago, the VNA ditched its answering service to institute call-forwarding to the cell phones of on-call nurses. By taking the calls directly instead of getting a message through the answering service, nurses can better assess the nature of the patient's "emergency" and help them avoid a trip to the emergency room.

For example, sometimes patients panic when they become short of breath. By providing immediate assistance, VNA nurses can lead the patients through breathing exercises - and keep them out of the emergency room. Such action was critical in lowering the agency's rate of emergent care to 16.5% from 20.5% before the change, she adds. But it wasn't cheap - the VNA's on-call nurses cost $18-22 per hour, compared to $25 per evening for the answering service. ◆

Fall risk-assessment chart created by HHA

Here's the tool used by Caledonia Home Health Care, in St. Johnsbury, Vt., to determine which of its patients are most at risk of falling. Use the chart below to tally up your score for each patient and apply the appropriate measure suggested. ◆

Client ID#: ____________________________ Date: ______________

Circle your answers and add up your score	*YES*	*NO*
Client is 75 years or older.	1	0
Client has had a fall within the last 3 months (Question 21).	3	0
Client is unsteady on feet or has general weakness.	3	0
Client has more than 4 prescription medications, including sedatives, psychotrophies, antihypertensives, that cause fatigue or dizziness.	2	1
Client has 3 or more drinks of beer, liquor or wine almost every day.	2	0
Client's physical environment includes:		
Unsafe footwear	1	0
Inadequate lighting	1	0
Scattered rugs/Slippery or uneven floor surfaces	1	0
Unstable furniture (low furniture)	1	0
Cluttered walkways	1	0
Poorly/improper use of/maintained home medical equipment	1	0
Bathroom accessibility	1	0
Other: ____________________	1	0
Client's physical health status includes:		
Cardiovascular arrhythmia or CVA	1	0
Diabetes	1	0
Lower extremity problems, such as neuropathy, arthritis or joint disease	1	0
Visual disturbances	1	0
Confusion, dementia, depression or anxiety	1	0
Fatigue/dizziness/declined agility	1	0
Fear of falling	1	0
Painful feet	1	0
Other: ____	1	0
TOTALS (SCORE: 28 maximum)		

COMBINED TOTAL:_________

(All questions must be answered in order for a valid score to be recorded)

If the total risk assessment score is: _____

0-5	*Distribute and discuss handout, "The Fall Prevention Checklist"*
5-10	*Refer to appropriate health care provider (MD, RN or PT)*
10 or more	*Case management to institute corrective safety measure and referral to appropriate health care provider immediately.*