

# Transforming Home Health Care: The Power of Evidence-Based Protocols

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OSF Healthcare

April 2026

# Disclosures

- ❖ Speakers have No Conflicts of Interest
- ❖ AI used for graphics and to summarize themes

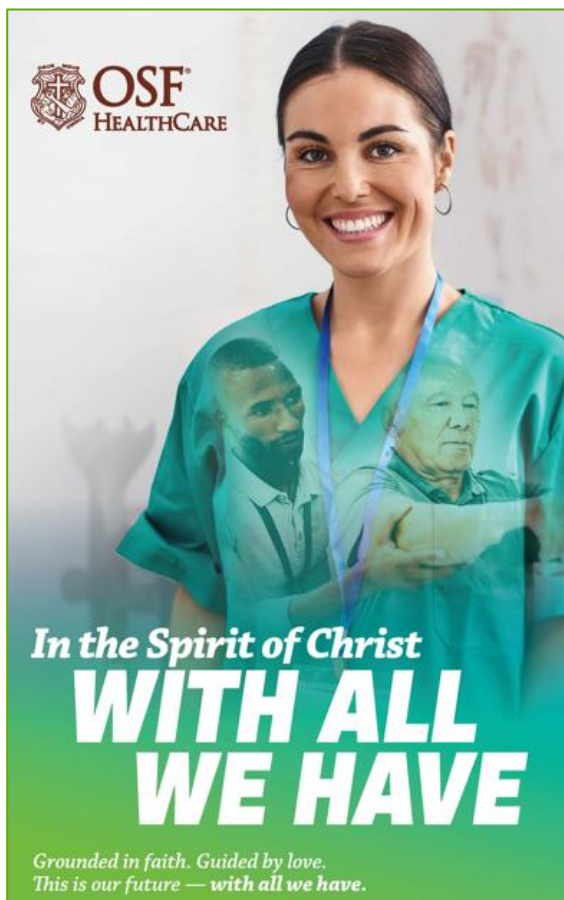




# Objectives

- Strengthen interdisciplinary collaboration and role delineation to ensure consistent top-of-licensure practice through evidence-based care.
- Implement and evaluate structured hospitalization-prevention checklists and evidence-based protocols using an evidence-based model to support PPH reduction and cost-effective care.
- Operationalize standardized HHUBPP care plan templates for high-risk patients.
- Apply consistent quality standards by integrating HHUBPP into daily practice.
- Demonstrate patient safety and error-reduction strategies by using HHUBPP-driven risk identification and escalation pathways that promote timely interdisciplinary action, meet evolving patient expectations, and reinforce performance in value-based care.

# Destination OSF-Rallying Cry



In the spirit of Christ and the example of Francis of Assisi, **our Mission calls us to serve with the great care and love.** When you walk through our doors, you're not met by a system, you're met by people. People who bring their skill, their purpose and their full heart to work.

From cancer to cardiology, from cities to rural communities, **we care with everything we have.** Every patient. Every moment. Every time.

Together, we're building something extraordinary, not just for today but for the future. **A destination for world-class care.** A national leader in innovation and clinical excellence.

Grounded in faith. Guided by love. This is our future, **with all we have.**

We are building the future of care together. Destination OSF means delivering exceptional care everywhere – with each of us playing a vital role.

Our goal: To be a nationally recognized leader in health care by 2035.

# OSF HealthCare Hospitals

## WESTERN REGION

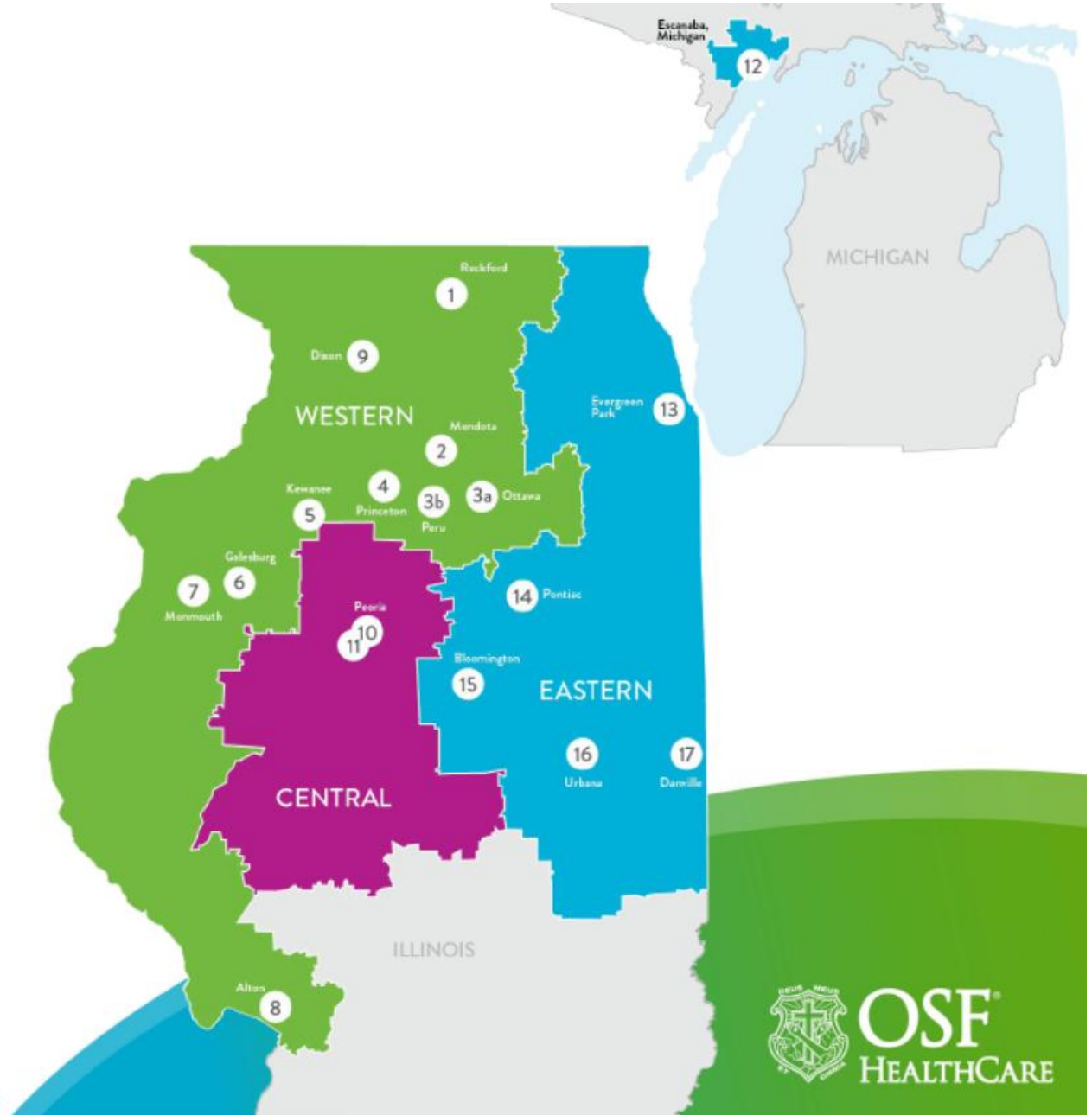
1. OSF HealthCare  
Saint Anthony Medical Center  
*Rockford, Illinois*
2. OSF HealthCare  
Saint Paul Medical Center  
*Mendota, Illinois*
- 3a. OSF HealthCare  
Saint Elizabeth Medical Center  
*Ottawa, Illinois*
- 3b. OSF HealthCare  
Saint Elizabeth Medical Center  
*Peru, Illinois*
4. OSF HealthCare  
Saint Clare Medical Center  
*Princeton, Illinois*
5. OSF HealthCare  
Saint Luke Medical Center  
*Kewanee, Illinois*
6. OSF HealthCare  
St. Mary Medical Center  
*Galesburg, Illinois*
7. OSF HealthCare  
Holy Family Medical Center  
*Monmouth, Illinois*
8. OSF HealthCare  
Saint Anthony's Health Center  
*Alton, Illinois*
9. OSF HealthCare  
Saint Katharine Medical Center  
*Dixon, Illinois*

## CENTRAL REGION

10. OSF HealthCare  
Saint Francis Medical Center  
*Peoria, Illinois*
- OSF HealthCare  
Children's Hospital of Illinois  
*Peoria, Illinois*
11. OSF HealthCare Divine Mercy  
Continuing Care Hospital  
*Peoria, Illinois*

## EASTERN REGION

12. OSF HealthCare St. Francis  
Hospital & Medical Group  
*Escanaba, Michigan*
13. OSF HealthCare  
Little Company of Mary Medical Center  
*Evergreen Park, Illinois*
14. OSF HealthCare Saint James –  
John W. Albrecht Medical Center  
*Pontiac, Illinois*
15. OSF HealthCare  
St. Joseph Medical Center  
*Bloomington, Illinois*
16. OSF HealthCare  
Heart of Mary Medical Center  
*Urbana, Illinois*
17. OSF HealthCare  
Sacred Heart Medical Center  
*Danville, Illinois*



Revised 12/2024

# OSF Home Care Services

- 8 home health agencies in IL, 1 in MI
  - ~ ADC 2500 patients
- 8 hospice agencies in IL, 1 in MI
  - ~ ADC 550 patients
- 16-bed Hospice Home in Peoria, IL
- OSF Home Infusion Pharmacy
- OSF Home Medical Equipment
- Outpatient Palliative Care
  - ~ ADC 450 patients



# Evidence Based Practice (EBP) in Home Health and Hospice

**Integration of evidence-based practice is essential for home health and hospice organizations seeking to improve care quality, strengthen outcomes, support workforce effectiveness, and remain sustainable in a rapidly changing healthcare environment.**

- Promotes safety and quality
- Reduces variation in practice through standardized, proven processes that improve care outcomes and promote efficiency
- Supports clinician decision-making in an increasingly complex environment
- Promotes workflows based on evidence vs. tradition (we have always done it that way)
- Shows a commitment to care excellence and supports value-based care through performance improvement
- Builds a culture of continuous learning, innovation, and practice improvement.
- Strengthens interdisciplinary collaboration through shared standards, goals, and evidence-informed care planning.

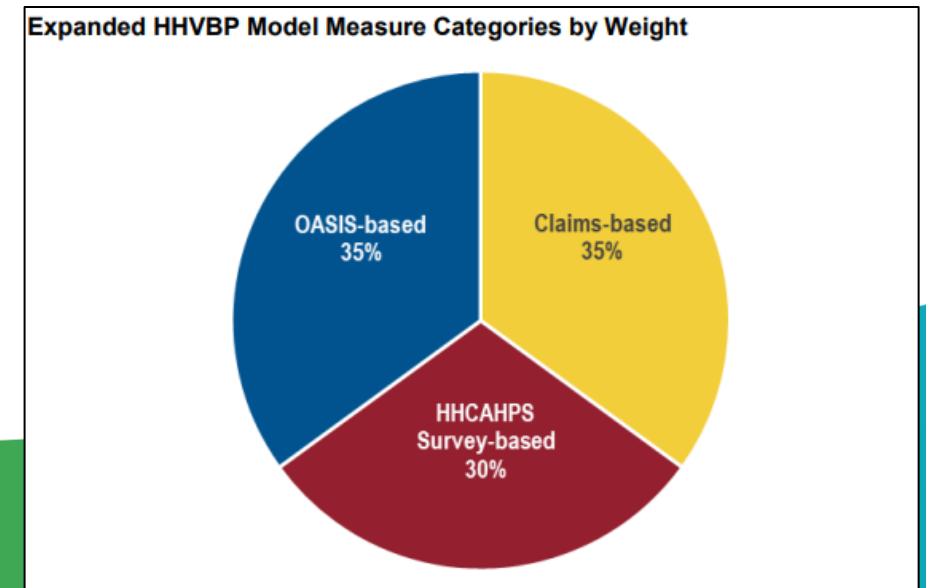
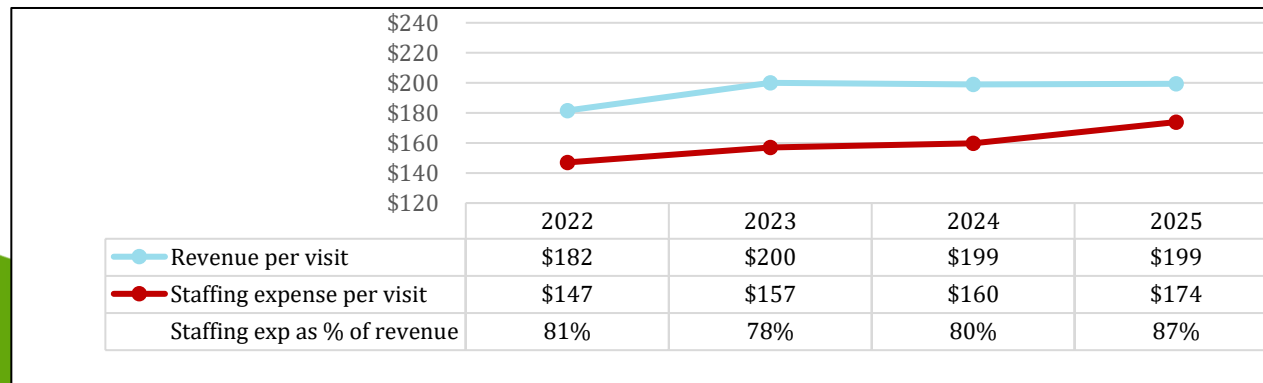
# Health Care Hotspotting and the Home Health Universal Best Practice Protocol (HHUBPP)

An evidenced-based practice project that evolved into the *Acute Care Hospitalization (ACH) Risk Care Plan*: A home health interdisciplinary (IDT) high-risk patient care planning tool

# Purpose and Trigger

## Home Health Value-Based Purchasing (HHVBP)

- **Reimbursement Shift**-Value over volume-CMS rewards value, not quantity
- **HHVBP Rate adjustments**-+/-5% CMS adjustments beginning 2025 (CMS.gov, 2023)
- **OSF Home Health FY25**-\$370,000 repaid to CMS due to HHVBP performance
- **Project Goal**-Reduce potentially preventable hospitalizations (PPH) through standardized protocols, data-driven targeting of high-risk patients, and stronger interdisciplinary communication



# Quality – PPH

Baseline January 2025- Small Market(LCM) Pilot Project start December 2025

Measure:  | Department:

Department	Score	Stars
OSF ROCKFORD HOME HEALTH	9.93%	2.5
OSF OTTAWA HOME HEALTH	9.68%	3.0
OSF ESCANABA HOME HEALTH	8.40%	4.0
OSF LCM HOME HEALTH	13.45%	1.0
OSF WESTERN REGION HOME HEALTH	12.56%	1.0
OSF URBANA HOME HEALTH	11.56%	1.5
OSF ALTON HOME HEALTH	11.42%	1.5
OSF PEORIA HOME HEALTH	11.22%	
OSF EASTERN REGION HOME HEALTH	11.15%	2.0

Measure:  | Department:

Department	Score	Stars
OSF EASTERN REGION HOME HEALTH	9.93%	3.0
OSF ESCANABA HOME HEALTH	9.63%	3.5
OSF ALTON HOME HEALTH	9.27%	3.5
OSF OTTAWA HOME HEALTH	9.06%	4.0
OSF URBANA HOME HEALTH	12.45%	1.5
OSF LCM HOME HEALTH	12.41%	1.5
OSF PEORIA HOME HEALTH	11.32%	2.0
OSF WESTERN REGION HOME HEALTH	11.05%	2.5
OSF ROCKFORD HOME HEALTH	10.57%	2.5

# Rationale & Background

## Evidence-Based Practice Summary

### Healthcare Hotspotting

Data-driven, intensive care management for high-risk post-acute superutilizers

*Finkelstein et al., 2020*



### HHUBPP

Evidence-based protocol to reduce ER visits & hospital readmissions

*Panozzo, 2017*

The Home Health Universal Best Practice Protocol

Patient Name: \_\_\_\_\_  
SOC data: \_\_\_\_\_  
7-10 day date from SOC: \_\_\_\_\_  
14 day date from SOC: \_\_\_\_\_

**Every Visit (SN/Therapy)**

- Teach Back
- PEP review
- Document on calendar next visit
- Universal Best Practice Protocol template utilized in kinrser
- Complete charting in 24 hours

**Day One Interventions (SN)**

- High-risk tool / Front load if high risk (i.e., 2w2, 1w3)
- SBAR chart note
- Transfer patient to SNF if qualifies and not appropriate for home care
- Medication reconciliation
- Teaching materials review on diagnosis
- PHQ and refer to MSW if positive
- Set up telehealth for COPD/Cardiac/Joint replacement patients
- Give report to MD
- Refer to wound care nurse for stage II or higher pressure ulcers and nonhealing wounds

**Day Two Interventions (SN/Therapy/MSW)**

- Wellness check or follow-up visit
- Therapy evaluation
- MSW evaluation
- Disciplines to read SN SOC/SBAR and document

**7-10 Days from SOC Interventions (SN)**

- Make follow-up MD appointment or coordinate with home healthcare provider
- Set two mutual goals with patient on goal sheet in SOC packet

**Last Visit Interventions (SN/Therapy/MSW)**

- Give report to continuing disciplines

**CATEGORIES**

- Utilization
- Communication
- Education
- Communication/Collaboration
- Consults
- Assessments

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### ACH Checklists

Checklists to enhance interprofessional communication & patient safety

*Wood, 2015*

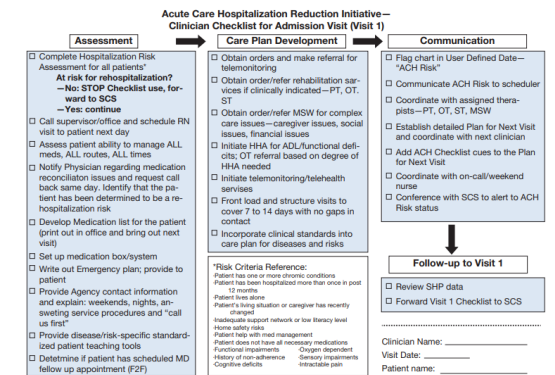
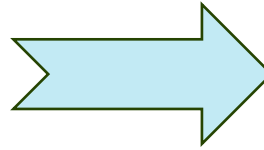


Figure 1. Page one of the checklist.

# Rationale & Background

Healthcare Hotspotting • HHUBPP • ACH Checklists



Evolved into the ACH Risk Care plan through the Iowa EBP model

Homehealth, Sally

70 y.o. (5/7/1955) Female Episode  
MRN: 07974973 Homehealth, Sally (PHH 5/7/25) (Ad...  
SOC  
Current Cert Period 9/5/25 - 11/3/25  
Encounter Cert Period Unlinked or N/A  
Primary Diagnosis Hypertensive heart and chronic kidney...  
Code Status Full Code

Care Planning Visit Sets Care Plan Summary Intervention Summary

Apply Template + Add Problem

Active Problems (Disciplines Filtered) -  
Applies to: PT, CM, SHARED

- ACH Risk Care Plan 9/26/2025 Skilled Clinicians
- PT COMPREHENSIVE 6/27/2025 Physical Therapy
- PT COMPREHENSIVE 6/27/2025 Physical Therapy

### ACH Risk Care Plan

9/26/2025 Skilled Clinicians

Resolve Delete

#### Goals

+ Add Goal

- ACH Risk Care Plan 9/26/2025 Skilled Clinicians  
+ Add Intervention X Delete
- 4. HHUBPP: Reduce hospitalization by implementing HHUBPP interventions based on patient's specific needs by \*\*\* visit.

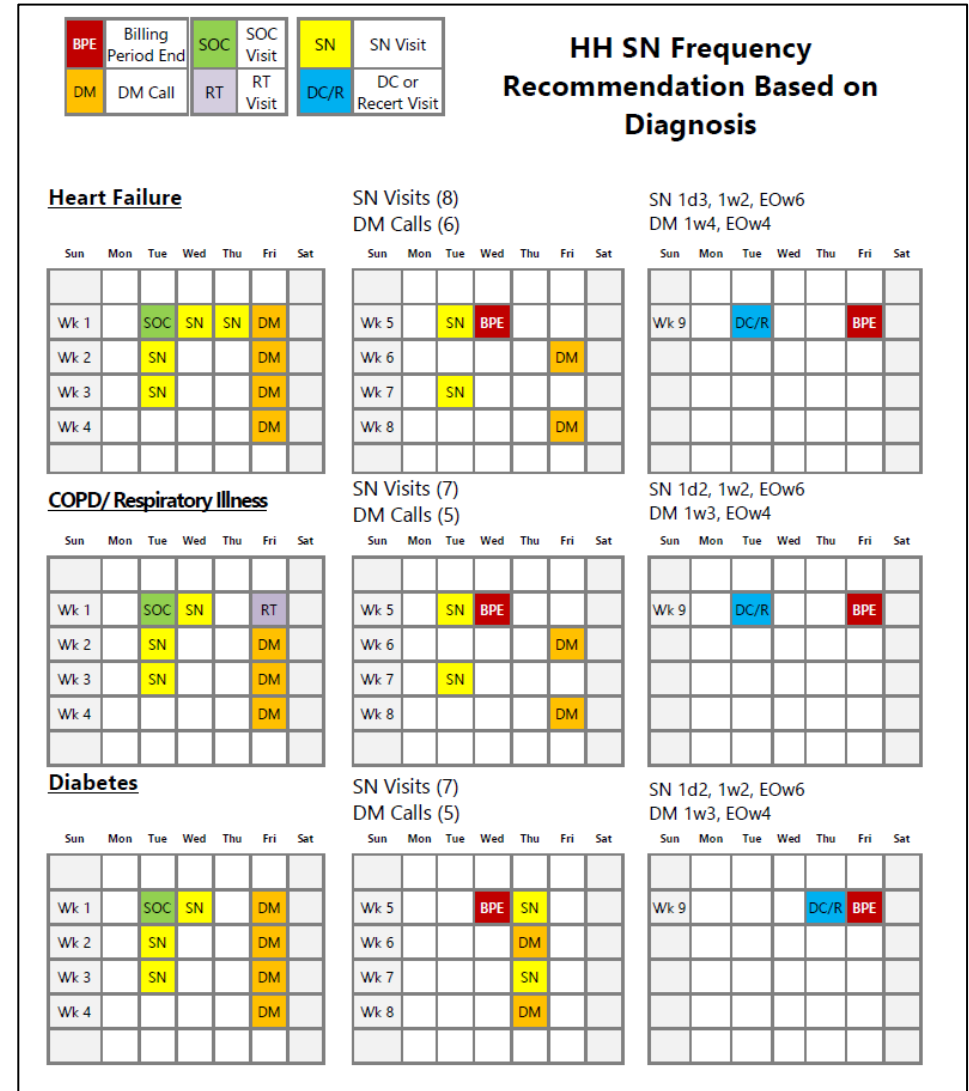
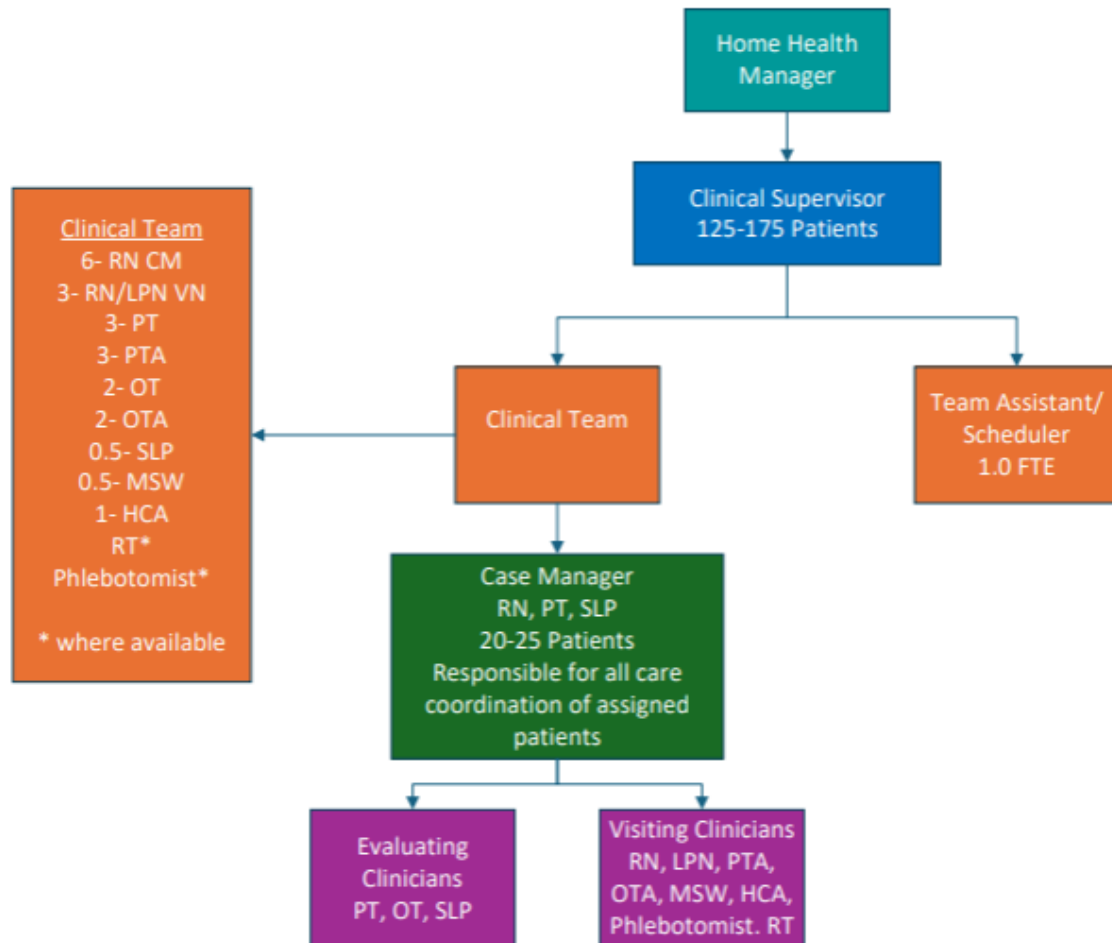
#### Interventions

+ Add Problem Intervention

- ACH Visit 1 Assessment 9/26/2025 PRN  
ACH 1  
Create Order X Delete
- ACH Visit 2 Assessment 9/26/2025 PRN  
ACH 2  
Create Order X Delete
- ACH Visit 3 Assessment 9/26/2025 PRN  
ACH 3  
Create Order X Delete

# Rationale & Background

## OSF Home Health Staffing Model



(OSF Healthcare, n.d.)

# WHY THE IOWA MODEL?



## BEST FIT FOR PRACTICE

Designed for IDT team- a team-based model shift in home health settings



## MOST WIDELY USED EBP FRAMEWORK

The preferred model among IDTs conducting evidence-based practice projects



## HIGHEST CITATION & MAGNET RECOGNITION

Most permission requests, citations, and adoption in Magnet-seeking organizations *(Melynk & Fineout-Overholt, 2023)*

# PROJECT QUESTION

In patients receiving **home health care**, how does a **checklist and clinical care protocol** compared to **no checklist and no clinical care protocol** affect **case manager engagement and PPH** after **60 days**?

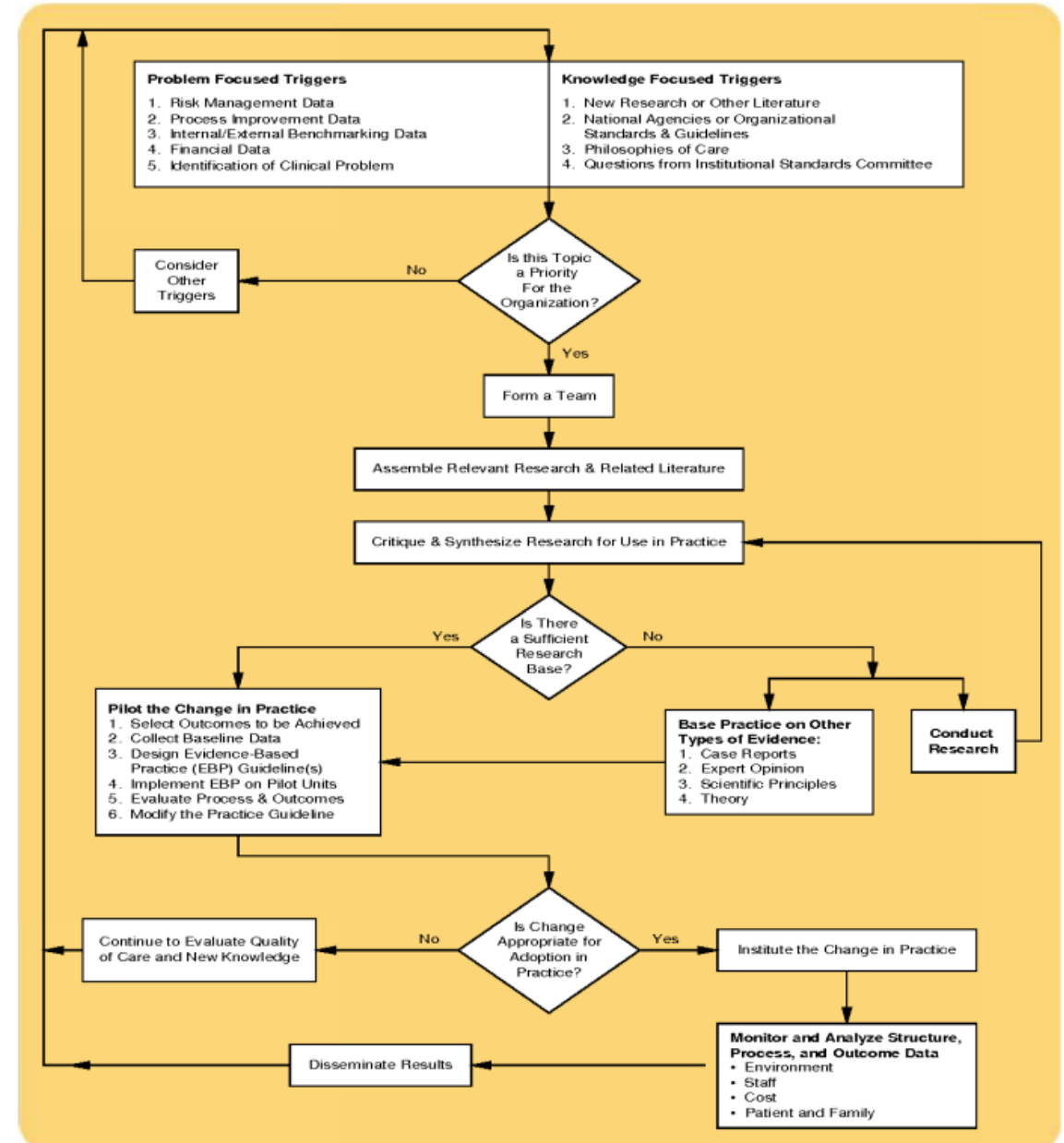
# The Iowa Model of Evidence-Based Practice to Promote Quality Care

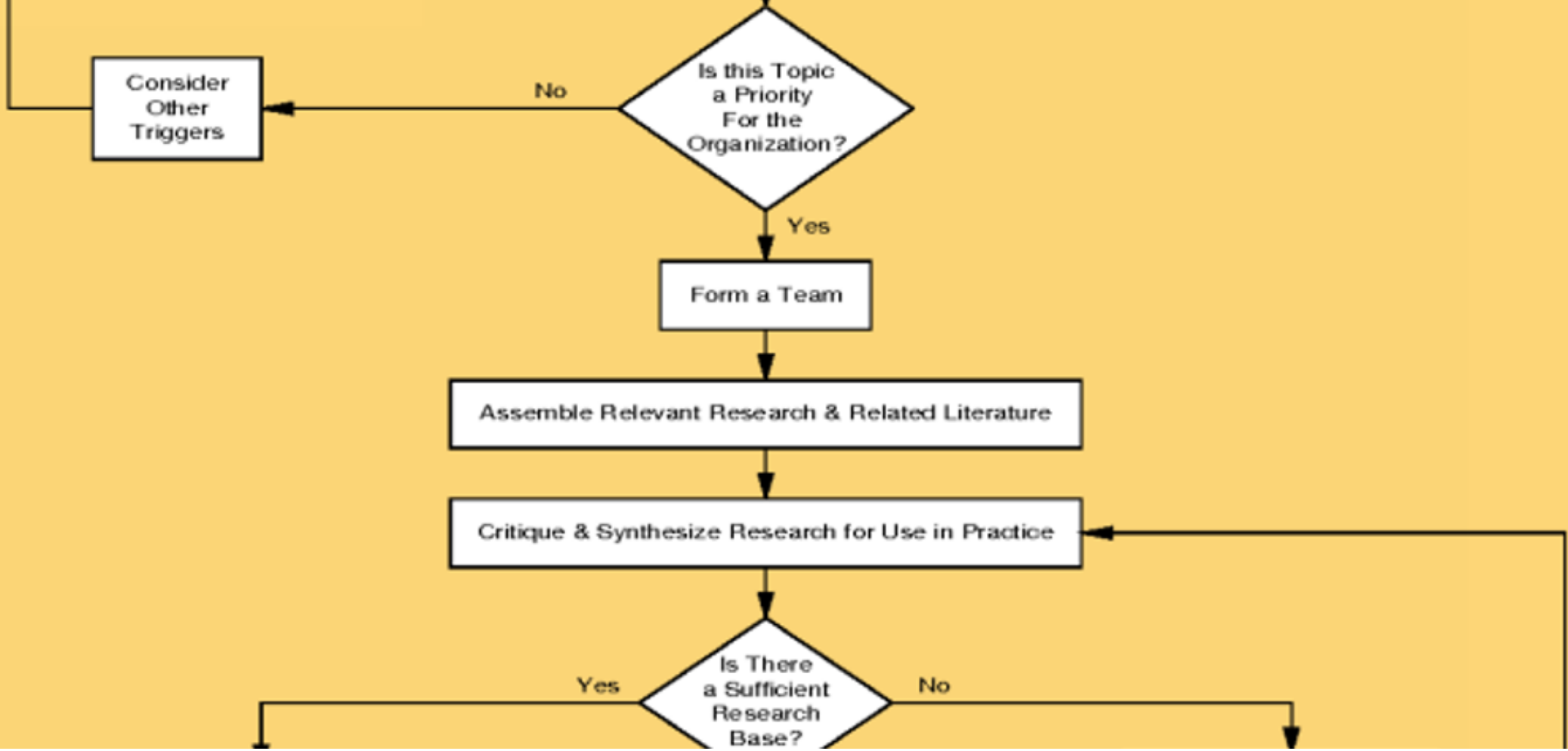
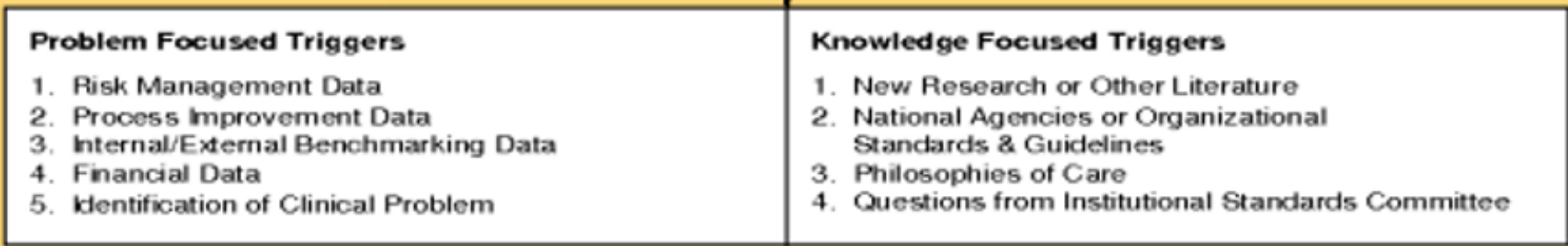


## EBP Model

This quality improvement project **supports the generation of knowledge** for IDTs to support high-risk patient management with EBP tools

The education for IDTs also **supports a gap in a problem-focused area of practice** where star ratings and quality improvement outcome scores have remained flat





# Team Members

## Project Lead

Bree Powers, DNP, RN, NE-BC

## Interdisciplinary Team

25 frontline medical professionals from the Eastern Region: RN, LPN, PT, OT, MSW, HCA, and APN Erin Ruud, FNP-BC

## Focus Group Members

Heather Arndt, DPT

Kimberly Tovrea, Data Analyst (Epic Integration)

Tammy Hepler, RN, Case Manager

Marie Jennings, BSN, RN, Clinical Education Nurse

Amy Christianson, PTA (AEMR Support)

Renee Schreiber, BSN, RN, Clinical Practice Coordinator

Meg Sallee, BSN, RN, Clinical Practice Coordinator

## Statistical Consultant

Tyler Jepsen

## Project Expert

Rachel Hamer, MSN, RN, Director of Clinical Practice

## Project Advisor

Christina Garcia, RN, PhD, Clinical Faculty

Saint Francis Medical Center College of Nursing

## Key Stakeholder Support

Jessica Kirby-Aranda, MSW, MBA Director of Home Health Operations

Sarah Overton, MSN, RN, CNO, Post-Acute Services

FY	FY2025	
Month	Dec	
Department	Score	Stars
⊕ OSF ALTON HOME HEALTH	15.79%	0.50
⊕ OSF EASTERN REGION HOME HEALTH	10.34%	2.50
⊕ OSF ESCANABA HOME HEALTH	10.00%	2.50
⊕ OSF LCM HOME HEALTH	13.64%	1.00
⊕ OSF OTTAWA HOME HEALTH	11.61%	1.50
⊕ OSF PEORIA HOME HEALTH	13.82%	1.00
⊕ OSF ROCKFORD HOME HEALTH	7.41%	4.50
⊕ OSF URBANA HOME HEALTH	10.00%	2.50
⊕ OSF WESTERN REGION HOME HEALTH	14.29%	0.50

# Analysis of Competition-Needs Assessment

The Center for Medicare and Medicaid Services (CMS) uses Oasis Compare to rate home health agencies with Star ratings

The agencies have been a 2-star rated agency for more than 3 years and 0.5 stars in 60-day hospitalizations; goal is to be at 15.7% or less and reach 5-star ratings; with shifts to PPH new targets are 8.5%; baseline for LCOM is 13.2%

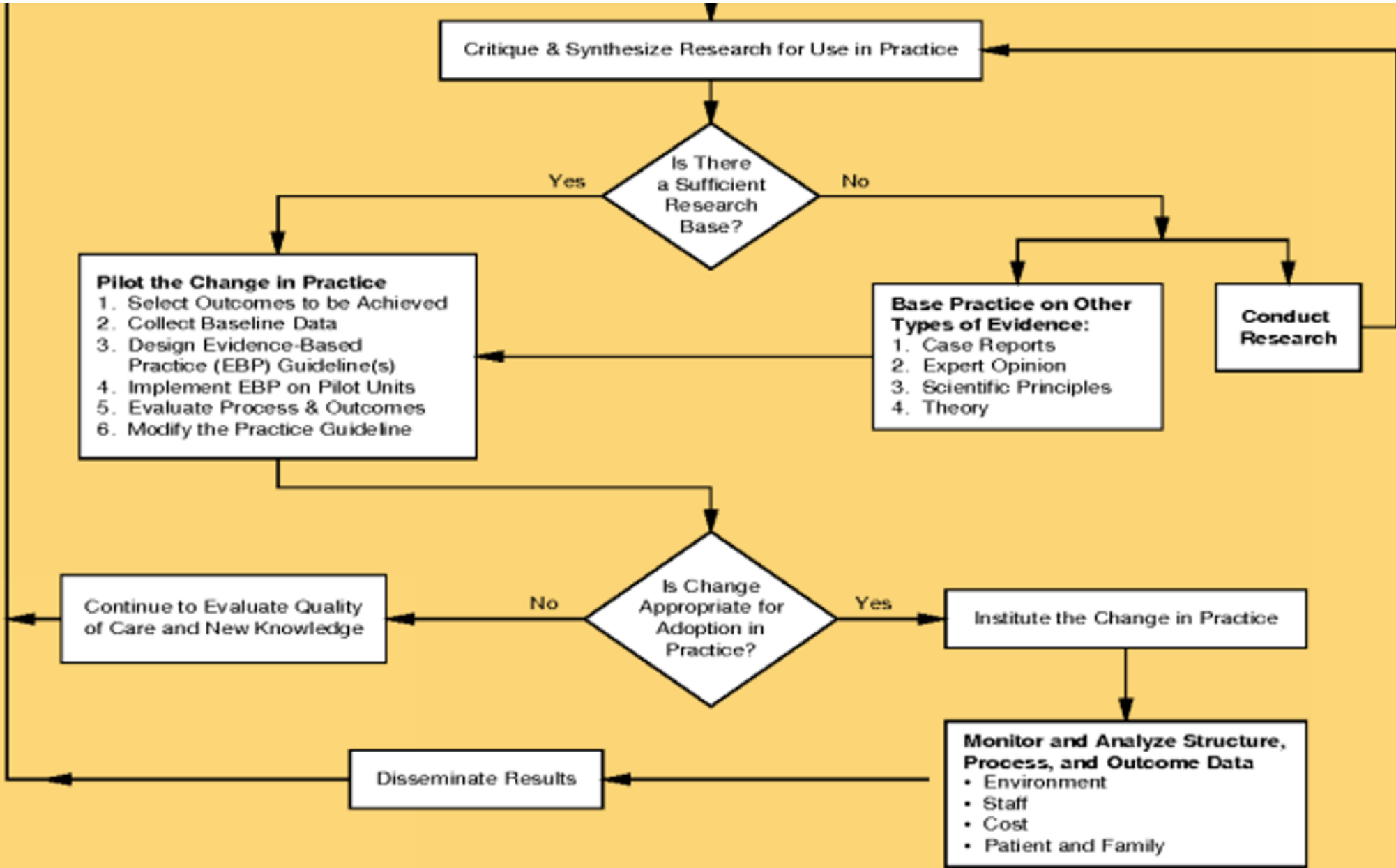
The success of innovative projects and ideas can make OSF home health care a destination agency for patients and prospective employees

Even though many models exist that have decreased hospitalizations, none have incorporated all recommended best practice guidelines specific to home healthcare in a protocol-guided format except for what can be found from Panozzo et al. (2017)

ACH %      Star rating

OSF OTTAWA HOME HEALTH	16.98%	1.5
OSF ALTON HOME HEALTH	18.70%	1.0
OSF ESCANABA HOME HEALTH	18.89%	1.0
OSF WESTERN REGION HOME HEALTH	20.53%	0.5
OSF ROCKFORD HOME HEALTH	21.08%	0.5
OSF EASTERN REGION HOME HEALTH	21.25%	0.5
OSF PEORIA HOME HEALTH	22.73%	0.5
OSF URBANA HOME HEALTH	23.53%	0.5
OSF LCM HOME HEALTH	26.10%	0.5

Agency	PPH	
	Baseline	Target
Alton	9.570%	8.5%
Eastern	9.931%	8.5%
Escanaba	6.566%	<7.1%
LCM	13.178%	8.5%
Ottawa	10.300%	8.5%
Peoria	10.151%	8.5%
Rockford	7.770%	7.1%
Urbana	10.127%	8.5%
Western	9.800%	8.5%



(Titler et al., 2001)

# Concepts of the Iowa Model



The model guides healthcare professionals to use evidence-based practice to form clinical decisions.



Promotes excellence in healthcare and improves outcomes.



Consists of multiple steps that consider the perspective of the healthcare professional and the organization.

(Melynk & Fineout-Overholt, 2023)

# Concepts of the Iowa Model



**THE FIRST STEP  
CONSISTS OF  
RECOGNIZING  
TRIGGERS OR  
OPPORTUNITIES  
TO IMPROVE CARE.**



**CAN OCCUR DUE  
TO NEW  
EVIDENCE BEING  
DISCOVERED,  
ACCREDITING  
REQUIREMENTS,  
NEW HEALTHCARE  
INITIATIVES,  
OR AN  
IDENTIFIED CLINIC  
AL ISSUE.**



**ONCE AN ISSUE IS  
IDENTIFIED, A  
QUESTION OR  
PURPOSE  
CAN BE FORMED.**



**THIS SHOULD BE  
SPECIFIC AND  
INCLUDE  
COMPONENTS  
SUCH AS THE  
PROBLEM,  
POPULATION, TEA  
M, ENVIRONMENT,  
AND OUTCOMES.**



**THE TOPIC  
SHOULD BE A  
PRIORITY ISSUE,  
SUCH AS PATIENT  
SAFETY OR OTHER  
IMPERATIVE  
CONCERNS.**

(Melynk & Fineout-Overholt, 2023)

# Concepts of the Iowa Model



**After the question or purpose is identified as a priority, a team needs to be formed.**



**The team can consist of staff nurses, managers, organizational leaders, advanced providers, interprofessional teams, shared governance committees, and patients/family members (if possible).**



**Team selection is followed by the selection, review, appraisal, and incorporation of the best evidence through library or online resources.**



**The evidence needs to be determined as being sufficient to proceed to the next step. If evidence is not sufficient, more research should be conducted.**

(Melynk & Fineout-Overholt, 2023)

# Synthesis of Evidence

**Research shows that the main drivers reducing readmissions include patient-centered care, empowering practices, team communication and development of a comprehensive interdisciplinary approach to care planning** (Volland & Blockberger-Miller, 2015)

Sixteen of the twenty studies suggested that the **implementation of protocols and checklists in home care to reduce these ED visits and readmissions has been shown to have a positive effect on certain populations**

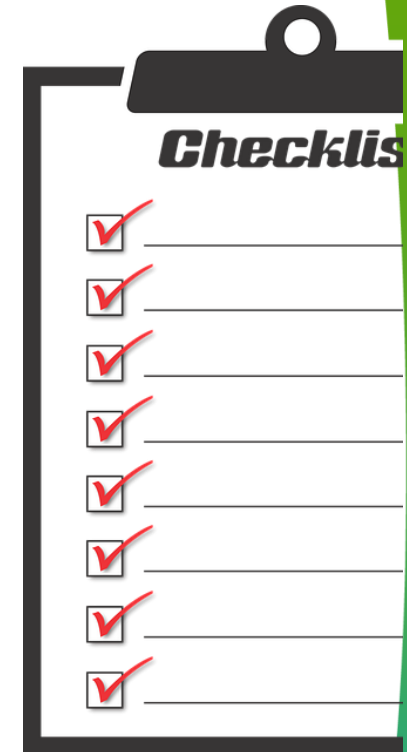
Intervention similarities between the studies included home visits by a healthcare professionals including timing of interventions, follow-up visits with physicians, medication management, disease-specific education, best-practice models of care, and the use of multi-disciplinary specialties

Hotspotting has shown a significant reduction in hospital admissions, emergency department visits, and overall healthcare costs by identifying high-utilization patient and providing them with targeted care (Alderman & Cocklin, 2022)



# Synthesis of Evidence

- The Agency for Healthcare Research and Quality (AHRQ) advocates that the use of checklists is a proven patient safety intervention (Wood, 2015)
- “in the home care, checklists may reduce hospitalizations by aiding the nurse in remembering to implement necessary interventions, improve patient safety by reducing errors of omission, and act as a conduit to improve communication between staff” (Wood, 2105, p. 432–433)
- Across high-risk industries, checklists are a standard safety mechanism to assure protocol adherence



# Concepts of the Iowa Model



Following sufficient evidence, the team designs and pilots the practice change.



Trialing the practice change is important for identifying concerns before integration. Patients should be included whenever possible.



Pre-pilot and post-pilot data should be collected to evaluate effectiveness.



The practice change should then be evaluated for adoption or modification. If modification is needed, then the team needs to reassemble to consider what changes need to be made.

# Concepts of the Iowa Model



# ACH Care Plan Order Template

The screenshot shows the Epic EMR interface for patient George Chocsyrup, 64 y.o. (5/24/1959) Male. The patient's MRN is 07987041 and they are in the HOAdmit (PHO) (Pending Admit) episode. The election date is 5/23/2024. The primary diagnosis is Hypertension. The interface is in the 'Care Planning' tab, showing the 'SN ADDITIONAL CARE/TX/DM' template. The template is active for 5/23/2024 and is categorized as Skilled Nursing. The description of the template is 'The home health universal best practice'. The 'SmartPhrases' section shows the abbreviation 'HHUBPP' and its expansion: 'The home health universal best practice protocol (HHUBPP) Every Visit Teach Back Pa...'. The 'Description' field contains the following text: 'The Home Health Universal Best Practice Protocol (HHUBPP); Inclusion Criteria: ACH Risk score of 4 or more; PHQ-9 score of 10 or more, or SDOH domain identified of 3 or more (Medium or high risk) (HC YES/NO/NA:109346) Every Visit: Teach Back (HC YES/NO/NA:109346) Patient education plan review (HC YES/NO/NA:109346) Document on calendar next visit (HC YES/NO/NA:109346) HHUBPP template pulled into Epic (HC YES/NO/NA:109346) Day one Interventions: Use high risk visit checklist tool (HC YES/NO/NA:109346) front load visits if high risk (HC YES/NO/NA:109346) SBAR handoff to team and PCP (HC YES/NO/NA:109346) Medication reconciliation (HC YES/NO/NA:109346) PHQ-9 score greater than 10 refer MSW for next day visit (HC YES/NO/NA:109346) Set up telehealth or provide vitals equipment, DM calls on days with no visit (HC YES/NO/NA:109346) WOCN referral for Stage 2 or higher PU or non-healing wound (HC YES/NO/NA:109346)'. The 'SmartPhrases' table has the following content:

Abbrev	Expansion
HHUBPP	The home health universal best practice protocol (HHUBPP) Every Visit Teach Back Pa...

Add the SN HH General order and also choose the SN additional care/tx/dm template

Future state-Our own HHUBPP care template\*\*\*

The 'Problem Description' window displays the following text: 'The Home Health Universal Best Practice Protocol (HHUBPP); Inclusion Criteria: ACH Risk score of 4 or more; PHQ-9 score of 10 or more, or SDOH domain identified of 3 or more (Medium or high risk) (HC YES/NO/NA:109346) Every Visit: Teach Back (HC YES/NO/NA:109346) Patient education plan review (HC YES/NO/NA:109346) Document on calendar next visit (HC YES/NO/NA:109346) HHUBPP template pulled into Epic (HC YES/NO/NA:109346) Day one Interventions: Use high risk visit checklist tool (HC YES/NO/NA:109346) front load visits if high risk (HC YES/NO/NA:109346) SBAR handoff to team and PCP (HC YES/NO/NA:109346) Medication reconciliation (HC YES/NO/NA:109346) PHQ-9 score greater than 10 refer MSW for next day visit (HC YES/NO/NA:109346) Set up telehealth or provide vitals equipment, DM calls on days with no visit (HC YES/NO/NA:109346) WOCN referral for Stage 2 or higher PU or non-healing wound (HC YES/NO/NA:109346)'. The window also includes a toolbar with icons for search, add, and other actions.

# ACH Care Plan Interventions

Your Care Plan will look like the picture to the right:

3 Total interventions  
ACH 1, ACH 2, & ACH 3

The screenshot displays a care plan for 'SN ADDITIONAL CARE/TX/DM' dated 9/6/2024, categorized as 'Skilled Nursing'. A yellow highlighted box contains the following text: 'The Home Health Universal Best Practice Protocol (HHUBPP): Inclusion Criteria: ACH Risk score of 4 or more; PHQ-9 score of 10 or more, or SDCH domain identified as 2 or more (medium or high risk) Yes. Every Visit'. Below this, the 'Goals' section has an '+ Add Goal' button. The 'Interventions' section has an '+ Add Problem Intervention' button and lists three items:

- SN Additional Care/ Treatment (O)** (9/6/2024 PRN Skilled Nursing) with a yellow box labeled 'ACH 1' and 'Create Order' / 'Delete' buttons.
- SN Additional Care/ Treatment (O)** (9/6/2024 Each Visit Skilled Nursing) with a yellow box labeled 'ACH 3' and 'Create Order' / 'Delete' buttons.
- SN Additional Care/ Treatment (O)** (9/6/2024 Each Visit Skilled Nursing) with a yellow box labeled 'ACH 2' and 'Create Order' / 'Delete' buttons.

# Practice Changes

## Team-Based Model: Development Timeline

May 2023

### Team-Based Model

CM role with visit nurse role, based on support from Simone Consultants

October 2024

### EBP Visit Frequencies

Implementing and supporting evidence-based practice visit frequencies

Jan–March 2025

### Pilot at LCM

Pilot program launched and evaluated at LCM

December 2025

### ACH Risk Care Plan

Integration of ACH Risk Care Plan into the team-based model

- Protocol & checklist to guide IDT care planning
- Earlier MSW identification for triaging
- HCA well-check support & shared care plan
- Telehealth/video calls with vitals, scale & increased touchpoints
- Two patient-centered goals in admit booklet
- Patient self-assessment: daily vitals, blood sugar & weights
- Written calendar for patient engagement

#### CHECKLIST

- 
- 
- 
- 



# What are we really changing?

This protocol was added as a smart text to “pull into a care plan template” for the additional disease management option

If the project is successful, a new care plan template will be created with this text already embedded

Along with this protocol, we will document to acute care checklists for visits 1,2, & 3

**The Home Health Universal Best Practice Protocol**  
Patient Name: \_\_\_\_\_  
SOC data: \_\_\_\_\_  
7-10 day date from SOC: \_\_\_\_\_  
14 day date from SOC: \_\_\_\_\_

**CATEGORIES**  
■ Utilization  
■ Communication  
■ Education  
■ Communication/Collaboration  
■ Consults  
■ Assessments

**Every Visit (SN/Therapy)**  
■ Teach Back  
■ PEP review  
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■ Give report to MD  
■ Refer to wound care nurse for stage II or higher pressure ulcers and nonhealing wounds

**Day Two Interventions (SN/Therapy/MSW)**  
■ Wellness check or follow-up visit  
■ Therapy evaluation  
■ MSW evaluation  
■ Disciplines to read SN SOC/SBAR and document

**7-10 Days from SOC Interventions (SN)**  
■ Make follow-up MD appointment or coordinate with home healthcare provider  
■ Set two mutual goals with patient on goal sheet in SOC packet

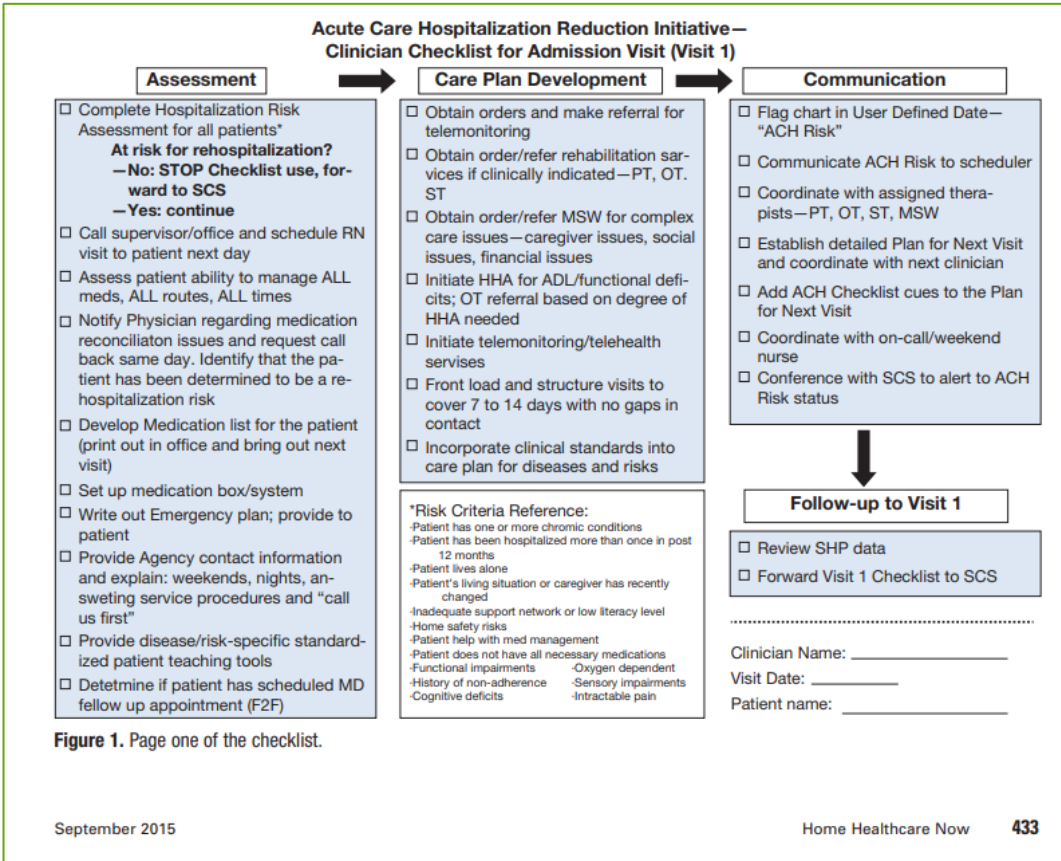
**Last Visit Interventions (SN/Therapy/MSW)**  
■ Give report to continuing disciplines

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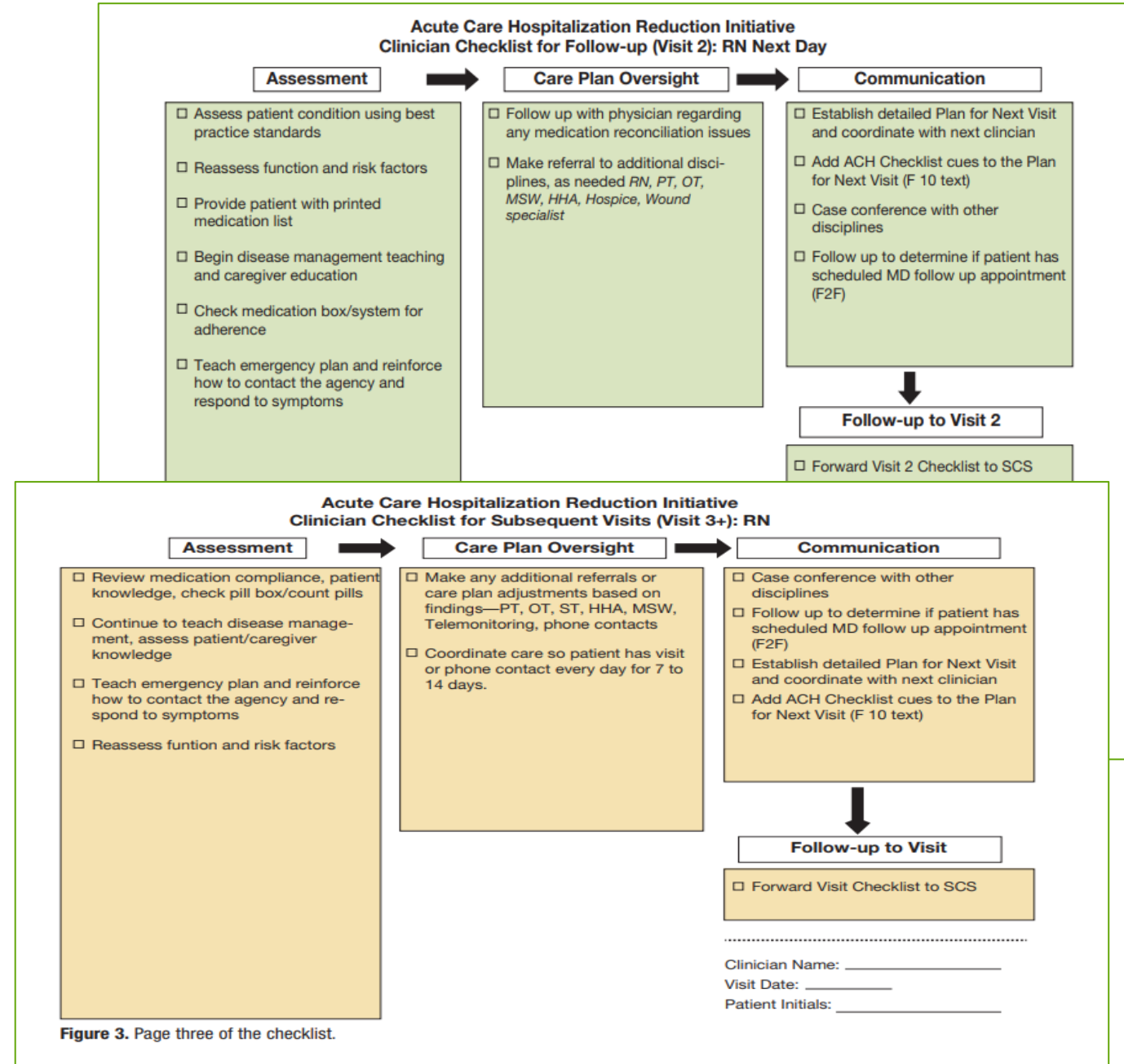
*The Home Health Universal Best Practice Protocol*

Within the checklist and care guide, the clinician follows outlined steps pertaining to communication, collaboration, education, assessments and consults.

- Wood (2015) asserts the Agency for Healthcare Research and Quality (AHRQ) advocates that the use of checklists improves patient safety



- **Supports the evolution of case management in home care and EBP**

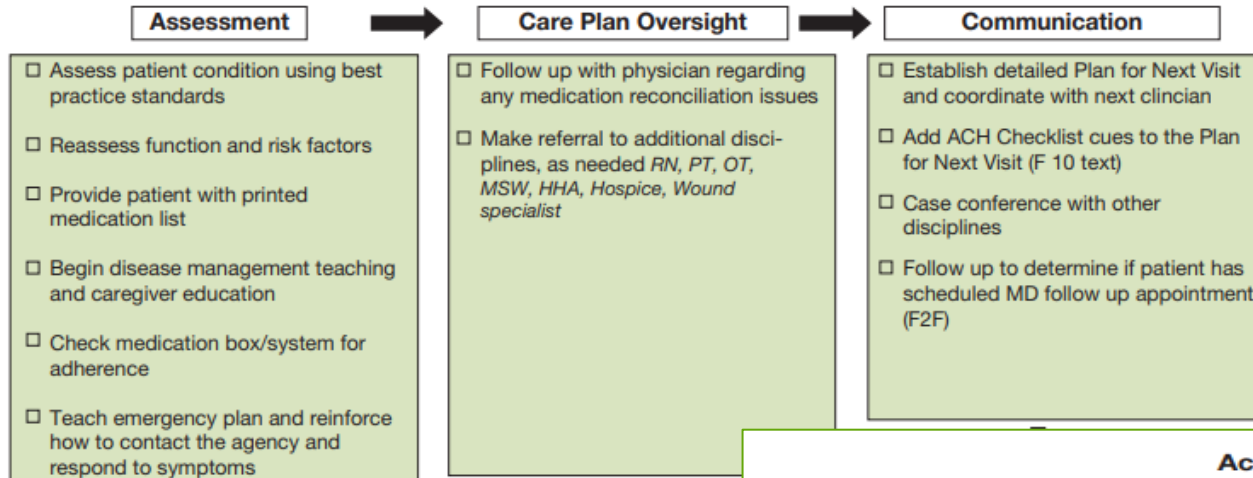


## Acute Care Hospitalization Reduction Initiative— Clinician Checklist for Admission Visit (Visit 1)

Assessment	Care Plan Development	Communication
<ul style="list-style-type: none"> <li><input type="checkbox"/> Complete Hospitalization Risk Assessment for all patients* <b>At risk for rehospitalization?</b> —No: <b>STOP Checklist use, forward to SCS</b> —Yes: <b>continue</b></li> <li><input type="checkbox"/> Call supervisor/office and schedule RN visit to patient next day</li> <li><input type="checkbox"/> Assess patient ability to manage ALL meds, ALL routes, ALL times</li> <li><input type="checkbox"/> Notify Physician regarding medication reconciliation issues and request call back same day. Identify that the patient has been determined to be a rehospitalization risk</li> <li><input type="checkbox"/> Develop Medication list for the patient (print out in office and bring out next visit)</li> <li><input type="checkbox"/> Set up medication box/system</li> <li><input type="checkbox"/> Write out Emergency plan; provide to patient</li> <li><input type="checkbox"/> Provide Agency contact information and explain: weekends, nights, answering service procedures and "call us first"</li> <li><input type="checkbox"/> Provide disease/risk-specific standardized patient teaching tools</li> <li><input type="checkbox"/> Determine if patient has scheduled MD follow up appointment (F2F)</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Obtain orders and make referral for telemonitoring</li> <li><input type="checkbox"/> Obtain order/refer rehabilitation services if clinically indicated—PT, OT, ST</li> <li><input type="checkbox"/> Obtain order/refer MSW for complex care issues—caregiver issues, social issues, financial issues</li> <li><input type="checkbox"/> Initiate HHA for ADL/functional deficits; OT referral based on degree of HHA needed</li> <li><input type="checkbox"/> Initiate telemonitoring/telehealth services</li> <li><input type="checkbox"/> Front load and structure visits to cover 7 to 14 days with no gaps in contact</li> <li><input type="checkbox"/> Incorporate clinical standards into care plan for diseases and risks</li> </ul> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p><b>*Risk Criteria Reference:</b></p> <ul style="list-style-type: none"> <li>-Patient has one or more chronic conditions</li> <li>-Patient has been hospitalized more than once in post 12 months</li> <li>-Patient lives alone</li> <li>-Patient's living situation or caregiver has recently changed</li> <li>-Inadequate support network or low literacy level</li> <li>-Home safety risks</li> <li>-Patient help with med management</li> <li>-Patient does not have all necessary medications</li> <li>-Functional impairments      -Oxygen dependent</li> <li>-History of non-adherence      -Sensory impairments</li> <li>-Cognitive deficits              -Intractable pain</li> </ul> </div>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Flag chart in User Defined Date—"ACH Risk"</li> <li><input type="checkbox"/> Communicate ACH Risk to scheduler</li> <li><input type="checkbox"/> Coordinate with assigned therapists—PT, OT, ST, MSW</li> <li><input type="checkbox"/> Establish detailed Plan for Next Visit and coordinate with next clinician</li> <li><input type="checkbox"/> Add ACH Checklist cues to the Plan for Next Visit</li> <li><input type="checkbox"/> Coordinate with on-call/weekend nurse</li> <li><input type="checkbox"/> Conference with SCS to alert to ACH Risk status</li> </ul> <div style="text-align: center; margin: 10px 0;"> </div> <div style="border: 1px solid black; padding: 5px; text-align: center; margin: 0 auto; width: 80%;"> <p><b>Follow-up to Visit 1</b></p> </div> <div style="border: 1px solid black; padding: 5px; margin-top: 5px;"> <ul style="list-style-type: none"> <li><input type="checkbox"/> Review SHP data</li> <li><input type="checkbox"/> Forward Visit 1 Checklist to SCS</li> </ul> </div> <hr style="border-top: 1px dotted black; margin: 10px 0;"/> <p>Clinician Name: _____</p> <p>Visit Date: _____</p> <p>Patient name: _____</p>

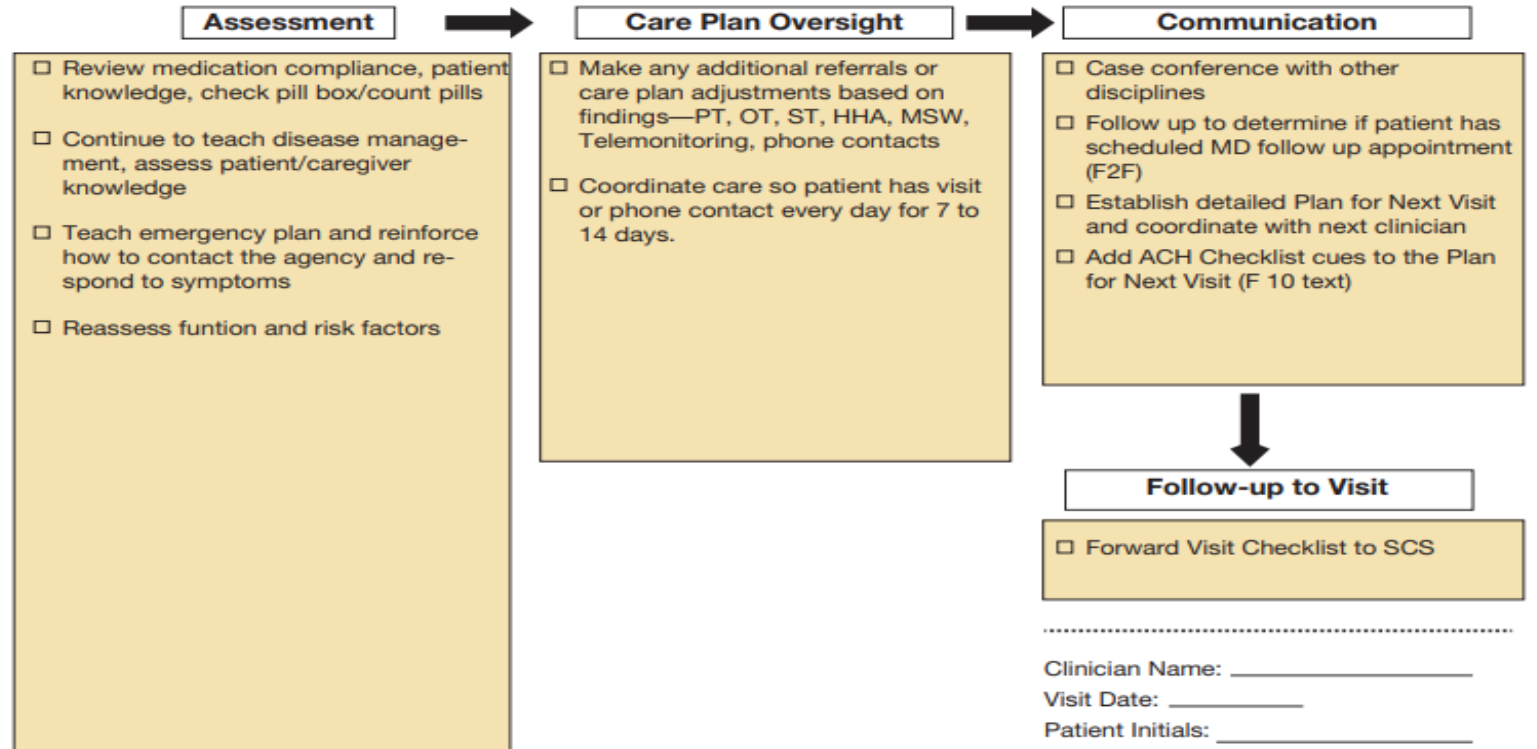
**Figure 1.** Page one of the checklist.

**Acute Care Hospitalization Reduction Initiative  
Clinician Checklist for Follow-up (Visit 2): RN Next Day**



**Figure 2.** Page two of the checklist.

**Acute Care Hospitalization Reduction Initiative  
Clinician Checklist for Subsequent Visits (Visit 3+): RN**



**Figure 3.** Page three of the checklist.

# Implementation Strategies

**The Home Health Universal Best Practice Protocol**

Patient Name: \_\_\_\_\_  
 SOC data: \_\_\_\_\_  
 7-10 day date from SOC: \_\_\_\_\_  
 14 day date from SOC: \_\_\_\_\_

**Every Visit (SN/Therapy)**

- Teach Back
- PEP review
- Document on calendar next visit
- Universal Best Practice Protocol template utilized in kinser
- Complete charting in 24 hours

**Day One Interventions (SN)**

- High-risk tool / Front load if high risk (i.e., 2w2, 1w3)
- SBAR chart note
- Transfer patient to SNF if qualifies and not appropriate for home care
- Medication reconciliation
- Teaching materials review on diagnosis
- PHQ and refer to MSW if positive
- Set up telehealth for COPD/Cardiac/Joint replacement patients
- Give report to MD
- Refer to wound care nurse for stage II or higher pressure ulcers and nonhealing wounds

**Day Two Interventions (SN/Therapy/MSW)**

- Wellness check or follow-up visit
- Therapy evaluation
- MSW evaluation
- Disciplines to read SN SOC/SBAR and document

**7-10 Days from SOC Interventions (SN)**

- Make follow-up MD appointment or coordinate with home healthcare provider
- Set two mutual goals with patient on goal sheet in SOC packet

**Last Visit Interventions (SN/Therapy/MSW)**

- Give report to continuing disciplines

**CATEGORIES**

- Utilization
- Communication
- Education
- Communication/Collaboration
- Consults
- Assessments

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*The Home Health Universal Best Practice Protocol*

## Interventions completed

- EBP committee workgroup for 6 months
- EMR support with Epic integration and creation of smart text for pilot work
- Education assignment created for tracking and pre-work
- Plan for in person education with sandbox practice in Epic EMR, desktop resource library, handouts
- Pushed on the larger organization and CNO for EMR integration; started with smart text to prove it would work with pilot
- Integrated into EPIC EMR 12/2025 for full implementation
- New IDT care plan called the *ACH Risk Care plan*

**Acute Care Hospitalization Reduction Initiative—**  
 Clinician Checklist for Admission Visit (Visit 1)

**Assessment**

- Complete hospitalization risk assessment for all patients
- At risk for rehospitalization? —No: STOP Checklist use, forward to SCS
- Yes: continue
- Call supervisor/office and schedule RN visit to patient next day
- Assess patient ability to manage ALL meds, ALL routes, ALL times
- Notify Physician regarding medication reconciliation issues and request call back same day. Identify that the patient has been determined to be at re-hospitalization risk
- Review Medication list for the patient print out in office and bring out next visit
- Set up medication box/system
- Write out Emergency plan; provide to patient
- Provide Agency contact information and explain weekends, nights, evening service procedures and cost
- Provide disease/symptom-specific standard bed patient teaching tools
- Determine if patient has scheduled MD follow up appointment (F23)

**Care Plan Development**

- Obtain orders and make referral for telemonitoring
- Obtain order/refer rehabilitation services if already indicated—PT, OT, ST
- Communicate ACH Risk to scheduler
- Coordinate with assigned therapist—PT, OT, ST, MSW
- Obtain order/refer MSW for complex care issues—caringer issues, social issues, financial issues
- Establish detailed Plan for Next Visit and coordinate with next clinician
- Initiate PHQ for ADL/functional skills. If elevated based on response of PHQ needed
- Initiate telemonitoring/telehealth services
- Front load and structure visits to cover 7 to 14 days with no gaps in contact
- Incorporate care plan into chart

**Communication**

- Flag chart in User Defined Note—ACH Risk
- Coordinate with assigned therapist—PT, OT, ST, MSW
- Establish detailed Plan for Next Visit and coordinate with next clinician
- Coordinate with on-call/wednesday nurse
- Conference with SCS to alert to ACH Risk status
- Teach emergency plan and reinforce

**Acute Care Hospitalization Reduction Initiative—**  
 Clinician Checklist for Follow-up Visit (2): RN Need Day

**Assessment**

- Assess patient condition using best practice standards
- Reassess function and risk factors
- Begin disease management teaching and caregiver education
- Check medication box/system for adherence
- Teach emergency plan and reinforce

**Care Plan Oversight**

- Flag chart in User Defined Note—ACH Risk
- Follow up with physician regarding any medication reconciliation issues
- Make referral to additional disciplines, as needed (RN, PT, OT, MSW, PHQ, Responder, Wound Specialist)
- Follow up to determine if patient has scheduled MD follow up appointment (F23)
- Check medication box/system for adherence
- Teach emergency plan and reinforce

**Communication**

- Establish detailed Plan for Next Visit and coordinate with next clinician
- Add ACH Checklist cues to the Plan for Next Visit (F 10 text)
- Case conference with other disciplines
- Follow up to determine if patient has scheduled MD follow up appointment (F23)
- Check medication box/system for adherence
- Teach emergency plan and reinforce

**Follow-up to Visit 2**

- Forward Visit 2 Checklist to SCS

Clinician Name: \_\_\_\_\_  
 Visit Date: \_\_\_\_\_  
 Patient Initials: \_\_\_\_\_

**Acute Care Hospitalization Reduction Initiative—**  
 Clinician Checklist for Subsequent Visits (Visit 3-): RN

**Assessment**

- Review medication completion, patient knowledge, check pill box/count tablets
- Continue to teach disease management, assess patient/caregiver knowledge
- Teach emergency plan and reinforce how to contact the agency and respond to symptoms
- Reassess function and risk factors

**Care Plan Oversight**

- Make any additional referrals or care plan adjustments based on findings—PT, OT, ST, RN, MSW, Telemonitoring, phone contacts
- Coordinate care so patient has visit or phone contact every day for 7 to 14 days

**Communication**

- Case conference with other disciplines
- Follow up to determine if patient has scheduled MD follow up appointment (F23)
- Establish detailed Plan for Next Visit and coordinate with next clinician
- Add ACH Checklist cues to the Plan for Next Visit (F 10 text)

**Follow-up to Visit**

- Forward Visit Checklist to SCS

Clinician Name: \_\_\_\_\_  
 Visit Date: \_\_\_\_\_  
 Patient Initials: \_\_\_\_\_

September 2015

Figure 1. Page one of the checklist.

Figure 3. Page three of the checklist.

# Implementation Strategies

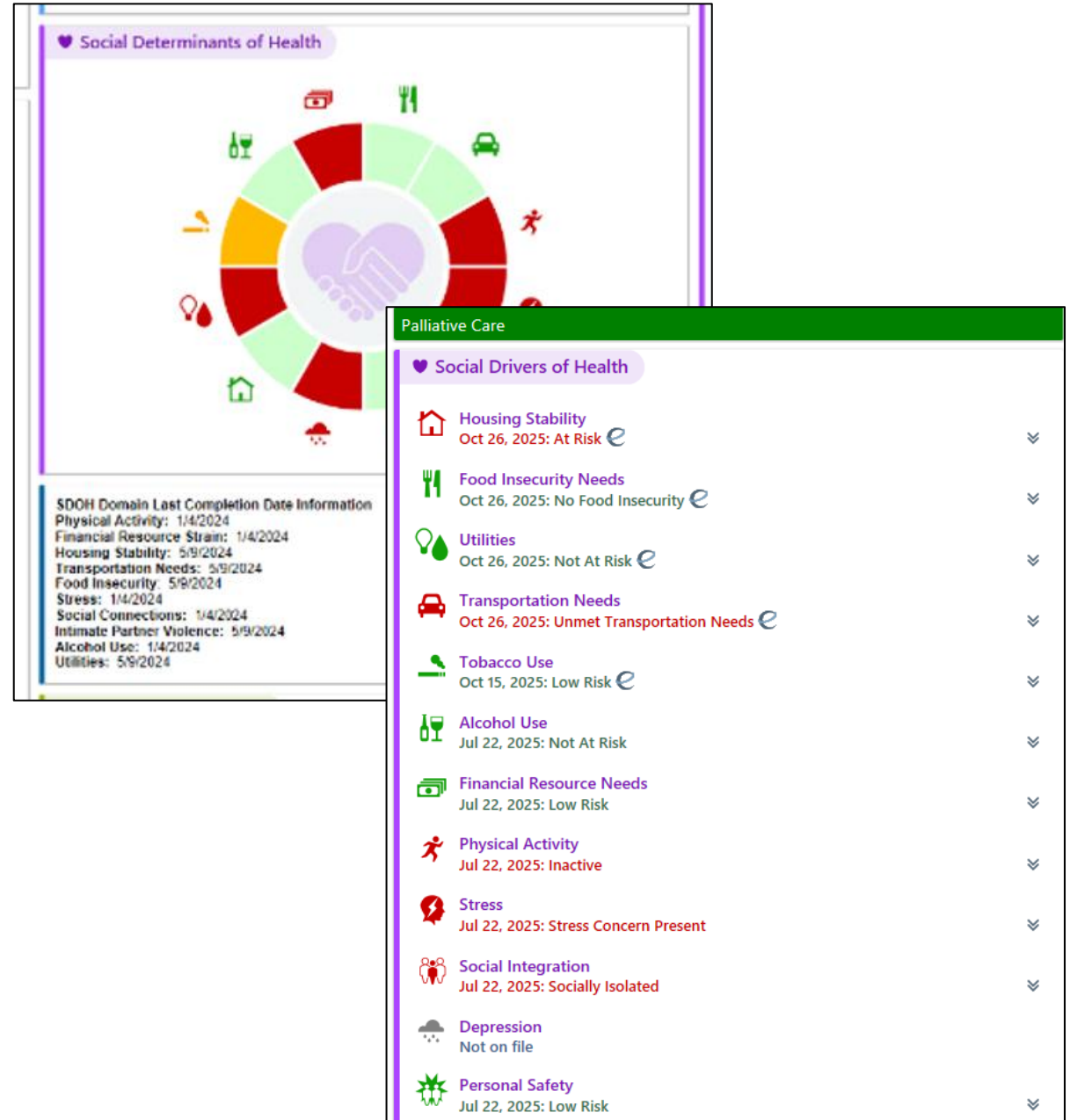
- Education in person throughout all agencies, demonstration and time to practice in EPIC EMR sandbox
- Nursing symposium, grand rounds, poster presentation, nursing and therapy practice councils, leadership meetings
- Continued the feedback loop with all agencies to integrate changes for efficiency

The screenshot displays the EPIC EMR Care Planning interface for a patient named Sally. The patient's information includes: 70 y.o. (5/7/1955) Female, Episode, SOC, Current Cert Period 9/5/25 - 11/3/25, Encounter Cert Period Unlinked or N/A, Primary Diagnosis Hypertensive heart and chronic kidney..., and Code Status Full Code. The interface is divided into several sections:

- Care Planning:** Shows the 'ACH Risk Care Plan' with a date of 9/26/2025 and 'Skilled Clinicians' as the provider. It includes 'Resolve' and 'Delete' buttons.
- Active Problems (Disciplines Filtered):** Lists three active problems: 'ACH Risk Care Plan' (9/26/2025, Skilled Clinicians), 'PT COMPREHENSIVE' (6/27/2025, Physical Therapy), and another 'PT COMPREHENSIVE' (6/27/2025, Physical Therapy). Each problem has a red exclamation mark icon.
- Goals:** Shows a goal for the 'ACH Risk Care Plan' (9/26/2025, Skilled Clinicians) with the text: '4. HHUBPP: Reduce hospitalization by implementing HHUBPP interventions based on patient's specific needs by \*\*\* visit.' It includes 'Add Goal', 'Add Intervention', and 'Delete' buttons.
- Interventions:** Lists three interventions: 'ACH Visit 1 Assessment' (9/26/2025, PRN, ACH 1), 'ACH Visit 2 Assessment' (9/26/2025, PRN, ACH 2), and 'ACH Visit 3 Assessment' (9/26/2025, PRN, ACH 3). Each intervention has 'Create Order' and 'Delete' buttons.

# Patient-Centered Care and EMR Requirements

- Ministry efforts have been underway to include SDOH assessments and address social factors
- Home health collects all this data, and it now flows into the SDOH wheel
- Opportunity to identify patients most at risk for SDOH barriers



# Case managers usually “know” which patients are high risk....but how do you find out?

**Medication Management**

**Systemic**

- Multiple Vitals
- Pain Assessment
- Neurological
- Cardiovascular
- Respiratory
- Musculoskeletal
- Gastrointestinal
- Genitourinary
- Integumentary
- Psychosocial Caregiver
- Psychosocial Patient

**OASIS-SOC**

- Demographics/General Info
- Additional Demographics
- Ethnicity, Race, and Language A1005-A1110
- Payment Information
- Clinical Record Items M0080-M0110
- Transportation A1250
- Recent Inpatient Discharge M1000-M1005
- Hearing, Speech, and Vision B0200-B1300
- Cognitive Patterns C0100-C1310, M1700-M1720
- Mood D0150-D0700**

**(D0150) Patient Mood Interview (PHQ-2 to 9)**

✓ Say to patient: "Over the last 2 weeks, have you been both

- A. Little interest or pleasure in doing things
- B. Feeling down, depressed, or hopeless
- C. Trouble falling or staying asleep, or sleeping too much
- D. Feeling tired or having little energy
- E. Poor appetite or overeating
- F. Feeling bad about yourself – or that you are a failure
- G. Trouble concentrating on things, such as reading
- H. Moving or speaking so slowly that other people could have noticed. You have been moving around a lot more than usual
- I. Thoughts that you would be better off dead, or of hurting yourself in some way

**(D0150 Not Assessed) PHQ-9 Not Assessed Reason**

**(D0160) Total Severity Score**

✓ Add scores for all frequency responses in Column 2. Symptom Responses to PHQ-2 to 9 can indicate possible depression if the total score is:

- 0-4: minimal depression,
- 5-9: mild depression,
- 10-14: moderate depression,
- 15-19: moderately severe depression,
- 20-27: severe depression

**Calculated score: 2**

**(D0700) Social Isolation**

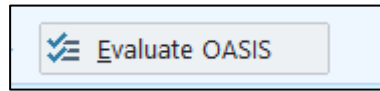
✓ How often do you feel lonely or isolated from those around you?

**2. Sometimes**

PHQ-2 to 9 oasis mood assessment

OSF HealthCare

Starting March 2026-use the ACH risk score for non-OSF patients



**SHP Alert Details**  
Run date: 10/26/24

Reports & Analytics

Patient: ALLEN, JOHN

Asmt: SOC (01) 10/25/24  
Patient: ██████████  
Patient ID: ██████████

Clinician: Anna M Hodel  
Case Mgr: Ryan P Crowley  
Team: Eastern Team 2

Evaluate OASIS button on the admin screen, or log in to SHP

My Patients | Expand | Print | Sync

Patient Summary (1) | Thumbnail Summary (2) | Referral Orders (3) | Care Plan (4) | HC DC Summary (5) | Problem List/Meds (6) | Inpatient AVS (7) | HC POC Update (8) | Insulin Instru

**Demographics**

Emergency Department and Hospital Treatment Plan for Complex Patient  
This print group is not intended for use with Inpatient Mode medications. Inform your administrator to have this issue fixed.

**Specialty Comments**

No comments regarding your specialty.

**Social Determinants of Health**

SDOH Domain Last Completion Date Information

- Physical Activity: 2/16/2024
- Financial Resource Strain: 2/16/2024
- Housing Stability: 10/4/2024
- Transportation Needs: 10/4/2024
- Food Insecurity: 10/4/2024
- Stress: 2/16/2024
- Social Connections: 2/16/2024
- Intimate Partner Violence: 10/4/2024
- Alcohol Use: 2/16/2024
- Utilities: 10/4/2024

**Last 10 Visits**

- Oct 24: This Visit: Home Health Admission with Home Health
- Oct 03: ED to Hosp-Admission (Discharged) with Kakollu, Venkat Rao, MD; Halle, Zewdu, MD. Aggressive behavior
- Sep 30: ED with EMERGENCY ME. Hip Pain
- Sep 30: Telephone with Lester, J. Follow-up (Patient safety Concerns - Patient with open Adult Protective Services Case. Self neglect)
- Sep 30: ED with EMERGENCY ME - Reyes, J. Lung mass
- Sep 28: ED with EMERGENCY ME - Lange, M. Chronic pain of left knee
- Sep 06: Registration
- Sep 06: Telephone with Oncology - Rowland, Kendriith; Rowland, Kendriith. Appointment Request

Reports>Care Plan

# Patient Risk Scores

**Candycane, Brian** HHAAdmit  
66 y.o. (1/25/1960) Male, MRN: 07990570

Episode: HHAAdmit (PHH) (Pending...)  
SOC: N/A  
Current Cert Period: N/A  
Encounter Cert Period: Unlinked or N/A  
Primary Diagnosis: Cellulitis of left lower limb [L0...  
Code Status: This patient does not have a r...  
Last Sync: Just Now

Alerts | Sync Patient | Remove Patient | Add Directions | Add Specialty Comments | Travel Screening

### Travel Screening/COVID-19 Status

COVID-19 Status

Database Update available! Please log out and re-start Epic Remote Client when connected to the network as soon as possible.

### Team Assignment Audit History

### Home Care Address & Directions/Precautions

Address: 2027 W Sherman Ave  
West Peoria, IL 61604

Phone Numbers:  
Home: 309-683-4152  
Mobile: 309-258-9632

Directions/Precautions:

## Starting March 2026 EPIC change-all OSF patients/one score

### Home Health Place of Service History

Home Care Phone: 309-683-4152

Dates	Place of Service	Location Type	Department	Phone
1/26/2026 - 1/25/2026	2027 W Sherman Ave West Peoria IL 61604 PEORIA	Home		—
1/25/2026 - 1/25/2026		Home		—

### Patient Infection Status

None to display

### EOLCI

End of Life Care Index  
5

### Predictive Admission Risk Score

Readmission Risk

# Readmission Risk

- Readmission risk scores in chart review; case management or Center of expertise notes

My Patients | Encounters | Labs | Imaging | Procedures | Cardiology | Referrals | Other Orders | Medications | Episodes | Letters | **Notes** | LDAs | Media | Advance Dir | Misc Reports | Wounds

Preview | Refresh (8:56 AM) | Review Selected | Rarely Used  
 Filters:  Default filter |  Me |  OSF URBANA HOME HEAL... |  Provider Only |  Consults |  HP |  DC Sum |  Exclude A and P Notes |  Hide Deleted

Encounter Date	Encounter Type	Type	Specialty	Author	Sta
Recent Visits					
Yesterday	Telephone	Telephone Encounter		Laurie A Marcott, RN...	Sig
Yesterday	Telephone	Telephone Encounter		Laurie A Marcott, RN...	Sig
Yesterday	Telephone	Telephone Encounter		Maria Perez, RN - Re...	Sig
Yesterday	Telephone	Telephone Encounter		Maria Perez, RN - Re...	Sig
10/03/2024	ED to Hosp-Admissio...	Interdisciplinary		Cravens, Rachel J, R...	Sig
10/03/2024	ED to Hosp-Admissio...	Plan of Care		Cravens, Rachel J, R...	Sig
10/03/2024	ED to Hosp-Admissio...	Interdisciplinary		Summers, Jodie L, R...	Sig
10/03/2024	ED to Hosp-Admissio...	Interdisciplinary		Beckman, Sara R - C...	Sig
10/03/2024	ED to Hosp-Admissio...	Interdisciplinary		Beckman, Sara R - C...	Ad
10/03/2024	ED to Hosp-Admissio...	Interdisciplinary		Summers, Jodie L, R...	Sig
10/03/2024	ED to Hosp-Admissio...	Consults	Psychiatry	Bakre, Sulaimon, MD...	Sig
10/03/2024	ED to Hosp-Admissio...	Plan of Care		Wolpert, Kayla C, RN...	Sig
10/03/2024	ED to Hosp-Admissio...	Plan of Care		Elliott, Tiffanie A, RN...	Sig
10/03/2024	ED to Hosp-Admissio...	Progress Notes	Internal Medicine	Kakollu, Venkat Rao,...	Ad
10/03/2024	ED to Hosp-Admissio...	Interdisciplinary		Upchurch, Richard K...	Sig
10/03/2024	ED to Hosp-Admissio...	Interdisciplinary		Riegle, Debra K, RN -...	Sig
10/03/2024	ED to Hosp-Admissio...	Plan of Care	Physical Therapy	Tucker, Phillip G, PT...	Sig
10/03/2024	ED to Hosp-Admissio...	Plan of Care	Occupational Ther...	Kuhlmann, Julie, OTA...	Sig
10/03/2024	ED to Hosp-Admissio...	Plan of Care		Elliott, Tiffanie A, RN...	Sig
10/03/2024	ED to Hosp-Admissio...	Interdisciplinary		Summers, Jodie L, R...	Sig
10/03/2024	ED to Hosp-Admissio...	Interdisciplinary		Summers, Jodie L, R...	Sig
10/03/2024	ED to Hosp-Admissio...	Interdisciplinary		Summers, Jodie L, R...	Sig
10/03/2024	ED to Hosp-Admissio...	Progress Notes	Family Medicine	Greenberg, Lawrence...	Sig
10/03/2024	ED to Hosp-Admissio...	Interdisciplinary		Elliott, Tiffanie A, RN...	Sig
10/03/2024	ED to Hosp-Admissio...	Interdisciplinary		Kelter, Dawn N, RN -...	Ad

**Beckman, Sara R** Interdisciplinary ⚠️

Center of Expertise Signed

Case Management

Date of Service: 10/24/2024 2:31 PM

**Transition Specialist - Transition Arrangements Coordinated**

Note - Transition Specialists do not coordinate all transitions or aspects of transitions- **CONFIRM PATIENT READINESS WITH CASE MANAGER PRIOR TO DISCHARGE**

Case Manager notified: yes, notified Jodie at the following time 1430 via sc.

**Additional Details of Discharge Plan: Complex notified of discharge**

**Home Health - coordination complete with OSF (Home Health Agency)**

Updates for Val's discharge sent to agencies and agency personnel notified: yes, notified OSF HH at the following time 1430 via sc.

Home Agency added to/ verified on patient's OSF Epic Care Team? Agency does not have a Direct Messaging Digital Address

Agency is OSF

**Hospital Follow-Up Appointment Information:**

Readmission risk level (if calculated) is: 3-Medium High (Note: TS makes the PRIMARY Hospital Follow Up appointment for Medium-High, High Risk and Heart Failure patients ONLY)

The following role is responsible to make the Hospital Follow Up Appointment for this patient:SHMC

# SDOH Documentation

- All 11 domains are documented to within the home health charting
- Many Items are present in the psychosocial patient assessment
- If more than 3 or more yellow or red items identified as being present, patient is medium risk or higher and can be used as inclusion criteria

Nutrition Concerns

- anorexia
- chewing problems
- dry mouth
- early satiety
- food preparation difficulty
- food safety concerns
- inadequate food budget
- inadequate facilities for food preparation and storage
- lack of cooking skills
- mucositis
- thick saliva
- ill fitting dentures
- changes in smell
- changes in taste
- cachexia
- alcohol consumption

(A1250) Transportation

! Has lack of transportation kept you from medical care?

- A. Yes, it has kept me from medical appointments
- B. Yes, it has kept me from non-medical appointments
- C. No
- X. Patient unable to respond
- Y. Patient declines to respond

Needs expressed: (select all that apply)

- no needs expressed
- coping need
- grief need
- emotional need
- financial need
- physical need
- spiritual need
- cultural need

Stress factors: (select all that apply)

- no stress factors
- exhaustion
- financial concerns
- health changes
- lack of caregivers
- child care issues
- lack of knowledge
- loss of control
- resistant to accept help
- strained family relationships
- loss of a loved one
- legal issues unresolved
- marital discord
- marriage within the last year
- separation/divorce
- paperwork overwhelming
- career/job change
- lifestyle change

Home Safety Risks

<input type="checkbox"/> no home safety risk	<input type="checkbox"/> bathroom lacks grab bars	<input type="checkbox"/> cooking facilities unsafe	<input type="checkbox"/> cooling inadequate	<input type="checkbox"/> electricity nonfunctioning
<input type="checkbox"/> entry lacks ramp	<input type="checkbox"/> floor coverings unsafe	<input type="checkbox"/> food stored without refrigeration	<input type="checkbox"/> heating inadequate	<input type="checkbox"/> residence in a high crime area
<input type="checkbox"/> living area infestation	<input type="checkbox"/> pets poorly controlled	<input type="checkbox"/> residence in a remote location	<input type="checkbox"/> residence structural problems	<input type="checkbox"/> residence without stairs
<input type="checkbox"/> unable to secure doors	<input type="checkbox"/> unable to secure windows	<input type="checkbox"/> unsafe use of space heaters	<input type="checkbox"/> waste disposal inadequate	<input type="checkbox"/> water supply contaminated
<input checked="" type="checkbox"/> water supply inadequate	<input type="checkbox"/> weapons/firearms in the home			

# Areas of Opportunity: Ethical, Legal, Cultural & Socioeconomic

In the United States, one overnight hospitalization visit can equate to \$2607 per/day as an average (Mamleeva, 2022)

The current percentage rate for hospitalizations for 8/9 home health agencies has been ranging over the goal of 8.5%

By reducing the percentage of patients being hospitalized, this will equate to thousands of dollars in potential savings

The protocol can be copied and replicated within a desktop resource manual or added to a care plan template to help guide case managers

The expense of using the protocol is zero

The expense of using a checklist is zero



No funding or fundraising efforts are required for this specific project

There will be no additional cost to implement this project and no additional monetary needs to be identified

The education of staff would be an expense to consider



# Evaluation-Process Indicators

## Short version of EBP belief scale

- EBP Beliefs Scale
- EBP Practice Implementation Scale
- Organizational Culture & Readiness for System-wide Integration of EBP scale

(Melynk et al., 2021)

- Process Indicators**
- PHQ-9 assessment for depression
  - Medication reconciliation each visit
  - Use of the ACH Care plan
  - Use of ACH checklist for visits 1,2,3
  - MSW visit on day 2
  - Telehealth support (modified)
  - HCA well-check visit

- Inclusion Criteria**
- 18 years or older
  - ACH risk score 4 or more=30% or more risk
  - PHQ-9 score of 10 or more
  - SDOH medium/high risk

SOC date	ACH risk	PHQ-9 score	SDOH risk	inclusion criteria	HHUBPP care plan present based on
1/10/2025	4	0 low	n		
1/10/2025	3	2 high	n		
1/11/2025	2	0 mod	n		
1/11/2025	6	0 low	n		
1/12/2025	6	0 high	n		
1/15/2025	3	0 med	y		
1/17/2025	4	1 low	n		
1/17/2025	5	0 med	n		
1/19/2025	5	0 low	n		
1/22/2025	2	0 med	y		
1/24/2025	4	2 med	y		
1/30/2025	5	0 low	y		
2/1/2025	7	0 low	y		
2/1/2025	4	0 low	y		
2/6/2025	4	0 low	Y		
2/8/2025	5	0 low	Y		
2/9/2025	5	0 low	Y		
2/10/2025	5	0 low	n		
2/11/2025	7	low	n		
2/12/2025	4	0 Med	y		
2/13/2025	5	0 low	y		
2/13/2025	4	1 low	y		
2/16/2025	8	0 low	y		
2/18/2025	5	0 low	y		
2/20/2025	5	0 low	y		
2/21/2025	4	0 low	y		
2/22/2025	4	0 low	y		
2/22/2025	2	0 low	y		
2/25/2025	4	0 low	y		
2/27/2025	5	0 low	y		
2/27/2025	3	0 low	y		
2/28/2025	6	0 low	y		
2/28/2025	4	0 low	y		
3/1/2025	6	0 med	y		
3/1/2025	7	0 low	y		
3/4/2025	4	0 low	y		
3/6/2025	4	0 low	y		
3/9/2025	4	0 low	n		

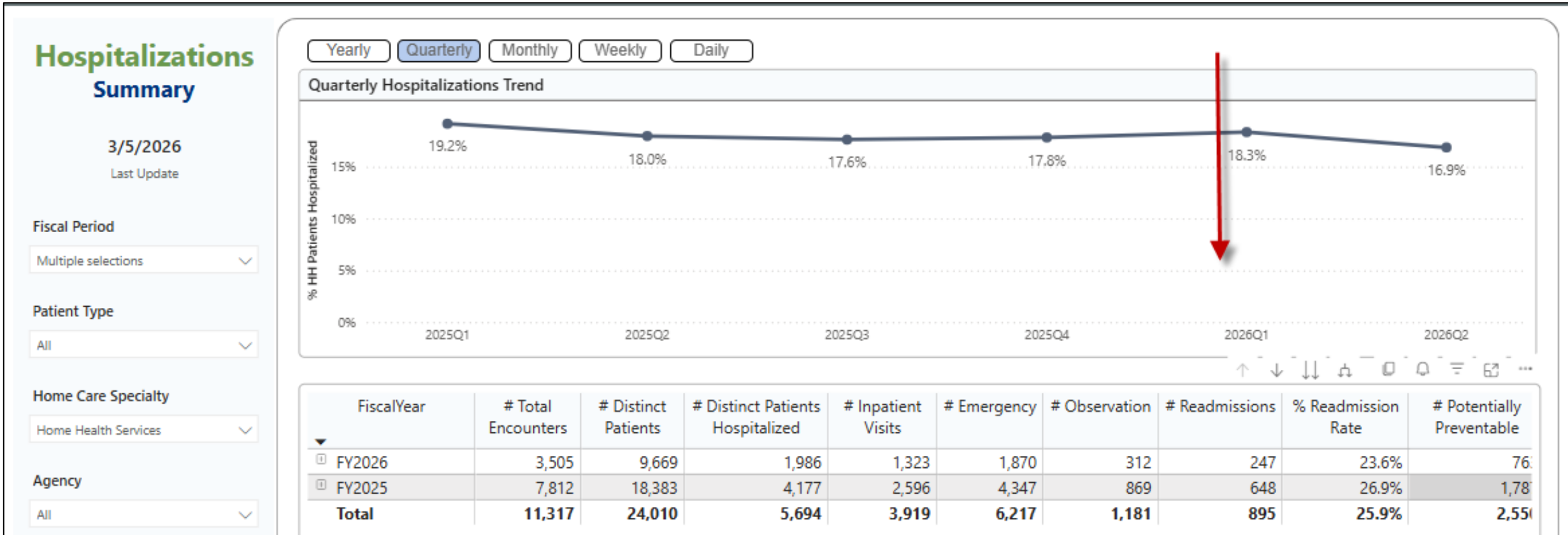
# Evaluation-Impact Indicators

Outcome Measure	baseline	Date	target	1/10/2025	2/10/2025	3/10/2025	Outcome
PPH% (169 charts/18 PPHs)	13.64%	24-Dec	1% decrease				10.70%
Quality Dashboard	13.64%	24-Dec	1% decrease	13.33%	9.52%	12.50%	11.78% ave
Overall rating of the agency	75%	24-Dec	>86.40%	85%	75%	100%	87%
Overall star rating-Monthly	3	24-Dec	>3.5 stars	4	3.5	4.5	4
Program Fidelity			>75%		50%	90%	70%
Overall nursing engagement			>75%	4.36 (87%)		3.89 (78%)	78%

Outcome Measure	Baseline Nov-25	TARGET	Dec-25	Jan-26	Feb-26	Mar-26	Target Apr-26
PPH Monthly (Enterprise) %	3	5	2.5	3	5		
PPH Monthly (Enterprise) %	10.10%	<9.1%	11.80%	10.30%	6.70%		
PPH RCY (Enterprise)	3	5	3	3	3		
PPH RCY (Enterprise) %	10.30%		10.40%	10.20%	10.10%		
CMS overall star rating-RCY	3	5	2.5	3	3		
HHCAHPS OVERALL RATING	58%	50%	43%	49%	44%		
MEAN engagement (Pre)		>75%					
Mean engagement (Post)		>75%					
Program Fidelity		>75%					

# Evaluation-Impact Indicators-All hospitalizations

Project start Dec 2025



# Evaluation-Impact Indicators PPH detail

Project start 12/2025

## Hospitalizations

### PPH Detail

**3/5/2026**  
Last Update

**Fiscal Period**  
Multiple selections

**Patient Type**  
All

**Home Care Specialty**  
Home Health Services

**Agency**  
All

**Facility**  
All

Yearly Quarterly Monthly Weekly Daily

#### Monthly Hospitalizations Trend

Month	% HH Patients Hospitalized
Oct 2024	3.3%
Nov 2024	3.1%
Dec 2024	3.9%
Jan 2025	3.5%
Feb 2025	3.4%
Mar 2025	3.7%
Apr 2025	3.5%
May 2025	3.5%
Jun 2025	3.6%
Jul 2025	3.3%
Aug 2025	3.6%
Sep 2025	3.3%
Oct 2025	3.8%
Nov 2025	3.3%
Dec 2025	4.1%
Jan 2026	3.5%
Feb 2026	2.4%

#### Hospitalizations by Fiscal Period

FiscalYear	# Hospital Visits	# Inpatient Visits	# Observation	% Readmission Rate
FY2026	761	645	116	26.3%
FY2025	1,787	1,431	356	28.0%
<b>Total</b>	<b>2,548</b>	<b>2,076</b>	<b>472</b>	<b>27.5%</b>

#### Hospitalizations by Disease and Diagnosis

PPH Category	# Total Encounters
Inadequate management of infections	1,061
Inadequate management of chronic conditions	955
Inadequate management of other unplanned events	532
<b>Total</b>	<b>2,548</b>

# Conclusion

Measure Scores Over Time - Monthly								
Department			Fiscal Year, Year Month					
Multiple selections			Multiple selections					
FY	FY2026							
Month	Nov		Dec		Jan		Feb	
Department	Score	Stars	Score	Stars	Score	Stars	Score	S
OSF ALTON HOME HEALTH	10.61%	2.50	13.51%	1.00	12.16%	1.50	5.56%	
Potentially Preventable Hospitalization	10.61%	2.50	13.51%	1.00	12.16%	1.50	5.56%	
OSF EASTERN REGION HOME HEALTH	10.40%	2.50	10.45%	2.50	6.98%	5.00	6.62%	
Potentially Preventable Hospitalization	10.40%	2.50	10.45%	2.50	6.98%	5.00	6.62%	
OSF ESCANABA HOME HEALTH	14.81%	1.00	13.04%	1.50	2.50%	5.00	5.36%	
Potentially Preventable Hospitalization	14.81%	1.00	13.04%	1.50	2.50%	5.00	5.36%	
OSF LCM HOME HEALTH	19.30%	0.50	12.50%	1.50	12.82%	1.50	4.76%	
Potentially Preventable Hospitalization	19.30%	0.50	12.50%	1.50	12.82%	1.50	4.76%	
OSF OTTAWA HOME HEALTH	10.33%	3.00	9.13%	3.50	8.48%	4.00	3.57%	
Potentially Preventable Hospitalization	10.33%	3.00	9.13%	3.50	8.48%	4.00	3.57%	
OSF PEORIA HOME HEALTH	8.78%	4.00	12.64%	1.50	8.53%	4.00	8.63%	
Potentially Preventable Hospitalization	8.78%	4.00	12.64%	1.50	8.53%	4.00	8.63%	
OSF ROCKFORD HOME HEALTH	10.65%	2.50	11.42%	2.00	7.65%	4.50	5.42%	
Potentially Preventable Hospitalization	10.65%	2.50	11.42%	2.00	7.65%	4.50	5.42%	
OSF URBANA HOME HEALTH	19.15%	0.50	8.06%	4.50	16.47%	0.50	7.27%	
Potentially Preventable Hospitalization	19.15%	0.50	8.06%	4.50	16.47%	0.50	7.27%	
OSF WESTERN REGION HOME HEALTH	7.95%	4.50	11.36%	2.00	12.20%	1.50	5.70%	
Potentially Preventable Hospitalization	7.95%	4.50	11.36%	2.00	12.20%	1.50	5.70%	

## Engagement survey results and frontline feedback identified key documentation challenges during the pilot phase

- Case manager time is more effectively utilized executing the care plan rather than building it
- Completed 37 of 40 planned education sessions
- Conducted 60-day follow-up survey
- Refined care plan based on aggregated recommendations

# Conclusion

- Final data for engagement and fidelity pending
- Final data for March & April pending

Measure Scores Over Time - Rolling 12 Months								
Department			Fiscal Year, Year Month					
Multiple selections			Multiple selections					
FY	FY2026							
Month	Nov		Dec		Jan		Feb	
Department	Score	Stars	Score	Stars	Score	Stars	Score	Stars
<input type="checkbox"/> OSF ALTON HOME HEALTH	9.22%	3.5	9.27%	3.5	9.66%	3.5	8.97%	
Potentially Preventable Hospitalization	9.22%	3.5	9.27%	3.5	9.66%	3.5	8.97%	
<input type="checkbox"/> OSF EASTERN REGION HOME HEALTH	10.09%	3.0	9.93%	3.0	9.53%	3.5	9.37%	
Potentially Preventable Hospitalization	10.09%	3.0	9.93%	3.0	9.53%	3.5	9.37%	
<input type="checkbox"/> OSF ESCANABA HOME HEALTH	9.02%	4.0	9.63%	3.5	8.97%	4.0	8.89%	
Potentially Preventable Hospitalization	9.02%	4.0	9.63%	3.5	8.97%	4.0	8.89%	
<input type="checkbox"/> OSF LCM HOME HEALTH	12.09%	1.5	12.41%	1.5	12.29%	1.5	11.88%	
Potentially Preventable Hospitalization	12.09%	1.5	12.41%	1.5	12.29%	1.5	11.88%	
<input type="checkbox"/> OSF OTTAWA HOME HEALTH	9.17%	3.5	9.06%	4.0	8.95%	4.0	8.59%	
Potentially Preventable Hospitalization	9.17%	3.5	9.06%	4.0	8.95%	4.0	8.59%	
<input type="checkbox"/> OSF PEORIA HOME HEALTH	11.23%	2.0	11.32%	2.0	11.26%	2.0	10.78%	
Potentially Preventable Hospitalization	11.23%	2.0	11.32%	2.0	11.26%	2.0	10.78%	
<input type="checkbox"/> OSF ROCKFORD HOME HEALTH	10.18%	3.0	10.57%	2.5	10.48%	2.5	9.97%	
Potentially Preventable Hospitalization	10.18%	3.0	10.57%	2.5	10.48%	2.5	9.97%	
<input type="checkbox"/> OSF URBANA HOME HEALTH	12.56%	1.5	12.45%	1.5	13.46%	1.0	13.14%	
Potentially Preventable Hospitalization	12.56%	1.5	12.45%	1.5	13.46%	1.0	13.14%	
<input type="checkbox"/> OSF WESTERN REGION HOME HEALTH	11.27%	2.0	11.05%	2.5	11.13%	2.5	10.55%	
Potentially Preventable Hospitalization	11.27%	2.0	11.05%	2.5	11.13%	2.5	10.55%	

# What Do Case Managers Need to Better Manage High-Risk Patients? | Themes from Staff Feedback

**1 Time & Productivity**  
Reduced expectations, lighter caseloads, dedicated CM time

**2 Physician Communication**  
Faster, direct access to PCPs; improved provider responsiveness

**3 Team Collaboration**  
Structured interdisciplinary communication and care model buy-in

**4 Transition of Care**  
Better hospital/SNF handoffs, complete referral info, pre-scheduled follow-ups

**5 Continuing Education**  
Consistent EBP training, diagnosis-specific education, CE resources

**6 Centralized Resources**  
One-stop reference library, checklists, cheat sheets

**7 Staffing**  
Adequate nurses, appropriate SOC assignments, aide support for high-risk visits

**8 Patient Resources**  
Transportation, medication access, visual education materials, family education

**9 Technology & Data**  
Lab notifications, centralized data dashboard, Epic tools

**10 Leadership Support**  
Accessible leadership, managerial backing, clear escalation pathways

# Implications for Practice



Improved patient experience



Improved Quality of Care for Population Health



Reducing per Capita Costs



Ensuring Provider Well-Being (Bodenheimer & Sinkov, 2014)

- Hotspotting helps the team to focus in on high-risk patients
- Supporting health literacy and self-management
- Reinforcing best practices
- EMR optimization is vital for the IDT care plan
- Impacting decisions that effect practice, shared care plan view request with EPIC
- IDT voice, feedback, team-collaboration
- EMR integration takes time
- Pilot can help to prove return on investment
- Future changes pending-moving to flowsheet
- Updating care plan based on feedback from the IDT

# Why?



The opportunity to reduce ED and ACH rates and future PPH rates in the post-acute space has created an opportunity for the IDT to utilize the ACH Risk Care Plan



Increased case manager engagement and opportunity to utilize and implement a best practice protocol care guideline with checklists to help impact patient outcomes



Healthcare hotspotting with the HHUBPP is an innovative and potentially beneficial concept that should be pursued in the landscape of the future for home care



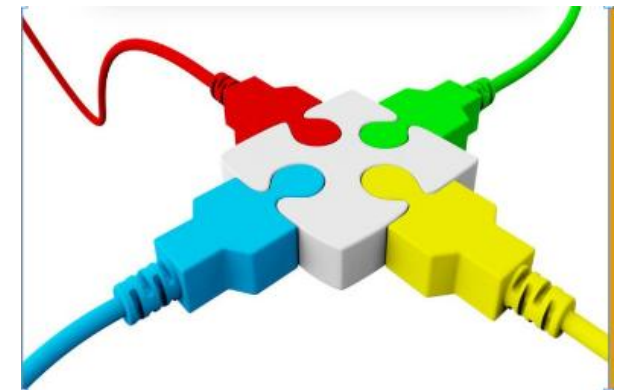
The use of an EBP comprehensive protocol can prevent avoidable, non-reimbursable hospital use; increase revenue for agencies through referrals; allow increased patient engagement, while allowing home healthcare agencies to maintain financial viability (Panozzo, 2017, p. 385)

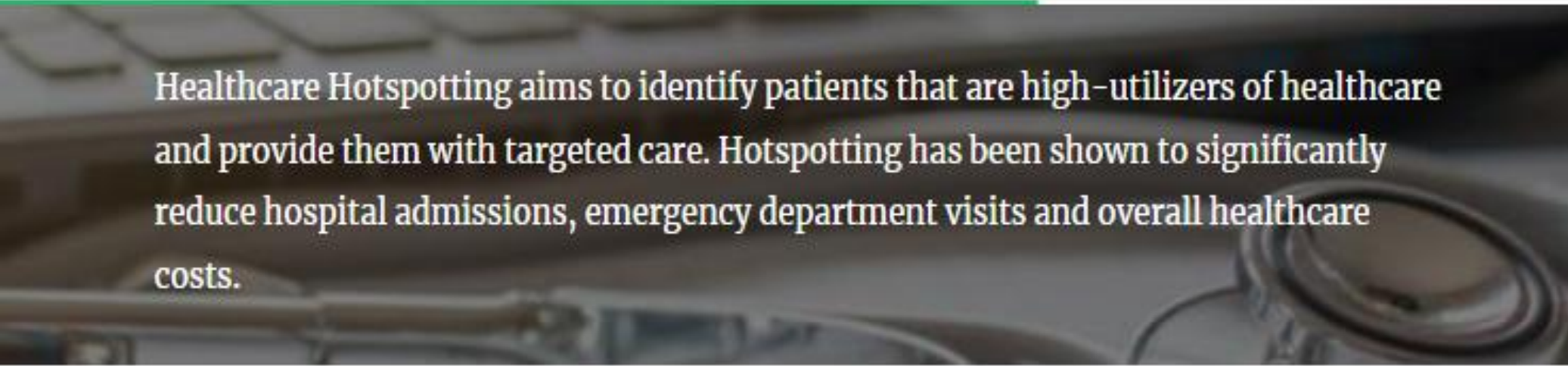
# Review of the Education

Process of care planning

What it all looks like

What are we really changing?





Healthcare Hotspotting aims to identify patients that are high-utilizers of healthcare and provide them with targeted care. Hotspotting has been shown to significantly reduce hospital admissions, emergency department visits and overall healthcare costs.

## **How do we Hotspot?**

Patients that are high-utilizers of healthcare often have chronic health conditions, such as COPD, CHF and diabetes. Remember, mental health conditions, such as depression and anxiety, can also be categorized as chronic health conditions.



**The HHUBPP is designed to:**

**Decrease the Impacts of Depression and Chronic Diseases**

**Decrease Emergency Room Visits**

**Decrease Hospitalizations**

**Decrease Healthcare Costs**

**Improve Patient Outcomes**

**The Home Health Universal Best Practice Protocol**

Patient Name: \_\_\_\_\_  
SOC data: \_\_\_\_\_  
7-10 day date from SOC: \_\_\_\_\_  
14 day date from SOC: \_\_\_\_\_

**CATEGORIES**

- Utilization
- Communication
- Education
- Communication/Collaboration
- Consults
- Assessments

**Every Visit (SN/Therapy)**

- Teach Back
- PEP review
- Document on calendar next visit
- Universal Best Practice Protocol template utilized in kinser
- Complete charting in 24 hours

**Day One Interventions (SN)**

- High-risk tool / Front load if high risk (i.e., 2w2, 1w3)
- SBAR chart note
- Transfer patient to SNF if qualifies and not appropriate for home care
- Medication reconciliation
- Teaching materials review on diagnosis
- PHQ and refer to MSW if positive
- Set up telehealth for COPD/Cardiac/Joint replacement patients
- Give report to MD
- Refer to wound care nurse for stage II or higher pressure ulcers and nonhealing wounds

**Day Two Interventions (SN/Therapy/MSW)**

- Wellness check or follow-up visit
- Therapy evaluation
- MSW evaluation
- Disciplines to read SN SOC/SBAR and document

**7-10 Days from SOC Interventions (SN)**

- Make follow-up MD appointment or coordinate with home healthcare provider
- Set two mutual goals with patient on goal sheet in SOC packet

**Last Visit Interventions (SN/Therapy/MSW)**

- Give report to continuing disciplines

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*The Home Health Universal Best Practice Protocol*

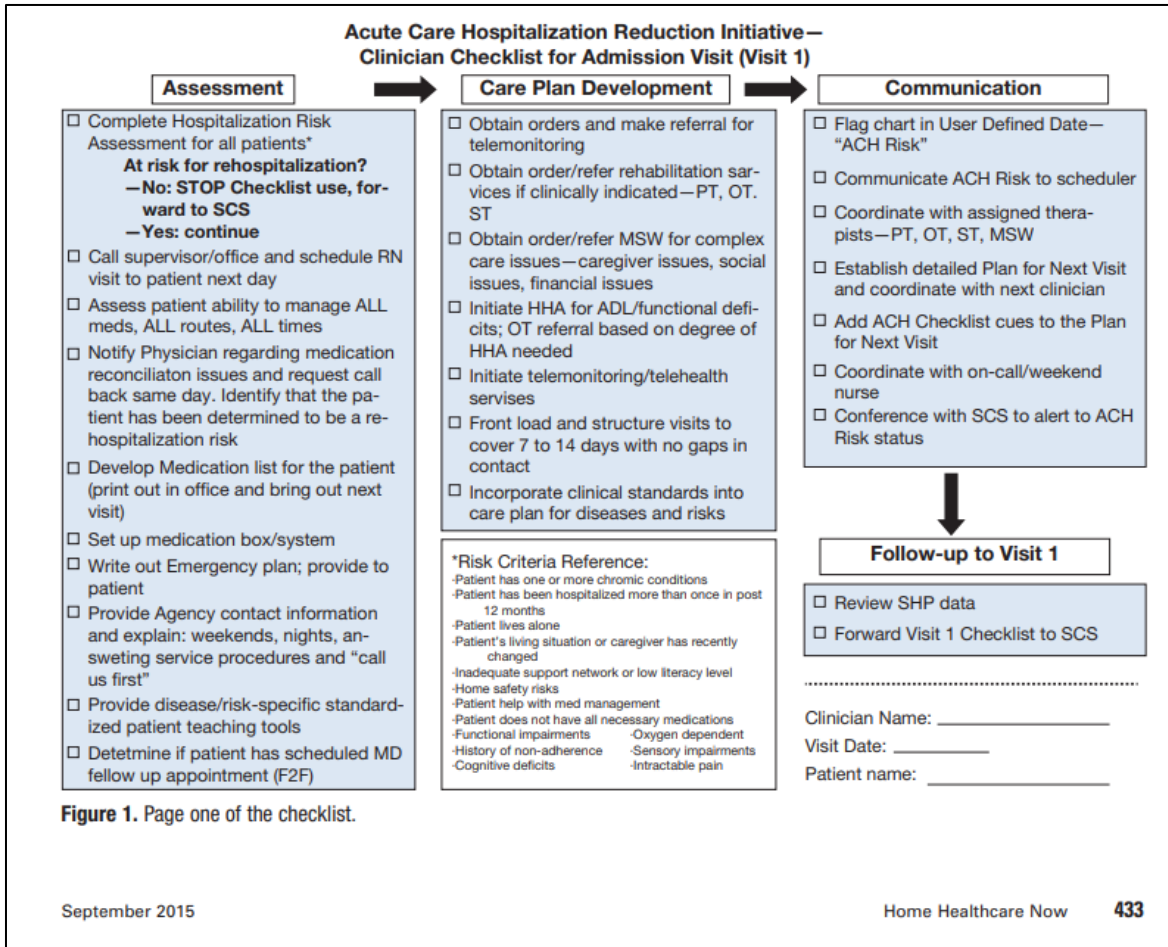
Admitting clinician will add this new care plan and document to the “checklists”

If something is not or cannot be done, pick n/a and communicate with next MP in the home or follow up at the next visit to complete

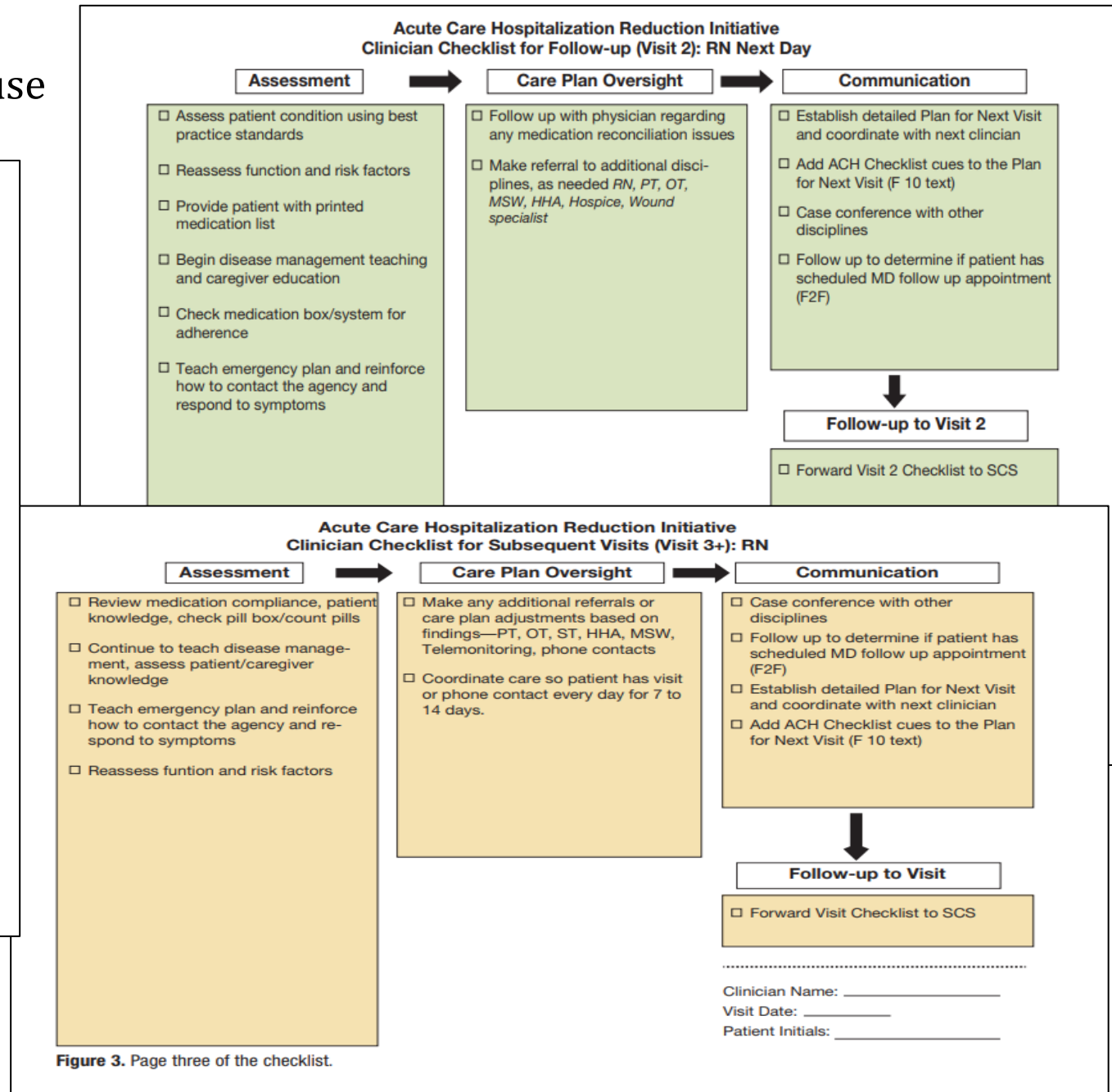
These are the EBP that will help to keep your most acute patients supported at home

Within the checklist and care guide, the clinician follows outlined steps pertaining to communication, collaboration, education, assessments and consults.

- Wood (2015) asserts the Agency for Healthcare Research and Quality (AHRQ) advocates that the use of checklists improves patient safety



Think of this as case management 2.0, our next steps toward best practices. You can be reassured you have done everything you can to help support keeping high risk patients at home



Care Plan Template

Template:  Template start date:

### Care Plan Problems

Problem	Start	POC?
<input type="checkbox"/> ACH Risk Care Plan ⓘ <ul style="list-style-type: none"> <li><input type="checkbox"/> Goal: ACH Risk Care Plan ⓘ</li> <li><input type="checkbox"/> Intervention: ACH Visit 1 Assessment ⓘ</li> <li><input type="checkbox"/> Intervention: ACH Visit 2 Assessment ⓘ</li> <li><input type="checkbox"/> Intervention: ACH Visit 3 Assessment ⓘ</li> </ul>	9/26/2025	Yes

**Homehealth, Sally** 70 y.o. (5/7/1955) Female Episode  
 MRN: 07974973 Homehealth, Sally (PHH 5/7/25) (Ad... SOC  
 Current Cert Period 9/5/25 - 11/3/25  
 Encounter Cert Period Unlinked or N/A  
 Primary Diagnosis Hypertensive heart and chronic kidney...  
 Code Status Full Code

Care Planning | Visit Sets | Care Plan Summary | Intervention Summary

Apply Template + Add Problem

Active Problems (Disciplines Filtered) - Applies to: PT, CM, SHARED

- ACH Risk Care Plan 9/26/2025 Skilled Clinicians ⓘ
- PT COMPREHENSIVE 6/27/2025 Physical Therapy ⓘ
- PT COMPREHENSIVE 6/27/2025 Physical Therapy ⓘ

### ACH Risk Care Plan

9/26/2025 Skilled Clinicians Resolve Delete

Goals

- ACH Risk Care Plan 9/26/2025 Skilled Clinicians + Add Intervention Delete
- 4. HHUBPP: Reduce hospitalization by implementing HHUBPP interventions based on patient's specific needs by \*\*\* visit.

Interventions

- ACH Visit 1 Assessment 9/26/2025 PRN ⓘ Create Order Delete
- ACH Visit 2 Assessment 9/26/2025 PRN ⓘ Create Order Delete
- ACH Visit 3 Assessment 9/26/2025 PRN ⓘ Create Order Delete

Complete the SmartList  
as indicated.

Click Accept.

ACH VISIT ASSESSMENT  
Complete M0133; review ACH risk score in SHP {HC YES/NO/NA:109346}  
Call supervisor and schedule next day visit {HC YES/NO/NA:109346}  
Assess patient ability to manage ALL meds, ALL routes, ALL times {HC YES/NO/NA:109346}  
Notify PCP of medication reconciliation issues and request call back same day. Identify that the patient has been determined to be an ACH high risk {HC YES/NO/NA:109346}  
Develop Medication list for the patient/print {HC YES/NO/NA:109346}  
Set up med planner/box {HC YES/NO/NA:109346}  
Write out safety plan and provide to patient {HC YES/NO/NA:109346}  
Provide Agency contact, explain weekends, nights, answering service procedures and to call home care first {HC YES/NO/NA:109346}  
Provide disease/risk-specific standardized patient teaching tools {HC YES/NO/NA:109346}  
Determine if patient has scheduled MD follow up appointment for F2F {HC YES/NO/NA:109346}

Care plan development:  
Set patient up to document daily vitals, provide/order equipment from team assistant if patient unable to afford {HC YES/NO/NA:109346}  
Schedule disease management calls on days with no visit as needed; schedule tuck in calls with shared visit set for telemonitoring support {HC YES/NO/NA:109346}  
Obtain orders/refer MSW for complex care issues (caregiver issues, social issues, financial issues) ▾

✓ Accept

✗ Cancel

Homehealth, Sally 70 y.o. (5/7/1955) Female Episode SOC Current Cert Period 9/5/25 - 11/3/25 Encounter Cert Period 8/5/25 - 10/3/25 Primary Diagnos Hypertensive heart and chronic kidney... Code Status Full Code

PT - HOME VISIT (9/26/2025) - Interventions Test, Homecare Pt, PT Restore

**Add/Remove Forms**

- Lower Extremity
- Bed Mobility
- Transfers
- Gait
- Stair Assessment/Home Exit
- Balance
- ADLs
- Psychosocial Patient
- Respiratory
- 30 Second Chair Stand Test
- Gait Speed
- 2 Minute Step Test
- Shoulder Pain and Disability Index (SPADI)
- Modified Borg Rating of Perceived Exertion Scale
- Berg Balance Scale
- Tinetti Balance and Gait Score
- Communication**
- Plan of Care Updates
- Actions/Narrative
- Notes
- Case Communication
- Care Plan**
- Interventions**
- If Condition Warrants**
- Diabetes
- Nutritional
- Supervisory
- Supervisory Visit 2
- Wound Assessment
- Wound/Ostomy Referral
- Lab
- Point of Care Test Result
- Depression/Suicide Screening

If you plan to use Rover, click Lock. To always unlock fields, update your preferences in the Actions menu. Lock Sync

Perform Scheduled Show Legend Filters:  Show Unscheduled  Show Performed  Show Prior Resolved

Interventions	Scheduled?	Problem	Goal
<p><b>Document Intervention: ACH Visit 1 Assessment</b></p> <p>Problems: HC ACH RISK CARE PLAN <span style="float: right;"><input type="checkbox"/> Resolve as of 9/26/2025</span></p> <p>Variance <input type="text"/></p> <p>Visit Note</p> <p>ACH Visit 1 Assessment:            Complete M0133; review ACH risk score in SHP {HC YES/NO/NA:109346}            Call supervisor and schedule next day visit {HC YES/NO/NA:109346}            Assess patient ability to manage ALL meds, ALL routes, ALL times {HC YES/NO/NA:109346}            Notify PCP of medication reconciliation issues and request call back same day. Identify that the patient has been determined to be an ACH high risk {HC YES/NO/NA:109346}            Develop Medication list for the patient/print {HC YES/NO/NA:109346}            Set up med planner/box {HC YES/NO/NA:109346}            Write out safety plan and provide to patient {HC YES/NO/NA:109346}</p> <p>Intervention Description</p> <p>ACH 1</p> <p>Goal Description</p> <p>4. HHUBPP: Reduce hospitalization by implementing HHUBPP interventions based on patient's specific needs by *** visit.</p> <p style="text-align: right;"><input checked="" type="checkbox"/> Performed for visit</p> <p style="text-align: right;">Accept Cancel</p>			
<input type="checkbox"/> ACH Visit 2 Assessment	No	HC ACH RISK CARE PLAN	ACH Risk Care Plan
<input type="checkbox"/> ACH Visit 3 Assessment	No	HC ACH RISK CARE PLAN	ACH Risk Care Plan

- Utilize the Plan of Care Updates section to indicate the plan for next visit.

**Cottoncandy, Paul** HHPTAdmit 64 y.o. (9/7/1959) Male Episcop MRN: 07988588 HHPTAdmit (PHH) (Admitted) SOC 9/6/2024

SN - INITIAL EVALUATION (9/6/2024) - Plan of Care Updates

**Plan of Care Updates**

Completed By:

Nurse	Physical Therapy	Occupational Therapy	Speech Therapy
Social Work	Pastoral Care	Bereavement Coordinator	Volunteer Coordinator
Respiratory Therapy			

Visit Summary/Plan for Next Visit:

Plan for next visit ACH2...

Updates to your Plan of Care since the last visit:

- Updated goals/Progress toward goals/Goal barriers
- Updated Medications/Treatment/Education
- What you need to work on/SMART goal
- Therapy Reassessment



## How do we Hotspot?

Patients that are high-utilizers of healthcare often have chronic health conditions, such as COPD, CHF and diabetes. Remember, mental health conditions, such as depression and anxiety, can also be categorized as chronic health conditions.

Patients with chronic health conditions often have additional risk factors. Home Care Mission partners can use the following indicators to identify high risk patients:

- 1 PHQ-9 Scores of 10 or greater
- 2 Acute Care Hospitalization (ACH) score of 4 or more
- 3 3 or more SDOH risk factors identified
- 4 18 years or older



## What's in it for me? (WIFM?)

- EBP and innovative protocol
- Assurance you are doing everything you can as a case manager to support your high-risk patient
- Supports a culture of quality and supportive care model
- Shift in how we surround and support our most high-risk patients
- Positive results can improve your team star rating
- Success with creation of this care plan is the ultimate application of our efforts to integrate EBP into our practice
- You are doing everything you can as a CM to keep your patients from ED/PPH
- Driving self-management habits
- Captain of the ship

# Actions and Steps



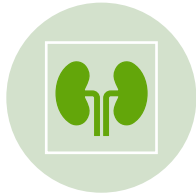
Use the admit booklet for two patient centered care goals within 14 days



Use the admit booklet to plot visits on the calendar on SOC



Use the admit booklet vitals page to engage patient in daily vital assessment



Provide scale, BP monitor, pulse ox and thermometer at 2<sup>nd</sup> visit PRN if patient unable to afford or unable to obtain equipment



Populate disease management visits on non-visit days/weekends



Send SBAR handoff to MD/care team-follow the HHUBPP actions to guide you on all best practice steps for care planning for high-risk patients



Schedule next day visit with CM, VN, or HCA-option for HCA for well-check visit



Schedule MSW eval on next business day and provide handoff

# Timeline



Education & webinars with engagement survey; practice in the sandbox



Go-live after education in each agency Dec/Jan



Clinical supervisor to complete 5 supervisory visits monthly; check home folders



Agency leaders to perform daily chart audits for compliance and feedback



Data collection for compliance for 60 days



Post project engagement survey 60 days after agency go-live

# FAQs and other tidbits

## 1. Can another discipline do the checklist for visits 2 and 3?

Yes, this can be done by the CM or delegated to any other discipline

## 2. What is the HCA well check visit?

Use the existing care plan, just exclude the shower or bath, there is a new template and education coming regarding this specific way to use the HCA

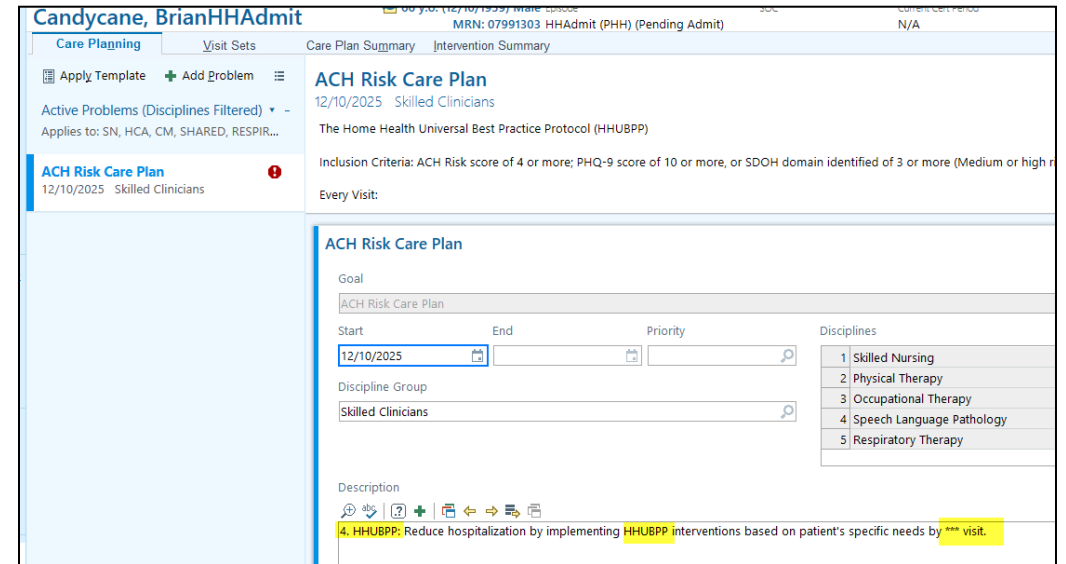
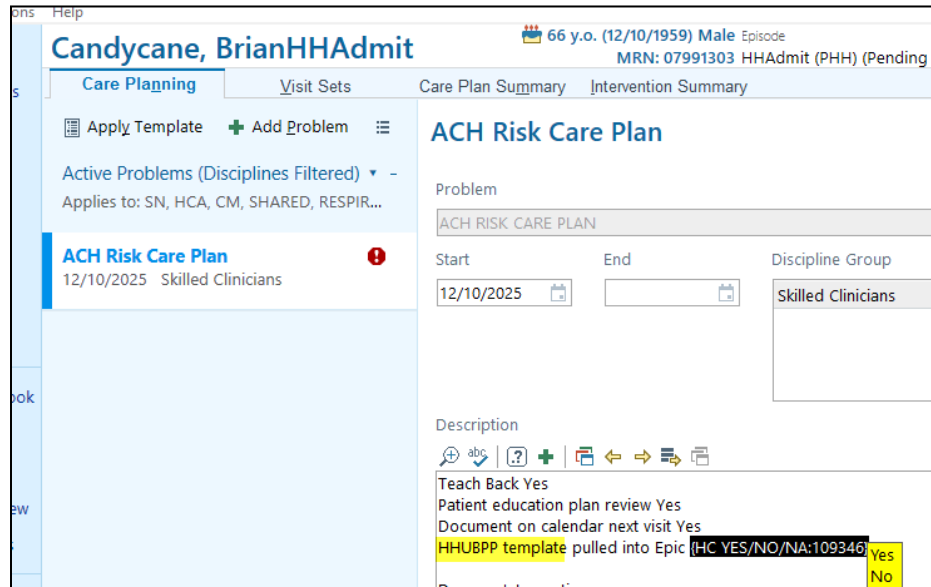
## 3. Will this replace the new EBP visit frequency guidelines?

No, we still want you to use the new visit frequency guidelines



# FAQs and other tidbits

4. Slight adjustments you will see coming after 12/15 will be consistent nomenclature with HHUBPP updated to ACH for the protocol and goal section



ACH Risk Care Plan: Reduce hospitalization by implementing ACH checklists based on patient's specific needs within\*\*\*days (30, 60)

# FAQs and other tidbits

**Care Plan Problems**

Problem

**ACH Risk Care Plan** ⓘ

Goal: ACH Risk Care Plan ⓘ

Intervention: ACH Visit 1 Assessment ⓘ

Intervention: ACH Visit 2 Assessment ⓘ

Intervention: ACH Visit 3 Assessment ⓘ

Care plan will auto-check the ACH interventions

Communication:

**Document in Directions/Precautions "ACH High Risk"**

Communicate ACH risk to scheduler and prioritize next day visit, send secure chat or Teams message {HC YES/NO/NA:109346}

Send case communication handoff to care team {HC YES/NO/NA:109346}

Establish detailed plan for next visit and coordinate with next clinician if admitting mission partner is not available {HC YES/NO/NA:109346}

Add ACH checklist cues to the plan for next visit {HC YES/NO/NA:109346}

Coordinate with weekend nurse as needed for handoff {HC YES/NO/NA:109346}

Updating "overview screen" to Directions/Precautions

# FAQs and other tidbits

**The Home Health Universal Best Practice Protocol**

Patient Name: \_\_\_\_\_  
SOC data: \_\_\_\_\_  
7-10 day date from SOC: \_\_\_\_\_  
14 day date from SOC: \_\_\_\_\_

**Every Visit (SN/Therapy)**

- Teach Back
- PEP review
- Document on calendar next visit
- Universal Best Practice Protocol template utilized in kinnser
- Complete charting in 24 hours

**Day One Interventions (SN)**

- High-risk tool / Front load if high risk (i.e., 2w2, 1w3)
- SBAR chart note
- Transfer patient to SNF if qualifies and not appropriate for home care
- Medication reconciliation
- Teaching materials review on diagnosis
- PHQ and refer to MSW if positive
- Set up telehealth for COPD/Cardiac/Joint replacement patients
- Give report to MD
- Refer to wound care nurse for stage II or higher pressure ulcers and nonhealing wounds

**Day Two Interventions (SN/Therapy/MSW)**

- Wellness check or follow-up visit
- Therapy evaluation
- MSW evaluation
- Disciplines to read SN SOC/SBAR and document

**CATEGORIES**

- Utilization
- Communication
- Education
- Communication/Collaboration
- Consults
- Assessments

"Refer for complex wounds, stage 3, stage 4, and unstageable PI" to live here"

# FAQs and other tidbits



## Tracking Requests

- Duplication of charting (notifying MD)-already on the SPOC
- Scheduling MD appt in care plan and checklist (remove from care plan-leave in the checklist)
- Request for flowsheet for PHQ-9
- Teach back (duplicate)
- Verbiage change for WOCN referral-remove Stage II
- Tuck in calls (discuss the value, frequency)-Intellatriage transition impact-Remove option
- ACH risk score may change with coding/Simitree oasis correction feedback-solution (use predictive risk score for OSF/ACH risk score for non-OSF patients)
- Care plan intervention summary-request for “shared” discipline view of care plan-OSF analyst has submitted a development request through EPIC
- Many more pts. With >3 yellow/red SDOH issues-PIA will focus on 3 red as the trigger
- Removed care plan from flowing to the plan of care (SPOC) ticket #CA1104736

# Spring 2026 Upgrade

## A New Way to Review All of a Patient's SDOH Interventions

- New Social Drivers of Health (SDOH) Interventions summary
- Automatically appears with other SDOH information
- Helps users immediately identify areas of focus
- Provides greater context of what has or has not been effective in the past
- Can now link orders, referrals, and procedures to SDOH domains to track them as interventions



**♥ Social Driver Interventions**

[Update community resources](#) | [View recommendations](#)

**Needs Review** ⓘ

**Financial Resource Strain** ⓘ  
**No intervention**

**Social Connections** ⓘ  
**No intervention**

**In Progress** ⓘ

**Physical Activity** ⓘ ⓘ  
Ambulatory referral to Physical Therapy  
Ordered 1 month ago

**Food Insecurity** ⓘ ⓘ  
CRD First Lutheran Church Food Pantry  
+2  
In Use starting 1 month ago

**Depression** ⓘ ⓘ  
Community Resource Coordination  
Enrolled

**Assistance Not Requested** ⓘ

**Social Drivers of Health** [Update community resources](#) | [View recommendations](#)

**Needs Review**

Some domains do not have an active intervention and might need follow-up because they are currently high or medium risk or have assistance requested. Other domains have not been screened.

<b>Financial Resource Strain</b> ⓘ Apr 15, 2025: Medium Risk Assistance Requested	<b>Social Connections</b> ⓘ Jul 11, 2025: Unknown Apr 15, 2025: Socially Isolated Assistance Requested
<b>Utilities</b> ⓘ Not on file Assistance Not Requested	

**Intervention In Progress**

These domains have an active intervention and are currently high or medium risk or have assistance requested.

<b>Physical Activity</b> ⓘ Jul 11, 2025: Insufficiently Active Assistance Requested Ambulatory referral to Physical Therapy ⓘ	<b>Food Insecurity</b> ⓘ Apr 15, 2025: Food Insecurity Present Assistance Requested CRD First Lutheran Church Food Pantry - Food Pantry Program - In Use +2 more ⓘ
<b>Depression</b> ⓘ Jul 11, 2025: At Risk Assistance Requested Community Resource Coordination - Active ⓘ	

**No Intervention Needed**

These domains do not need an intervention because assistance was not requested or they are not currently high or medium risk.

<b>Alcohol Use</b> ⓘ Jun 1, 2025: Not At Risk Apr 15, 2025: Alcohol Misuse Assistance Not Requested	<b>Stress</b> ⓘ Apr 15, 2025: No Stress Concern Present Assistance Not Requested
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# ACH Risk Care Plan

The home health universal best practice protocol (HHUBPP)

Pick yes/no/na

Every Visit

Teach Back \_\_\_ (duplication)

Patient education plan review \_\_\_

Document on calendar next visit \_\_\_

HHUBPP template pulled into Epic \_\_\_ (confusing/not really necessary)

Visit one Interventions

Use high risk visit checklist tool \_\_\_

front load visits if high risk \_\_\_

SBAR handoff to team and PCP \_\_\_

Medication reconciliation \_\_\_ (also in the checklist for day one...duplicate)

PHQ-9 score greater than 10 refer MSW for next day visit \_\_\_

Set up telehealth or provide vitals equipment, DM calls on days with no visit \_\_\_

WOCN referral for Stage 2 or higher PU or non-healing wound \_\_\_ (Updated to remove stage 2, added stage 3 and 4 and unstageable)

# Questions?



[Watch OSF Home Care admission educational videos | OSF HealthCare](#)

**Bree Powers DNP, RN, NE-BC**  
**Director Home Health Operations**  
**OSF Healthcare**  
**April 29<sup>th</sup>, 2026**

Thank you!

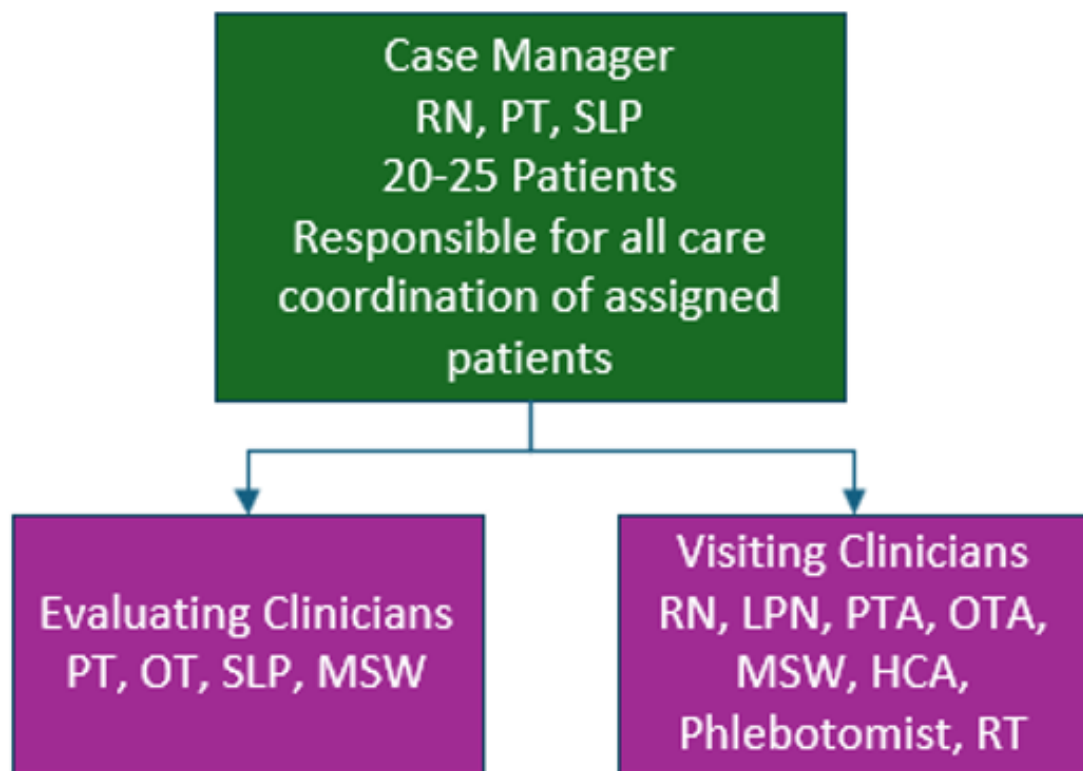


[www.linkedin.com/in/bree-powers-961448366](http://www.linkedin.com/in/bree-powers-961448366)

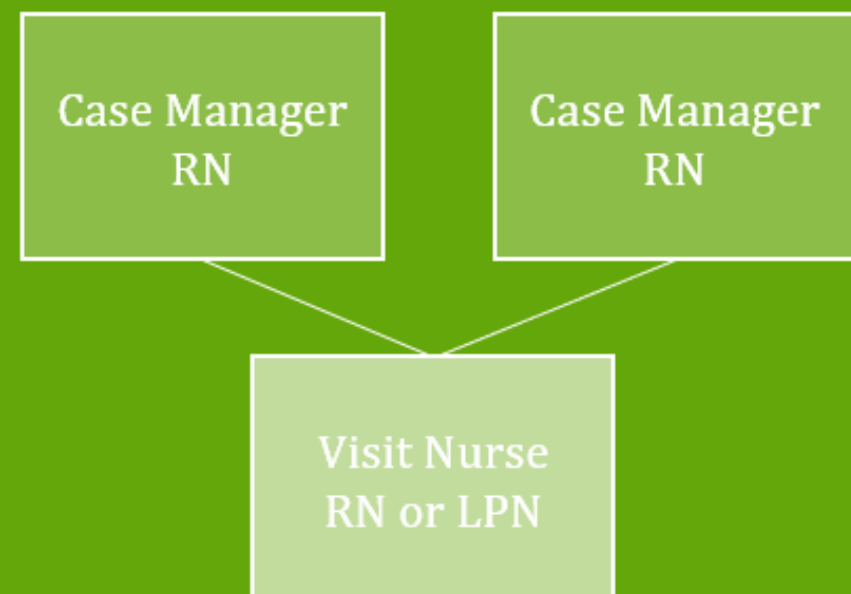
# Case Management Structure and Future Initiatives



# Home Health Staffing Model



## Nursing Teams



# HH Case Management (CM) Opportunities and Interventions



All Home Health RNs were considered Case Managers whether they were able to perform Case Management duties successfully or not.

- Delineated CM/VN roles to support focused case management



Home Health nurses did not have an opportunity for career advancement within their role.

- Separate CM/ VN job descriptions with different compensation and responsibilities



Outcome monitoring was focused only on the organization as a whole- Case Managers were not routinely evaluated or held accountable for effectiveness.

- Developed CM metrics and dashboard for leader oversight.

# HH Case Management Metrics

Continuity

LUPA percentage

Hospitalization/ ED utilization

Number of Triage Calls (patients calling in to Clinical Support for assistance)

OASIS driven VBP items

Improvement in Dyspnea

Timely Initiation of Care

Improvement in Oral meds

Use of best practice guidelines (ex. Visit frequency guidelines)



# Case Manager Dashboard

Leaders use this report to evaluate case management effectiveness.

## Home Health Case Manager Dashboard: Active Case Load Summary

Last Update: 4/3/2026 8:13:25 AM

Agency All	Case Manager All	Case Manager Discipline All	Job Description All
Patient Name, Patient MRN All	Supervisor All	Valid Active Case Load Valid	Visit Nurse Flag All

<b>2,654</b> # Active Census	<b>10.93%</b> % LUPA Risk	<b>13.19%</b> % High Hospitalization Risk	<b>22.46%</b> % Health Equity Risk	<b>1.70</b> # Average SN Continuity
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### Active Home Health Case Manager Summary

To be considered "Valid", the Active Case Load records need to meet these 3 criteria: 1. The certification period is active — today falls between the certification period start and end dates. 2. The patient is alive — no death date is recorded. 3. No Ready to Discharge (RTD) issue exists — there is no OASIS or Pediatric Discharge encounter completed more than five days ago within the certification period. You can view "Invalid" records by using the "Valid Active Case Load" slicer above.

Supervisor	# Active Census	# INP & OBS Visits (Active)	# ED Visits (Active)	# LUPA Risk	# High Risk	# Average SN Continuity	HCA Scheduled Visits	HCA Completed Billable Visits	MS
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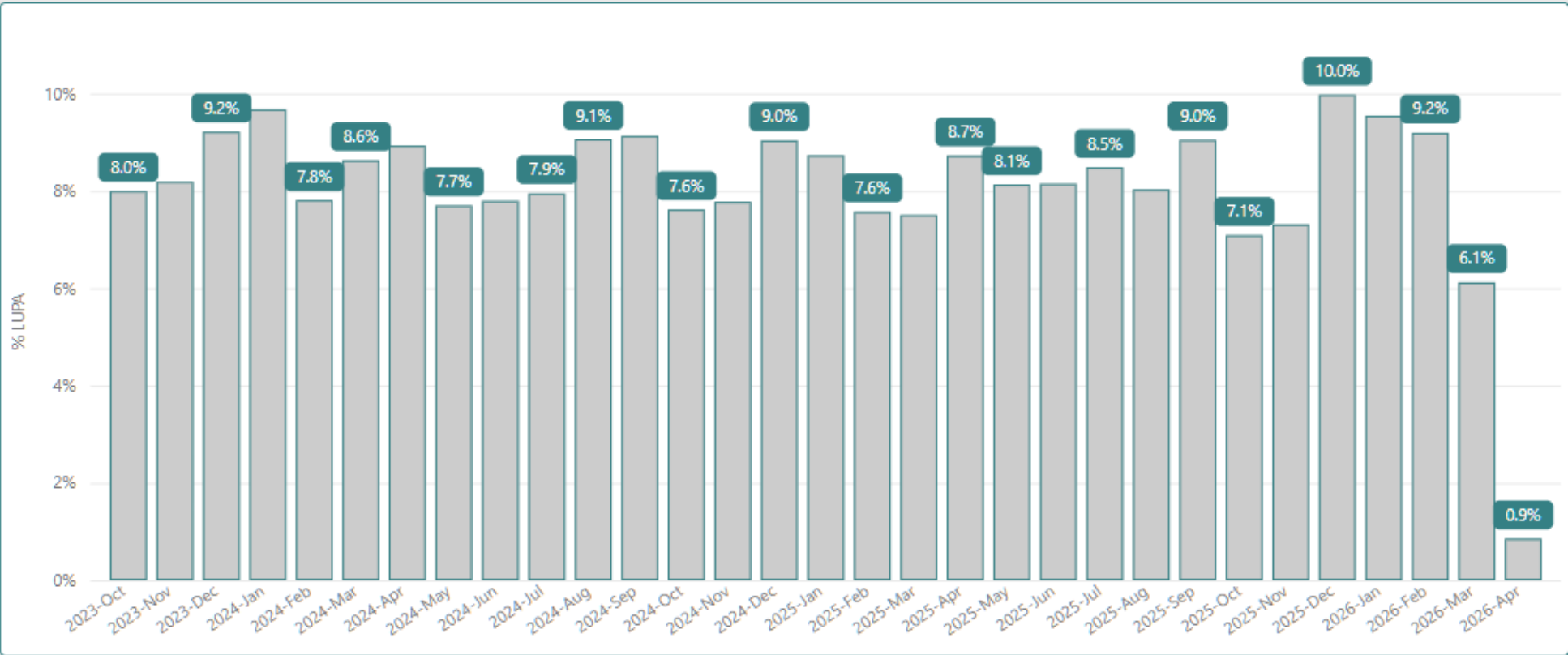
# Home Health Case Manager Dashboard: Historical

Last Update: 4/3/2026 8:13:25 AM

Agency All	Case Manager All	Case Manager Discipline All	Job Description All
Patient Name, Patient MRN All	Supervisor All	Time Period All	Visit Nurse Flag All

Historical trending data includes only certification periods that have ended. In all visualizations on this page, the time period is determined by the certification period end date.

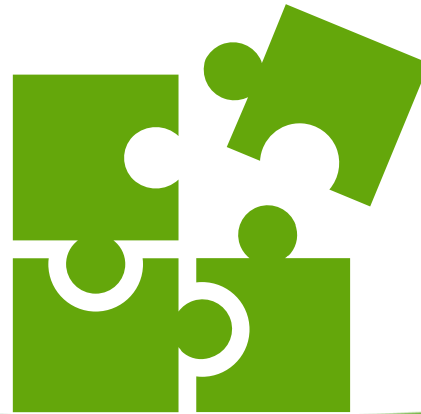
- Dashboard Measures
- Percent
    - % ED Visits
    - % High Risk Patients
    - % IP and OBS Visits
    - % LUPA
    - % PPH
    - % Recertifications
  - Volume
    - # Average Daily Census
    - # Certification Periods
    - # ED Visits
    - # High Risk Patients
    - # INP and OBS Visits
    - # LUPA Episodes
    - # PPH
    - # Recertifications
    - # Average SN Continuity
    - # SN Visits
    - # SN Visits Per Period
    - # Triage Calls



Trend Comparison

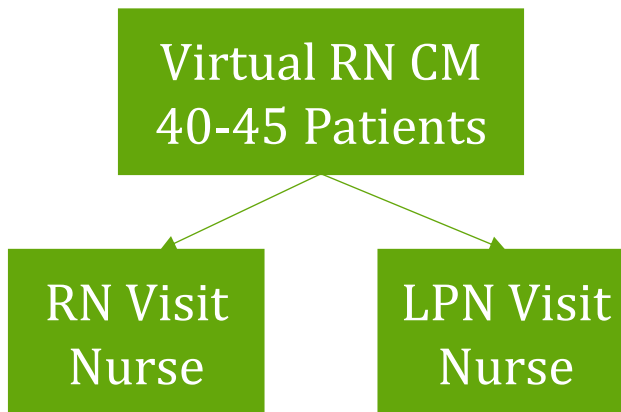
# Additional Initiatives

- Visit frequency guidelines (Nursing and therapy)
- HCA Wellbeing visits
- Hospice Case Management and Staffing Model
- Care Model innovation



# Future EBP Initiative: Home Health Virtual Case Management

- Developed to address workload, care coordination, and productivity challenges within the traditional home health nursing model- seeking an alternative care delivery model that allows time for focused case management oversight, visit scheduling and caseload flexibility, and maximum efficiency for visiting nurses.
- Intervention: A virtual RN case manager supports care coordination while visiting nurses focus on in-home care
- Goal: Improve care coordination, nurse efficiency, and patient and organizational outcomes
- Framework: Guided by the Iowa Model of Evidence-Based Practice
- Measures: Potentially preventable hospitalizations, productivity, visits per episode, and nurse experience



# Questions? Discussion

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