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OASIS Alert

Case Study: DON'T UNDERESTIMATE THE POWER OF PATIENT EDUCATION TO BOOST YOUR OUTCOMES

Here's how one agency decreased hospital readmission rates.

Hospital readmissions can hurt your HHA. One of the outcomes released for public comparison is the percentage of patients who "had to be admitted to the hospital." This has home health agencies nationwide working to understand why patients are readmitted and how to prevent unnecessary readmissions. Despite the challenges of serving a rural community, **Shore Health Care At Home** in Olney, VA has been able to keep many patients from being readmitted, decreasing its acute care hospitalization rate by 19 percent in one year, reports administrator **Glenna Melson**.

As one step in the process, the agency audited for patient and family educational efforts, using the assistance of the state's quality improvement organization, **Virginia Health Quality Center**, Melson says. "They have been very helpful with all of our outcome-based quality improvement efforts," she adds. The agency found several areas of concern.

Problem: Patients often weren't sure what to do when they encountered medical difficulties.

Strategy: SHC focused on providing the best possible education to patients to teach them self-care and help them understand what problems to look for and how to handle them. Melson provides these agency-tested tips:

1. Clinicians kept booklets and handout material in their cars for immediate access.

2. Staff chose booklets with color pictures -- even though they were more expensive -- because they appealed to patients and made instruction more successful.

3. When going over material with patients, clinicians underlined the most important sections. They never just handed the patient the material.

4. To involve the patient even more, clinicians often pointed out what they would cover next and encouraged the patient to "get a head start" by reading the material before the next visit.

5. When supervisors made joint or follow-up visits, they asked the patient to explain what the clinician had taught them. "It's encouraging to see how often they pull out the booklet, turn to one of the underlined sections and explain what they are supposed to do," Melson tells **Eli**.

   Problem: Patients often called either their physician or 911, rather than the home health agency providing their care, when they encountered medical difficulties, Melson says.

   Strategy: The agency focused on maintaining closer contact with patients more likely to experience difficulties.

6. Every agency has its "frequent fliers," Melson explains. For those patients who seem to go in and out of the hospital

more often, clinicians concentrated on maintaining frequent phone contact in between visits, to head off admissions if possible. "We have definitely prevented some emergent care this way," she notes.

7. The agency encouraged patients to call the nurse before calling 911 if it was safe to do so. The nurse would then determine if the patient's problem was urgent, and whether it was reasonable to wait 10 or 15 minutes for the home health nurse to get to the patient's house to assess the situation.

   "Once they got used to calling us instead of 911 for problems, patients found that the agency was able to respond quickly to their needs," Melson says.