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Development of a Home Health Transitional Care Program for Elderly Heart Failure

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This is to certify that the doctoral study by

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has been found to be complete and satisfactory in all respects,
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Walden University
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Abstract

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BSN, University of Phoenix, 2008

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Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Nursing Practice

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Abstract

Ineffective transitional care programs for ensuring the continuation of care from the hospital setting to the home setting often result in rehospitalization for elderly heart failure patients age 65 and older. The purpose of this project was to develop a home health transitional care program for elderly patients transitioning from inpatient settings to home settings using care bundles consisting of evidence-based practices to reduce preventable rehospitalizations within 30 days of discharge. The home-based chronic care model, which provides a foundation for home health's integral role in chronic disease management by ensuring patient-centered evidence-based care, guided the development of this program. The developmental process elicited feedback from a team of home health advisory members, 3 home health experts, and 2 health care consumers who may use this program in the future. The readability of the program was at a 5th grade level for easy comprehension. A 3-item survey was given to 2 members from the target population, and a 5-item survey was given to 3 content experts to evaluate the transitional program. The advisory members were asked to read and provide feedback on the transitional care program. Data were analyzed using descriptive statistics to obtain a content validity ratio score of 1.00. Findings suggested universal agreement on the content of the transitional care program, which was developed as a resource tool to provide evidence-based care bundle interventions from scholarly literature. Implications for social change include improving the outcomes of elderly heart failure patient by providing home health care agencies with a comprehensive transitional care program to prevent avoidable rehospitalizations and help patients effectively manage the disease.

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Dedication

I dedicate this project to my son, Treyvon Markezz Wright, as he gives me the strength and motivation to complete my Doctor of Nursing Practice Degree. In addition, to Dorothy and Ike Brown, the best mother and father that anyone could ever have, who have supported and encouraged me my entire life and taught me that life's options are limitless.

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First and foremost, I would like to Thank God for granting me the wisdom, health, and strength to undertake this Doctor of Nursing Practice Degree and enabling me to its completion.

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for my DNP study. I am indebted to the home health agencies that allowed me to complete my practicum experience at their organizations, thank you.

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Section 1: Nature of the Project

Introduction

This chapter will identify the project statement, purpose statement, and project objective for this Doctor of Nursing Practice (DNP) project. It will outline the significance of the project to nursing practice, present the project question, define key terms, and identify assumptions, limitations, and implications for social change in nursing practice

Heart failure is a complex, costly disorder that affects nearly 6 million individuals in the United States (Hall, Levant, & DeFrances, 2013), and it is the primary source of premature death and rehospitalization in patients over the age of 65 years (Stamp, Machado, & Allen, 2014). In 2010, heart failure was the contributing factor of 1 in 9 deaths in patients age 65 years and over and was the major cause of rehospitalization among Medicare beneficiaries (Centers for Medicare and Medicaid Services, 2013). The maturing of the United States population coupled with the growing occurrence of chronic disease supports the need for strategies to address transitional care across health care settings (Joint Commission, 2014).

Transitional care is not a new concept; in general, it refers to the movement of patients from one health care setting to another. Researchers have identified the transition from the hospital setting to the home care setting as a time of vulnerability for our elderly patient population fraught with risks for poor health outcomes (Berwick, Nolan, & Whittington, 2010). Transitional care is time-sensitive, patient-centered services intended to ensure health and continuity of care and safe and efficient transition among health care

settings (Naylor et al., 2011). Many efforts to prevent avoidable rehospitalization have focused hospitals' responsiveness on delivering better health care, such as increasing patient education and improving discharge planning, but these efforts have not specifically addressed the needs of patients once discharged home with home health care services (Berwick et al., 2010). In home health care, practitioners recognize the home the inviolable domain of the patient—as the care setting (Ellenbecker, Samia, Cushman, & Alster, 2008). Transitional care is essential for improving the health of the elderly heart failure population and improving patient experiences and quality of care (Inglis et al., 2011). This developmental project entails a home health transitional care program to address elderly heart failure patients' transition of care from inpatient hospital settings to home using a care bundle comprised of evidence-based practices. This home health transitional care program addressed the successful management of elderly heart failure patients in the home setting.

Problem Statement

Heart failure is the major source of hospitalization and rehospitalization in patients 65 years and older (Jencks, Williams, & Coleman, 2009). Nearly 20% of elderly Medicare beneficiaries are rehospitalized with heart failure related complications 30 days post discharge (Jencks et al., 2009). The vulnerability of this population when admitted to home health care is a matter of great concern. Rehospitalizations are often influenced by a lack of patient initiatives to ensure continuity of care when patients are admitted to the home care setting (Z. Montgomery, Executive Director, personal communication, March 7, 2014). This gap in continuity exacerbates issues of symptom management, medication

management, and health care providers' ability to follow up. A transitional program with standardized tools and process steps could reduce rehospitalizations of heart failure patients admitted to home health care (D. Jackson, Chief Executive Officer, personal communication, December 13, 2013). Increased rehospitalization rates associated with a heart failure diagnosis are often the result of avoidable complications resultant of poorly executed transitions across settings and inadequate self-management of heart failure conditions (Bradke, 2013). Reducing rehospitalizations will require improving transitions of care and coordination of care efforts (Jencks et al., 2009). In an effort to address these problems, I designed this developmental evidence-based transitional care program specifically for the home health setting.

Purpose Statement

Transitioning from an inpatient hospital setting to the home setting is a period of vulnerability for elderly heart failure patients. Inappropriately managed transitions place this population at risk for rehospitalization and have dire implications on health care costs (Jencks et al., 2009). The purpose of this project was to develop a home health transitional care program for elderly patients transitioning from inpatient settings to home care settings using care bundles consisting of evidence-based practices. According to the Institute for Health Improvement (2014), a care bundle is a compendium of three to five evidence-based practices that are implemented concurrently and consistently to accomplish positive patient outcomes.

Project Objective

Transitional care denotes the transfer of patients between practice settings and home based on their condition (Voss et al., 2011). Unfortunately, transitional care is not always a smooth process. This transitional care program will assist elderly heart failure patients to successfully transition from the hospital setting to home after an inpatient admission for a heart failure related diagnosis. An unsuccessful transition of care often results in adverse events, increased rehospitalization rates, and increased cost (Joint Commission, 2013).

Relevance to Nursing Practice

Nurses are charged with providing safe and efficient evidence-based care to heart failure patients. Improving the care of patients with heart failure entails integrating chronic care management strategies. Adequate patient education is an essential component of compliance with self-management and medical regimens for heart failure patients (Riegel, Lee, Dickson, & Carlson, 2010). Understanding reasons for the lack of medical and self-management compliance enables nurses to individualize patient care to help patients manage their disease (Riegel et al., 2010).

The Centers for Medicare and Medicaid Services (2013) have identified several transitional care programs that have been launched to augment the quality of care; however, no programs have been designed specifically for home health. Improving transitions of care is significant to nursing practice as nurses play a key role in the transition and continuity of care for elderly heart failure patients transitioning from the inpatient settings to home. Successful transitional care programs depend on collaboration

among health care providers regardless of the health care setting (Burton, 2012). Literature reviewed for this scholarly project supported the use of bundles for the collaboration and coordination of patient care post inpatient discharge to home. Using registered nurses (RNs) or advance practice nurses (APNs) can bridge gaps in transitional care to prevent complications and improve health care outcomes with elderly heart failure patients (Naylor et al., 2011; Stauffer et al., 2011; Ventura et al., 2010).

Project Question

Rehospitalizations of elderly heart failure patients are frequently the result of ineffective care transition programs to ensure ongoing care during the transition from the inpatient settings to the home setting (Kahn, 2011). Poorly executed transitional care increases the likelihood of deterioration in health status and increases the probability of rehospitalization (Kahn, 2011). The project question that guided this scholarly project was as follows: What evidence-based resources are needed to develop a Home Health Transitional Care Program for elderly heart failure patients (age 65 years and older) transitioning from an inpatient setting to home care setting?

Evidence-Based Significance

Heart failure places a substantial inconvenience on the health care system in the United States (Boutwell, Jencks, Nielsen, & Rutherford, 2009). In 2011, inadequate transitions of care were accountable for $25 to $45 billion in careless spending related to avoidable rehospitalizations and preventable complications (Burke & Coleman, 2013). Three barriers that can cause below optimal patient outcomes and inconsistencies in heart failure management include provider-level, system-level, and patient-level barriers

(McEntee, Cuomo, & Dennison, 2009). The Centers for Medicare and Medicaid Services (2013) have targeted rehospitalization rates as one of the most significant areas for needed improvement. Multiple rehospitalizations place the elderly population in jeopardy for additional deterioration in health and decreased quality of life (Boutwell et al., 2009). The Institute of Medicine (2001) asserted a multidisciplinary approach must be taken to care effectively for the needs of chronically ill patients and provide quality health care. Increasing illness trajectory, recurrent rehospitalizations, and the fragmentation of transitional care between health care settings supported the development of a home health transitional care programs designed for elderly patients with heart failure (Desai & Stevenson, 2012).

Rehospitalization of heart failure patients is often preventable and the result of a fragmented health care system (Desai & Stevenson, 2012). While several transitional care programs have been developed, further work is needed to improve the process, especially in the home setting (Lonowski, 2012). This scholarly project utilized evidence-based literature to develop this home health transitional program for elderly heart failure patients transitioning from inpatient settings to home. The concept of using APNs to manage transitional care programs has emerged but is infrequently used by many home health care organizations (Naylor et al., 2011). Using APNs for initial and follow-up home health visits post inpatient discharge promotes disease management and coordination of care with family members and physicians (Naylor et al., 2011; Ornstein, Smith, Foer, Lopez-Cantor, & Soriano, 2011; Stauffer et al., 2011). This can be an effective strategy to provide patients with heart failure management education while

preventing rehospitalizations and reducing health care costs (Naylor et al., 2011; Ornstein et al., 2011; Stauffer et al., 2011).

Implications for Social Change

Health care in the United States has been inundated with exceptionally high costs, fragmented delivery of care, and poor quality of care (Jencks et al., 2009). Demographic trends in the United States showed an ongoing rise in the number of elderly adults who will be subject to the delivery of fragmented care (United States Census Bureau, 2013). Approximately 20% of elderly Americans live with five or more chronic medical conditions (Centers for Medicare and Medicaid Services, 2014). Heart failure is the most recurrent source of rehospitalization within 30 days of inpatient hospital discharges (Boutwell et al., 2009). Approximately 1 in every 5 patients released from the hospital is readmitted within 30 days, accounting for nearly 3 million elderly patients, costing over $25 billion annually (Centers for Medicare and Medicaid Services, 2014). Many rehospitalizations are preventable; therefore, this heart failure transitional care program aids in bridging gaps in the transition and coordination of care (Jencks et al., 2009; Lonowski, 2012). Improving health care systems for safe and effective management of chronic illnesses is vital to transforming health care in America (Institute for Health Improvement, 2014).

Traditionally hospitals have operated as the focal point of efforts to reduce rehospitalizations. However, several social and health-related factors along the continuum of care have an impact on rehospitalizations (Desai & Stevenson, 2012). Although several effective transitional care programs have been designed to decrease the

frequency of potentially preventable rehospitalization, some of the causes that contribute to rehospitalization reach far beyond traditional care. For example, what happens when a heart failure patient is discharged with no scale or cannot identify new or worsening symptoms that should alert them to contact their primary health care provider (Resar, Griffin, Haraden, & Nolan, 2012)? This home health transitional care program for elderly heart failure patients emphasizes the incorporation early and ongoing assessments to assure safe transition from inpatient settings to home. Other key elements of the program include post-acute physician follow-up, evidence-based education and effective communication with family and health team members, and the review and reconciliation of medications (Bradke, 2013). This home health transitional care program for elderly patients transitioning from inpatient settings to home presents a win-win opportunity for heart failure patients, health care providers, and insurance payers.

Terms Defined

For the purpose of this home health transitional care program, the following key terms are defined.

Transitional care is defined as activities intended to safeguard the management and continuity of care as patients transfer between settings and care levels within the health care setting (Brock & Boutwell, 2013).

The Institute for Health Improvement (2014) defined *care bundle* as a set of three to five evidence-based interventions for a targeted population /sector and health care setting, when employed collectively, that will ensue substantially improved patient results than when executed independently. This heart failure education project consists of

engagement of patients and caregivers, medication management, physician follow-up, shared responsibility across setting and organizations, and transitional care planning (National Transitions of Care Coalition, 2012).

Rehospitalization refers to an admittance to the hospital that ensues a specific timeframe following an inpatient discharge (Centers for Medicare and Medicaid Services, 2013).

Gardetto (2011) defined *self-management* as an individual's ability to carry out and accomplish daily tasks, physical symptoms, necessary lifestyle changes, and psychosocial health and wellbeing over the duration of illness.

Assumption and Limitation

One assumption was that the development of a home health transitional care program for elderly heart failure patients could reduce hospital readmissions and improve patients' health outcomes. One limitation of the project was that it is reasonable to predict that elderly heart failure patients will be inappropriately discharged home from inpatient hospital settings and, consequently, the condition of these patients will deteriorate and result in poor patient outcomes and unforeseeable rehospitalizations. One way to address these limitations was the development of this transitional health care program that specifically addressed the needs of this patient population upon discharge from inpatient hospital settings.

Summary

In summary, improving transitional care has substantial importance to the health care system of the United States. This scholarly project contributes to and addresses

transitional care in the home setting. Poor transitions of care often result in poor patient outcomes (Burke & Coleman, 2013; Hansen, Young, Hinami, Leung, & Williams, 2011; Naylor et al., 2013). According to the Centers for Medicare and Medicaid Services (2014), over $40 million is spent annually treating heart failure as a result of hospital admissions and readmissions. Best practices in transitions of care through the implementation of successful programs can reduce rehospitalizations and overall cost (Burke & Coleman, 2013; Burton, 2012; Desai & Stevenson, 2012). This evidence-based home health transitional care program supports transitions from inpatient settings to home while improving health care outcomes for elderly heart failure patients.

Section 2: Review of Literature and Theoretical and Conceptual Framework

Introduction

Evidence-based transitional care programs for heart failure patients are underdeveloped (Jencks, 2009). As a result, it was vital to identify evidence-based findings that practitioners can apply successfully in the home health setting. Before developing this transitional care program, it was important to examine the strengths and reliability of the evidence. This chapter will focus on the scholarly evidence found with a literature search.

Literature Search Strategy

An extensive literature search was conducted using Cumulative Index of Nursing and Allied Health (CINAHL), Medline, PubMed, and Ovid Nursing Journals databases. Search terms used for the literature review included *transitional care, care bundle, home health, advance practice nurse, elderly, rehospitalization, readmission*, and *heart failure*. The search concentrated on peer-reviewed literature published from 2000 to 2014, yielding 52 articles. Articles excluded from this literature review included those published prior to 2000, studies not performed in the United States, articles published in a language other than English, and studies that were not related to the project question. Articles prior to 2000 were excluded because several transitional models developed prior to 2000 have since been revised. Studies not performed in the United States were excluded because utilizing APNs in different countries varies. Upon further review, 10 articles were determined to be those most applicable for inclusion in this literature review. Once identified for inclusion, the selected studies were appraised for (a) research

design, (b) sample, (c) methods, (d) findings, and (e) limitations. Common themes identified were benefits of transitional care programs, use of APNs in transitional care, and care bundles.

Research Findings

Conversion of evidence into practice is a task for many health care settings. Regardless of the substantiation that reinforces the efficacy of health care programs, gaps exist between evidence-based everyday practices (Stauffer et al., 2011). The recently increased interest in transitional care to address rehospitalization requires a thorough evaluation of existing evidence before developing a transitional care program (Naylor et al., 2004). The development of several models focused on the use of comprehensive care transition programs that undertook multiinterventional approaches (Voss et al., 2011). The models used transitional care interventions to improve patient health care outcomes. Although several successful interventions have been proven to reduce adverse events and rehospitalization rates, none of the models in the literature review were specifically tailored to home health care (Ornstein et al., 2011).

Benefits of Transitional Care Programs

Coleman et al. (2006) conducted a randomized controlled trial study to measure readmission rates at 30, 90, and 180 days. Participants in the study included 750 community residing adults 65 years or older admitted to the hospital with one of 11 selected diagnoses, such as congestive heart failure, stroke, cardiac arrhythmias, coronary artery disease, and so forth. Participants were randomized to receive the intervention or usual care. Intervention patients obtained (a) tools to advance site-to-site interaction, (b)

support to participate more actively in their care and to support their preferences, (c) continuity across health care settings, and (d) guidance from a transition coach (Coleman et al., 2006). Findings showed that intervention patients had reduced rehospitalization rates at 30 (48%) and at 90 days (40%) when compared to the control group. Intervention patients had reduced rehospitalization rates for similar medical conditions that triggered the index hospitalization at 90 days (40%) and at 180 days (46%) when compared to the control group (Coleman et al., 2006). The average hospital costs were less for intervention patients ($2,058) versus control patients ($2,546) at 180 days. Findings of the study suggested that the interventions led to improved self-care management and reduced rehospitalization rates (Coleman et al., 2006). One limitation was that the findings could not be generalized beyond the geographical location of the study.

Voss et al. (2011) conducted a randomized controlled trial to test the effectiveness in reducing hospital admissions. Participants (n = 257) in the study were recruited from six Rhode Island acute care hospitals. Patients were separate into three groups: internal control group (patients contacted but refused), external control group (patients not contacted but qualified for participation in the study), and the intervention group (Voss et al., 2011). The complete intervention ensued over 30 days and included a transition coach completing a hospital visit, a home visit, and two follow-up phone calls. Findings showed that ,when compared to individuals who did not receive any of the interventions, 30-day rehospitalizations were fewer for participants who received transitional coaching (12.8%; Voss et al., 2011). A limitation of this study was that

individuals who declined to complete the intervention represented a sample least expected to enroll in a randomized controlled trial.

Use of APNs in Transitional Care Programs

Stauffer et al. (2011) conducted a randomized controlled trial to examine the effects of an APN-led transitional care program for patients with heart failure. The study sample included 56 participants, and all patients were 65 years or older discharged from an acute care setting with a principle diagnosis of heart failure (Stauffer et al., 2011). The intervention was a 3-month program that involved transitional care provided by an APN. Visits by an APN occurred within 72 hours of the index hospitalization, and an additional eight home visits were conducted for each participant (Stauffer et al., 2011). If hospitalization occurred, an APN conducted hospital visits. Patients were released upon program completion, upon admission to a skilled nursing facility, upon request, or on death. A budget analysis was conducted using costs and repayment knowledge from the intervention (Stauffer et al., 2011). The intervention considerably decreased adjusted 30-day readmission rates to the acute care facility by 48% during the postintervention period. The intervention had minimal effect on the length of stay or total 60-day direct cost for the facility and decreased the financial subsidy margin on an average of $227 for each patient with heart failure (Stauffer et al., 2011). A limitation of this study was the difficulty recruiting potential candidates hospitalized with heart failure for this study presenting significant time and resources.

Naylor et al. (2004) conducted a randomized controlled trial to study the value of a transitional care intervention provided by APNs to elders hospitalized with heart

failure. This study included 239 qualified participants 65 years and older hospitalized with heart failure (Naylor et al., 2004). The participants were recruited from six Philadelphia academic and community hospitals. The mean age of the participants was 76, 36% were African American, and 43 %were male. The intervention included a 3-month APN-directed discharge preparation and home follow-up procedure through 52 weeks post discharge (Naylor et al., 2004). At 52 weeks, the intervention group patients had fewer readmissions (47%). For intervention patients, only temporary improvements were confirmed in overall quality of life, physical aspect of quality of life, and patient satisfaction (Naylor et al., 2004). One limitation was that the study was conducted at six academic and community hospitals, which compared rehospitalizations rates based on unique index hospitalizations that may have been overestimated.

Neff et al. (2003) conducted a prospective study to examine an intervention group care for by APN-guided and -managed pulmonary disease management team compared to a control group, cared for by nurses delivering everyday home health care. The authors performed the study at a large multidisciplinary home health care organization that provided services to Medicare participants in four Ohio counties (Neff et al., 2003). Participants in this study included 80 Medicare beneficiaries age 62 or older with a primary or secondary diagnosis of chronic obstructive pulmonary disease. The participants were mostly female (61%) and Caucasian (88%) with an average age of 75.5. The control group received primary care by RNs or licensed practical nurses (LPNs) with comprehensive abilities. Care encompassed assessment of patients' psychological, physical, social support needs and environmental needs (Neff et al., 2003). The

intervention group received care from pulmonary-trained RN/LPNs who were managed and guided by a cardiopulmonary care APN expert. Care encompassed telephone contacts, home visits, and a nurse expert accessible by telephone 24 hours a day. Findings of this study indicated significant differences in rehosptializations rates for the intervention group when compared to the control group (4 versus 11; Neff et al., 2003). All four rehospitalizations in the intervention group happened within the first month and were resultant of injuries from falls. A limitation of this study was that causality could not be assumed because the patients were not arbitrarily appointed to usual care or transitional care (Neff et al., 2003). Preceding adjustments between patients may have affected the findings of this study.

Care Bundles

Pogorzelska et al. (2011) conducted a cross-sectional survey that examined the efficacy of individual elements; implementation of ventilator bundle elements; and the success of infection specific elements on ventilator associated pneumonia to prevent adverse events in ventilated patients including ventilator-associated pneumonia. The study included 415 intensive care units from 250 hospitals (57% response rate). Participants included hospital managers and directors of infection prevention and control departments who evaluated the implementation and consistency with ventilator bundle components. The ventilator bundle elements included head of bed elevation, daily patient sedation holiday, an assessment of extubation readiness, and deep venous thrombosis and stomach ulcer prevention. Hospital demographics were examined for duplication from a single institution (n = 31). Surveys completed in entirety were used. This large-scale

study was the first in the nation to study implementation and conformity of the ventilator bundles in the intensive care unit setting. Findings of this study indicated that ventilator bundles were frequently a policy and implementing bundle leads to a general impression of care and attentiveness and prevented ventilator associated pneumonia. A limitation of this study was that despite a 57% response rate there was potential response bias and the potential for unrestrained perplexed variables in unmeasured features such as patient safety values.

Home-Based Chronic Care Model

The home-based chronic care model guided this DNP project (Wagner, 2009). The home-based chronic care model was developed by the Baptist Home Health Network to concentrate on the necessities of patients with chronic illnesses. This model was adapted from the chronic care model (Suter et al., 2009). The home-based chronic care model focuses on four areas: (a) high touch delivery system, (b) theory-based self-care management and support, (c) specialist oversight, and (d) the use of technology (Suter et al., 2009).

High Touch Delivery System

In the home setting, home health care visits enable the formation of collaborative associations among caregivers, patients, and home health clinicians. Home health care clinicians are accustomed to providing treatment and care for patients in the home setting (Suter et al., 2011). The initiation of care that is high touch care entails the completion of a detailed assessment that is vital to the interpretation of barriers and needs to manage chronic condition. Paramount to patient goals is the relationships built between the

patients, and the home care clinician (Suter et al., 2011). A face-to-face visit supplemented with prearranged telephone calls confirms patient's continued progress toward established goals. Positive support and reassurance are also afforded by a home care multidisciplinary team, which may include home health aides, therapists, and nurses (Suter et al., 2011).

Theory-Based Self-Management Support

Self-care encouragement is a fundamental element in the home-based chronic care model (Wagner, 2009). Self-care management is supported by face-to-face home health visits. The aim is to facilitate patient's attainment of self-confidence and skills to manage their chronic disease (Suter et al., 2011). Home visits by members enable the home care clinician to observe activities of daily living effective chronic care management. Preparing and presenting disease specific health education is not sufficient. The home health provider must identify and address behavior patient understanding of behavior modification impact chronic illnesses (Suter et al., 2011).

Specialist Oversight

Clinical guidelines that supports evidence-based practice protocols are a necessity for the patient's plan of care. APNs must manage patient care to demonstrate evidence-based practices are implemented (Suter et al., 2011). A study by Rhoads, Bankston, Roach, Jahnke, and Roth (2014) from the University of Pennsylvania analyzed the effect of using both a telephonic contact and telehealth with patients diagnosed with chronic illnesses. Home health care clinicians followed evidence-based guidelines for patients with diabetes and heart failure. APNs utilized by home care organizations are adept and

can manage a multidisciplinary team by examining patient quality of care and health care outcomes (Rhoads et al., 2014).

The Use of Technology

Elements of the home-based chronic care model guide the development of the home health transitional care program for elderly heart failure patients. To develop the proposed home health transitional care program the following areas will be included: (a) Patient centered evidence-based care plans which are individualized to heart failure and individualized to address the patient's goals and needs; (b) telephonic follow up using standardized heart failure questions by the APN over the phone based on the patient's plan of care; (c) Face-to-face encounters within 24 to 48 hours post discharge from an inpatient hospital setting to establish a collaborative relationship and identify patient goals, assess barriers, develop care plan, facilitate self-care management, and progression evaluation; and (d) oversight by a specialist will entail using APNs, who will coordinate patient care and monitoring and analysis of health care outcomes.

Summary

In summary, features of effective home health programs include comprehensive care bundles such as in-person interaction with clinicians' physicians or APNs, telephone follow-up, and self-care support and education. For patients discharged home, complete discharge support and education that includes timely follow-up with health care providers can be essential to a successful transition. The home based chronic care model outlined in this section was used to guide development of this home health care transitional program for elderly heart failure patients.

Section 3: Methodology

Introduction

The chapter outlines the proposed home health transitional care program, which includes care bundles with activities, tools, and resources for a successful transition. This chapter details the selected population and sample, data analysis, and the project evaluation plans. Program planning that is more systematized and is generally more efficient (Hodges & Videto, 2011). Health care professionals continually develop programs to achieve specific goals in efforts to attain a desirable impact on patients' health and quality of life (Hodges & Videto, 2011).

Project Design

The appropriate selection of the right design is essential to demonstrate that the selected program will create an impact (Kettner, Moroney, & Martin, 2013). This project identified evidence-based resources that were used to develop this home health transitional care program for elderly heart failure patients. Care bundles include activities, tools, and resources needed for a smooth transition. Home health transitional care programs are effective in preventing rehospitalization and poor health outcomes among vulnerable populations (Naylor et al., 2011). The final product is a scholarly manual divided into three sections:

- Section 1: Highlights of key components of the care bundle
- Section 2: Step-by-step series of actions to support staff in implementing care bundle interventions described in Section 1

- Section 3: Assessment forms, educational resources, and tools for care bundle tasks implementation

Each section of the manual will be available online at the Home Care Association of Florida website. Members of the Home Care Association of Florida will be able to access the transitional program manual as a resource available to all provider types.

Care Bundle

Improved strategies for heart failure disease and self- management are urgently needed (Institute for Health Improvement, 2014). This transitional care program was based on evidence-based findings. Key concepts include transition care planning, medication management, patient education and engagement, and physician follow-up care.

Transition planning. Based on a study by Naylor et al. (2004) is program utilizes APNs for transition care planning 24 to 48 hours post inpatient discharge, weekly follow-up home visits, and weekly follow-up phone calls. Transitional care planning consists of working with patients and families to complete an individualized health record, reconciliation medication, provide disease specific education, and schedule follow-up physician appointment. A scripted discussion will occur with the elderly patient and family regarding this planning.

Medication management. Best practices in transitions of care programs focus on reconciliation of medications to assess for accurateness of medication records, dosages, contraindications, and evaluation of financial difficulties (Kim & Flanders, 2013). To effectively manage medication regimens and prevent adverse events, another essential

component of the programs care bundle entailed developing a medication tracking log similar to Coleman et al. (2004) medication discrepancy tool.

Patient education and engagement. The care bundle includes printed educational information on heart failure written at a fifth grade reading level or lower and in large print for the targeted population. Communicating health information to the elderly population can be challenging. Culture, literacy skills, and text size are important factors to consider when designing health communication materials for the elderly population (Centers for Disease Control and Prevention, 2009). The printed material addresses heart failure disease management, self-care and medication regimen management, and early warning signs. Patient education using the "teach back" method supplemented with written materials has been effective in this age group (Sokol & Wynia, 2013). Microsoft Office Word for MAC was used to examine the readability of the educational documents. Revisions were made to ensure a reading level of fifth grade or below.

Follow-up care. A patient follow-up visit and follow-up phone call schedule log was developed to document supplemental appointments. In addition to APN visits, post-inpatient follow-up visits with the primary provider and cardiologist offer ongoing symptom and medication management (Kim & Flanders, 2013). A checklist for weekly and standardized script for follow-up phone calls by the APN was developed to monitor and re-enforce education and self-care activities.

Population and Sampling

The target population for this developmental project includes elderly home health patients with heart failure related diagnoses. The sample for this project includes elderly home health heart failure patients in the state of Florida. The program design includes patients of any ethnicity, gender, and those 65 years or older.

Data Collection and Analysis

An effective transitional program integrates a number of concepts to ensure patients a safe and efficient transition home (Bradke, 2013). As a part of the care bundles, checklists and forms were developed for implementation by home health staff to ensure fidelity with the program. The staff will be able to analyze this data using descriptive statistics to measure program compliance and decease rates of 30-day rehospitalization with elderly heart failure patients.

Project Evaluation Plan

Program evaluation is an essential part of planning a program and should be constructed so that it demonstrates program accomplishments, program improvement, and whether the program goals and objectives are being met (Hodges & Videto, 2011). This home health transitional care program was reviewed by a home health advisory committee and included two patients from the target population. Representatives included the agency's administrator; the director of nursing; the medical director, and two community selected consumers who were not employees or owners of the agency. According to the Centers for Medicare and Medicaid Services (2005) conditions of participation federal guidelines, a group of home health professional personnel reviews

an agency's policies governing services offered, program evaluation, admission and discharge policies, and medical plans of care annually and as needed. The health care consumer participants for this home health transitional program content review were contacted via telephone to determine readiness to participate in the review. The home health professional advisory committee members were also contacted via telephone regarding the home health transitional program content review. Program review participants reviewed the program content over the course of 2 weeks and no additional time was warranted.

Peer-review groups are deemed valuable for health care quality improvement. Effective health care programs synthesize and review unpublished and published evidence-based practice data; create new analytical and scholarly tools; and translate findings into beneficial layouts for diverse audiences (Agency for Healthcare Research and Quality, 2014). Questions for the content review can be found in Appendix A. Feedback from this content review is incorporated in the final version of the program. Checklists, forms, and scripted discussions were developed to ensure program fidelity with each home health care nurse. Home health staff can review the checklists, forms, and 30-day rehospitalization rates annually for evidence of quality improvement. The development of the home health transitional care program using a care bundle of evidence-based resources provides a comprehensive approach to providing quality home health care to elderly heart failure patients.

Summary

Heart failure affects an increasing number of elderly patients annually (Jencks et al., 2009). Inadequate coordination of care from inpatient settings to the home care setting often results in poor health care outcomes and cost up to an estimated $44 billion annually (Burke & Coleman, 2013; Jencks et al., 2009). This home health transitional program consists of care bundles, checklists, and forms for home health staff to use to measure program improvement and staff compliance. The staff will be able to see if rehospitalization rates have decreased.

Section 4: Findings, Discussion, and Implications

Introduction

The purpose of this DNP project was to develop a home health transitional care program for elderly patients ages 65 years old and older transitioning from inpatient settings to reduce preventable rehospitalizations through the implementation of evidence-based care bundle interventions. The home health transitional care program was developed to address inappropriately managed transitions across settings and inadequate self-management of heart failure care among elderly patients who are at risk for rehospitalization (Jencks et al., 2009). As a resource, the home health transitional program was developed based on a review of the literature and from my practicum experiences as a DNP student. The home health transitional care program was developed to assist elderly heart failure patients to successfully transition from the hospital setting to home after an inpatient admission for a heart failure related diagnosis.

Summary and Discussion of Findings

Utilizing the home health transitional care program would provide home health care agencies with care bundles of activities, tools, and resources to ensure effective transitional care for elderly patients with heart failure related diagnosis transitioning from inpatient settings to home. This project addressed gaps in transitional care by providing patients with support and educational resources they would need to understand and take an active self-care role, and this helps reduce preventable rehospitalizations. The planning and development of this home health care transitional program for elderly heart failure patients was guided by elements of the home-based chronic care model focusing

on specialist oversight, self-care management and support, and high touch care (Suter et al., 2009).

According to the Institute for Health Improvement (2014), improved evidence-based strategies to reduce preventable rehospitalization of heart failure patients are needed. The home health transitional care program addressed potential threats to the well-being and health care outcomes of elderly heart failure patients during transitions of care. This transitional care program provides a compendium of evidence-based care bundle activities that address transitional care planning, medication management, patient education and engagement, and physician follow-up to assist the targeted heart failure population to successfully transition from the hospital setting to home.

The final transitional care program manual includes evidence-based care bundle strategies and a step-by-step series of actions to support staff in implementing care bundle interventions. The manual also includes assessment forms and educational resources for care bundle tasks. The final manual was amended based on comments from the home health advisory committee's content review. To ensure easy comprehension the patient educational materials were assessed for readability to be at a fifth grade level, and this process was outlined under the evaluation of findings. The home health transitional program manual underwent a modification to ensure continuity of assessment tools regardless of patient referral source or payer type. To ensure program goals and objectives were met, the content revision was reviewed and accepted by advisory committee members.

My participation in practicum experiences provided the opportunity to effectively develop this project. The practicum experiences provided me the opportunity to participate in various activities that reinforced my project development. It gave me the opportunity to identify current practices and collect pertinent educational resources and tools to develop and complete this DNP project. Although this transitional care program specifically focuses on home health patients with heart failure, the program can be adapted to support transitions of care to improve health care outcomes for all patients and advance nursing practice across all settings.

The heart failure transitional program was designed to reduce preventable readmissions for heart failure related diagnosis by closing transitional care gaps in care. The transitional care program consists of evidence-based care bundle components including assessment tools, educational resources, and tools from scholarly sources. The home health transitional care manual will be assessable online at the Home Care Association of Florida website as a resource available to all provider types. Appendix B includes a Microsoft Word version of the transitional program. The final version of the manual comprises core care bundle components, resources, and tools of the Home Health Transitional Care Program for Elderly heart failure patients.

Care Bundle Interventions

Care bundles are evidence-based interventions that are categorized together in a single protocol, in efforts to improve patient health care outcome. According to the Institute for Health Improvement (2014), care bundles aim to improve care standards and patient health care outcome by promoting the consistent implementation evidence-based

interventions. The effective and consistent implementation can improve patient health care outcomes (Institute for Health Improvement, 2014). The major concepts of the care bundle include transition care planning, medication management, patient education and engagement, and physician follow-up care.

Transitional care planning. Within 24 to 48 hours post inpatient discharge, an APN conducts a comprehensive assessment of patient and caregiver needs. Standardized transition planning documents to include the Outcome and Assessment Information Set version C1 (OASIS–C1) is utilized to document patients' admission assessment. The APN conducting the admission transitional care planning follows a scripted dialogue to inform patients and caregivers regarding their plan of care.

Medication management. A universal Medication Profile form enables standardized documentation of medications and reconciliation of medication. This form provides a list of the patient's medication regimen. Up to four medication reviews can be conducted per form, and each form provides a comprehensive side effect reference. The side-effect reference is a teaching tool to help patients and their caregivers identify and monitor for potential side effects associated with medications on the patient's regimen.

Patient education and engagement. Heart failure education and counseling conducted with patients and caregivers promote active participation in plan of care including informed decision-making. Educational resources on indications of worsening condition and how to respond using knowledge of "red flags" enables patients and caregivers to manage their care effectively. Education practices include "teach-back" to assess the degree of patients' and caregivers' understanding and allows details of

education to be explained in their words. Educational materials designed for this program align with the patient's ability to understand as documents are at a fifth grade reading level or below.

Physician follow up care. A visiting APN schedules or verifies patient follow-up visits with the patient's specialist or primary care provider. A follow-up visit log is completed by the APN denoting post inpatient discharge appointments with the patient's specialist or primary care provider, other supplemental appointments, and the weekly APN follow-up phone call. The scripted weekly phone call conducted by the APN examines and emphasizes heart failure education and self-care management activities.

Step-by-Step Series of Actions

The care bundle interventions for this Home Health Transitional Program for Elderly heart failure patients are addressed through an amalgamation of home visits and weekly follow-up phone calls by an APN. APN home visits and weekly follow-up phone calls focus on a 60-day home health episode post inpatient hospital discharge for heart failure related diagnoses. The 60-day intervention period includes the following:

- Initial start-of-care visit
    - APN contacts patient via telephone post inpatient discharge and schedules visits within 24 to 48 hours.
    - APN visit within 24 to 48 hours post inpatient discharge; provides introduction of transitional care program; completes a comprehensive assessment (OASIS-C1).

  - APN reconciles the patient's medications using the Medication Profile and Side Effects form. A consultation with the patient's primary care physician and pharmacist is conducted as needed.
  - APN explains the purpose and how to utilize the patient's personal health record. A care plan is developed with the patient and caregiver based a comprehensive assessment completed by the APN. APN reviews the "red flag" symptoms and recall using "teach back" method. APN provides the patient and caregiver with the home health agency's phone number and explains the after-hours on-call protocol.
  - APN schedules or confirms follow-up appointment with the patient's primary care physician or specialist, schedules subsequent APN visits and weekly APN follow-up phone calls. All patient appointments are documented on the follow-up visit log.

- Subsequent home visits
  - APN completes a weekly patient assessment using a designated form for corresponding visits.
  - APN reviews and reconciles the patient's medications each visit as needed to avoid medication errors.
  - APN reviews the patient's personal health record and personal goals with patient and caregiver each visit.

  - APN reviews the disease process, red flag symptoms, and diet each visit with the patient and caregiver using the teach back method to assess their understanding and recall of the information.
  - APN reviews and updates the patients follow-up visit log each visit as needed.
- Weekly APN follow-up phone call
  - APN makes weekly phone call to patient to assess the patient's compliance with their plan of care.

Educational Resources and Forms

The assessment forms and educational resources provided in this manual provide a foundation for the Home Health Transitional Care Program for Elderly heart failure Patients. Key assessment forms, educational resources, and tools used include the OASIS-C1, subsequent visit forms, Medication Profile and Side Effects form, personal health record, and heart failure zone flyer. The manual includes evidence scripts for the APN to follow as a measure to effective approach evidence-based treatment and enhance knowledge base of patient regarding heart failure.

Evaluation of Findings

The focus of the evaluation process for this scholarly developmental project began with the recognition of the key purpose and proposed use of the Home Health Transitional Care Program for Elderly heart failure Patients. This section outlines the transitional care program evaluation of findings. I analyzed the evaluation indicators and performance measures to ensure the program construct demonstrated program

improvement, program accomplishments, and met program goals and objectives (Hodges & Videto, 2011). A home health advisory committee reviewed the project. Representatives included a home health agency's administrator; the agency's director of nursing; the medical director, and two community health care consumers from the targeted patient population. The health care consumers assessed the transitional program not only in terms of writing clarity and subject importance, but also in terms of their own experiences and knowledge related to heart failure.

The advisory committee members were invited via telephone to determine readiness and willingness to participate in the home health transitional program content review. The committee members were given two weeks to review content of the programs and provide feedback. At the end of the two-week time limit all content review feedback forms were returned to the agency's administrator and I collected the forms from the agency.

I analyzed the content review from the agency's personnel using content validity for questions numbers 1, 2, and 3 and face validity for questions numbers 4 and 5 as a supplement form of validity. The agency's staff responses indicated that they strongly agreed with number 1, 2, and 3 of the content review and their responses indicated yes for number 4 and 5 of the review questions indicating unanimous consensus. I analyzed the content review from the two health care consumer members using a combination of content validity and face validity as a supplemental form of validity. The responses from both members signified yes with number 1, 2, and 3 of the content review survey indicating unanimous consensus on the review questions. Analysis of the feedback

provided by the advisory committee members yielded a Content Validity Ratio score of 1.00. Face validity was also measured to ensure clarity and unambiguousness of the construct and yielded unanimous conclusion of content validity.

The health care consumer review participants did not make any recommendation and comments were concurrent with the gaps in transitional care and the need to develop the home health transitional care program. The only recommendation from the agency's review members was to replace OASIS-C with the updated version OASIS-C1 that is set for implementation January 1, 2015, per the Centers for Medicare and Medicaid. The modification was made and all committee members deemed the content applicable and relevant for the intended usage.

The patient educational resources and tools of the Home Health Transitional Care Program for Elderly heart failure patients was assess for readability to be at a fifth grade level or below using the readability feature in Microsoft Word for Macintosh computers. Readability formulas found at www.readabilityformulas.com was used as a second evaluation tool to ensure readability met the criteria to be at a fifth grade level or below. Patient-facing materials were assessed using guidelines to determine reading level, identify jargon, and complex words. These processes were completed to ensure educational materials presented to patients aligned with their abilities to understand the material. Like many innovations, the home health transitional care program using a care bundle of evidence-based resources will be refined through trial and practice.

Findings in Context of Literature and Framework

This transitional care program encompassed care bundle interventions to include patient education and engagement, self-care management, medication management, and system factors such as care coordination to include follow-up appointments for supporting transitional care from inpatient hospital settings to home to prevent avoidable rehospitalizations (Naylor et al., 2013). A review of the literature confirmed that increased complexity of health care, rising numbers of patients with chronic illnesses, and mounting costs of health care amplify the need to address gaps and improve transitional care (Coleman et al., 2006). The studies reviewed varied in design from cross-sectional survey, prospective study, to randomized-controlled trials.

According to Coleman et al. (2009) a high percentage of heart failure rehospitalizations occur within 30 days post inpatient discharge. This transitional care program found that comprehensive follow-up home health visits directed by an APN utilizing standardized documents and scripted dialogue facilitates the identification of individualized patient care goals and coordination of care. Findings similar to literature conducted by Pogorzelska et al. (2011) demonstrated that transitional care programs care bundle interventions were an effective evidence-based strategy for decreasing avoidable rehospitalizations among elderly heart failure patients ages 65 years old and older transitioning from inpatient hospitals settings to home. This transitional care program found that a comprehensive plan of care guided by APNs enabled them to individualize patient education, self-care management activities, medication management, and health care provider follow-ups post discharge for improving clinical outcomes among the target

population. This approach is especially important to reduce preventable heart failure exacerbations. Findings similar to literature conducted by Stauffer et al. (2011) and Voss et al. (2011) showed that the versatility of APNs or transition coaches help to ensure patient needs are met across health care settings in effort to improve clinical and financial outcomes and reduce preventable rehospitalizations for the target population. This prompted the development of this transitional care program for elderly home health heart failure patients age 65 years old and older.

According to Naylor (2011) individuals with heart failure often face significant medication management challenges due to lack of adherence to medications prescribed post discharge which is a leading cause of avoidable rehospitalizations among the target population. This transitional care program provides continuity of care by the same APN to address medication management behaviors utilizing standardized documentation and medication reconciliation protocols. Weekly home visits and weekly follow-up phone calls by the APN reinforce medication teaching and monitoring for potential side effects. The findings similar to research conducted by Neff et al. (2003) literature findings support APN directed medication management emphasizing adherence to medication regimens and patient education about medications to reduce avoidable rehospitalizations among the target patient population.

In developing and designing this transitional care program, the home-based chronic care model guided the development of the program as it expands the potential for heart failure self-management success and provided a foundation for home health's integral role in the management of chronic diseases (Wagner, 2009). Heart failure

education is a key care bundle intervention of the transitional program and emphasizes recognition of heart failure red flag symptoms and self-care management activities. Face to face contact with the APN helps to ensure patients and caregivers understand teaching provided using teach back practices to assess their degree of understanding. Similar to research conducted by Coleman et al., (2009) the findings of this DNP project show that the principle behind patient education and engagement led by an APN who uses teach back methods to promote self-care management among patient and caregivers is crucial to transitional care. Post hospital follow-up visits with heart failure patients' primary care physician and specialist is another important strategy of the transitional care program to prevent unnecessary rehospitalizations. The coordination of follow-up appointments by the APN is an effective strategy to help ensure patients attend and effectively participate at their follow up appointments. This evidence supports the value of post hospitalization follow-up with primary care providers and specialist (Burke & Coleman, 2013). Coleman and colleagues (2009) reported that patients with heart failure who fare followed up by their primary care provider and specialist within 30 days of inpatient hospital discharge had lower rates of rehospitalization.

Evidence was sufficient to support the development of this transitional care program designed to address the challenges faced by the current health care systems in decreasing preventable rehospitalizations among elderly home health heart failure patients ages 65 years old and older. The care bundle interventions guided by APNs provide an effective approach in bridging gaps in transitional care while achieving optimal health care outcomes among the target patient population. Keeping the targeted

patient population from returning to the hospital will substantiate of success of this transitional care program.

Implications for Practice

Heart failure is a multifaceted, costly condition that affects approximately six million people in the America annually (Jencks, 2009). Heart failure is the leading cause of many preventable rehospitalization among elderly adults age 65 years and older in the United States (Lonowski, 2012). Despite the validated effectiveness of piloted transitional programs nationwide, inadequately implemented transitions in care and self-care management adversely impact the health and wellness of patients and health care outcomes remain suboptimal (Bradke, 2013). The evidence-based home health transitional care program will play a pivotal role in addressing these problems, specifically in the home setting.

Implications for Future Research

Effective transitions of care from inpatient hospital settings to home are vital to delivering high quality patient care and decreasing preventable rehospitalization. Evidence-based practices in the home health transitional care program can inform current and future initiatives. Home health care agencies can implement the transitional care program to reduce heart failure rehospitalizations and health care costs. More research is needed on transitions between inpatient settings to home, which present further opportunities to improve both quality of care and health care cost.

Implications for Social Change

Our fragmented health care system often fails to effectively transition patients between health care setting and as a result, poor care coordination contributes to the revolving door syndrome. Heart failure rehospitalization is a frequent and sometimes life-threatening event that accounts for a large proportion of national health care expenditure and is associated with gaps in transitional care (Jencks, 2009). Reimbursements to hospitals have been reduced for heart failure patients who are readmitted within 30 days of discharge for heart failure related diagnosis (Centers for Medicare and Medicaid Services, 2014). Many hospital readmissions are avoidable; therefore, the evidence-based heart failure transitional care program could bridge gaps in transitional care.

The Centers for Medicare and Medicaid Services (2014) reports that ineffective transitional care from inpatient hospital settings often lead to rehospitaliztion within 30 days. Preventable rehospitalizations are often the result of patients failure to adhere to prescribed medical regimens and self-care management. Effective self-care management has often been difficult for elderly patients age 65 years and older. Therefore, the innovative and effective approaches outlined in this evidence-based home health transitional care program could improve individual heart failure disease and self-care management among the identified patient population. The transitional program could potentially help patients with heart failure follow a plan of care resulting in a better quality of life and improved health outcomes.

Project Strengths, Limitations, and Recommendations

Strengths

The strength of the project supports the need for effective transitions of care from inpatient hospital settings to home in efforts to reduce avoidable rehospitalzation. The project advocates for home health care to be part of the continuum of health care. Since many patients are discharge with home health care services, it is essential that home health care providers provide continuity of care (Centers for Medicare and Medicaid Services, 2014). Another strength of this project is that it could be simply replicated and initiated in various health settings.

Limitations

Health care is in a continuous state of constant change and the numbers of patients diagnosed with heart failure are estimated to continue to rise annually. One limitation of the project is the reasonable prediction that elderly heart failure patients will be inaptly discharged from inpatient hospital settings to home and subsequently, these patients conditions will decline and result in rehospitalizations. Another limitation is despite the evidence-based recommendations for transitional care strategies and guidelines to improve quality of care and health care outcomes implementation of the program could introduce new challenges for health care providers.

Recommendations for Reduction in Limitations

To help reduce the limitations of this project the home health transitional care program specifically addresses the needs of the identified patient population upon admission to home health care from inpatient hospital settings. It is recommended that

home health care organizations implement the evidence-based transitional care program to achieve goals of reducing avoidable rehospitalization. It is vital to implement the transitional care program strategies to ensure successful care transitions occur. An additional recommendation would be to increase the amount of further research on transitional care specific to home health care.

Analysis of Self

It is constructive to perform a self-analysis of yourself at the conclusion of a project to evaluate the knowledge and understanding you have gained and to learn how you have matured professionally. Self-analysis is vital for interpersonal and professional development and should be done on a continuous basis. My self-analysis will outline my accomplishments related to the development of this evidence-based scholarly project.

Scholar

As a scholarly I possess a foundation that is constructed on two decades of knowledge and experience in expert nursing care, evidence-based clinical decision-making and nursing leadership skills. I reviewed scholarly literature to ensure the project practices were grounded in evidence-based practices. As a DNP trained practitioner I have developed scholarly skills throughout the development of this project to improve patient outcomes based on evidence-based practices. I will remain up to date on current practice information in efforts to translate research findings to improve nursing care and practices.

Practitioner

As a practitioner my practice will be guided by using evidence-based practices to meet the demands of the ever-changing health care environment. The DNP education provided me with the clinical expertise, knowledge, and skills to be an effective and practical change agent. The DNP education enables me to assume clinical and leadership roles to provide high quality, cost-effective, and evidence-based care to guide nursing practice. As a DNP trained practitioner I possess the ability to evaluate evidence, translate research into practice, and apply study findings in decision-making, and execute practical clinical innovations to change nursing practice.

Project Developer

To finalize my DNP education I chose to plan and design a developmental project to address transitional care in elderly home health patients with heart failure ages 65 and older. As a home health nurse and nurse educator I recognize the importance of effective transitional care and the need for evidence-based interventions to reduce avoidable rehospitalizations in elderly heart failure patients. My scholarly project embraces the synthesis of both my practicum experience and coursework. My practicum and educational experiences as a project developer enabled me the opportunity to evaluate home health organizational policies and procedures and identify the need for the development of this evidence-based transitional program to improve the quality of patient care and health care outcome. The deliverable scholarly product was guided and reviewed by my practicum preceptor, my committee chair, committee member, and a home health advisory committee.

As a project developer I focused on using health care research and evidence-based strategies to support the development of this home health transitional program. Best practices are generated from the development and application of new knowledge into practice. As a project developer with the desired outcome of developing a home heath transitional care program, the challenging process and knowledge attained have revealed a different perspective toward the development of future scholarly projects.

Future Professional Development

Reducing preventable rehospitalizations is an opportunity to improve patients' quality of care and reduce health care cost. This home health transitional care program for elderly heart failure patients will serve as a guide for home health care agencies to assess, prioritize, implement, and evaluate strategies to reduce preventable rehospitalizations. This transitional care program could be duplicated and initiated in other health settings to improve transitional care and reduce rehospitalizations and improve patients' quality of life. As a new DNP leader I am looking forward to working with home health care agencies and other health care entities to support transitional care from inpatient settings to home while improving health care outcomes of patients.

Summary

The public burden of heart failure is evident in the hospitalization, rehospitalization, and rising health care cost of caring for this patient population Jencks et al., 2009). Effective transitional care programs could prevent rehospitalizations, improve quality of care and decrease cost for patients with heart failure (Coleman et al., 2009). This home health transitional program for elderly heart failure patients ages 65 years and

older provides health care organizations and health care providers with an evidence-base program that could optimize health care outcomes. This evidence-based scholarly project has increased my knowledge and understanding to be an effective nursing scholar, practitioner, project developer, and personal and professional growth and development.

Section 5: Scholarly Product

Introduction

As a DNP prepared practitioner the development, evaluation, and dissemination of evidenced-based care delivery strategies that meet the needs of patients is essential (American Association of Colleges of Nursing, 2006). Improving transitional care is an essential strategy to decreased rehospitalization rates among elderly heart failure patients ages 65 years and older (Coleman et al., 2009). Effective transitional care can potentially reduce readmissions, enhance patient care quality and safety, improve patient health outcomes, and lower health care costs (Naylor et al. 2009). The focus of this DNP project was to develop a home health transitional care program for elderly patients ages 65 years and older transitioning from inpatient settings to home care settings using evidence-based care bundles strategies.

Manuscript Publication

Plans for dissemination include making the Home Health Transitional Care Program accessible online on the Home Care Association of Florida website. The final scholarly manual comprises three sections to include highlights of key components of the care bundle; step-by-step series of action to support implementing care bundle interventions; and assessment forms and educational resources and tools for care bundle task implementation. Each section of the manual will be accessible to members of the Home Care Association of Florida as a resource for all provider types. The Home Care Association of Florida provides advocacy, communication, and representation for home

health care providers, with information needed to deliver high quality and cost effective care to patients in the home setting.

A second fit for dissemination would be in the Home Health Care Management and Practice journal. The Home Health Care Management and Practice journal provides an opportunity for writing about home health care in a peer-reviewed journal. This educational journal appeals to nurses and other specialty areas that impact the lives of patients at home. Specific peer-reviewed guidelines and requirements for publication would need to be met prior to publication in the journal. Submitting the manuscript for publication is important because it provides a peer review on the topic (Terry, 2014).

Project Summary

Some of the greatest inefficiencies in the health care system come during the time of transitions of care. The developmental project I selected was based on the need for effective transitional care programs especially since older and chronically ill patients are entering the health system at rapid rates due to the aging population of baby boomers. I developed this home health transitional program as a resource for home health care agencies to provide effective evidence-based care utilizing care bundles of interventions obtained from scholarly literature.

This project underwent several modifications to attain the final product. Modifications made to the project were based on recommendations from my program chair, my second committee member, my preceptor, and the selected home health advisory committee members. My practicum experiences were completed in two separate home health agencies. This opportunity enabled me to partake in activities to develop the

transitional care program. Based on the recommendation of my second committee chair previously printed educational resources were utilized as part of the program ensuring the materials readability was at a 5th grade level.

The home health transitional care program was developed for elderly heart failure patients ages 65 years and older because the literature suggests that heart failure is the most common cause of hospitalization and rehospitalization in this patient population. The transitional care program could advance the practice of nursing as it provides a comprehensive focus, concentrating on the patients understanding of HF, medication reconciliation and management, and helping patients with self-care management to prevent decline, and promote physician follow-up. This program utilizes an APN as the primary coordinator of care to actively engage patients and caregivers to achieve improved patient outcomes and prevent events that lead to rehospitalization.

Program Evaluation Report

This evaluation plan describes how the program was analyzed and evaluated and how the evaluation results were used to make modifications. Program evaluations should be designed to establish accomplishments of the program, any improvements needed, and the accomplishment of program goals and objectives (Hodges & Videto, 2011). A home health advisory committee conducted a content review of this developmental project. The measurement tools used for this developmental project included content validity and face validity. Face validity was used as supplement to improved the measurement procedures.

The evaluation report yielded results based on a review of content by a home health advisory committee. Committee members included two patients from the targeted

patient population and representatives from a home health agency to include the administrator; the director of nursing; and the medical director. I collected the content review responses from the home health agency's administrator who initially distributed printed copies to the designated committee members during the agency's scheduled a bi-annual professional advisory committee meeting. I analyzed the feedback provided by the advisory committee members and based on that analysis calculated the Content Validity Ratio score of 1.00. Face validity was also measured and yielded undisputed conclusion of content validity.

Feedback provided by the advisory committee members endorsed the contents of my transitional care program. The committee members responded to content review questions and comments suggested that the transitional care programs care bundle assessment and educational resources and tools were relevant and based on current evidence-based practices. The home health transitional care programs care bundle of evidence-based assessments, resources, and tools were examined to ensure readability for a reading level of 5th grade or below.

Conclusion

The focus of this evidence-based scholarly project was to develop a home health transitional care program for elderly patients ages 65 years and older transitioning from inpatient settings to home using care bundles comprised of evidence-based strategies. Transitions of care from inpatient settings to home are a period of susceptibility for elderly patients with HF related diagnosis. Transitions of care that are ineffective leave this patient population at risk for rehospitalization (Jencks et al., 2009). The transitional

care program provided resources to assist elderly heart failure patients to effectively transition from inpatient hospital settings to the home post admission for a HF associated diagnosis. According to the Joint Commission (2013) Poorly executed transitional care frequently lead to increased adverse events, rehospitalization rates, and health care cost.

The outcomes of this scholarly evidence-based project will impact gaps in transitional care by addressing potential risks to HF patients during transitions of care by providing educational resources, tools, and support need for self-care management. This project will advance the practice of nursing by providing an evidence-based resource for nurses in various health care settings. The final DNP project serves as a basis for future scholarly practice in transitional home health settings (American Association of Colleges of Nursing, 2006).

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Appendix A: Content Review Questions

Health care consumers transitional care content review questions

1. The home health transitional program collaborates with patients and caregivers to develop a plan of care?

   1 ☐ Yes
   2 ☐ No

2. The home health transitional programs patient education process is designed to improve patient and caregiver understanding of heart failure self-care?

   1 ☐ Yes
   2 ☐ No

3. The home health transitional program provides satisfactory management and education from admission to discharge, appropriate follow-up, and appropriate medication management that can reduce rehospitalization rates and improve quality of care?

   1 ☐ Yes
   2 ☐ No

Comments:

Areas for improvement:

Professional Advisory Committee transitional care content review questions

1. The home health transitional program design, care bundle interventions, and tools describe characteristics that are aimed at avoiding rehospitalization among heart failure patients?

   1 ☐ Strongly Agree
   2 ☐ Agree
   3 ☐ Disagree
   4 ☐ Strongly Disagree

2. The home health transitional program includes: (1) a systematic arrangement of patient care from admission through discharge, (2) comprehensive patient assessments, (3) patient and caregiver education, and (4) coordinated follow-up care, which can have a positive impact on patient health care outcomes?

   1 ☐ Strongly Agree
   2 ☐ Agree
   3 ☐ Disagree
   4 ☐ Strongly Disagree

3. The transitional care program design will help health care was developed with insight and best practices contributed from key home health and transitional care leaders?

   1 ☐ Strongly Agree
   2 ☐ Agree
   3 ☐ Disagree
   4 ☐ Strongly Disagree

4. The content of the home health transitional program is accurate based on the review of literature?

1 ☐ Yes
2 ☐ No

5. The readability of the information presented in the home health transitional program is appropriateness for the target population?

1 ☐ Yes
2 ☐ No

Comments:

Areas for improvement:

Appendix B: Transition Program

A Home Health Transitional Care Program for Elderly Heart Failure Patients

Section One

Key Components of Transitional Care Bundle Interventions

Transitional Care Program Application Overview

This home health transitional care program was designed to addresses potential threats to the well-being and health care outcomes of elderly heart failure (HF) patients during transitions of care. This transitional care program provides a compendium of evidence-based care bundle activities that address transitional care planning, medication management, patient education and engagement, and physician follow-up to assist the targeted HF population to successfully transition from the inpatient hospital settings to home.

This manual includes evidence-based care bundle strategies and step-by-step series of actions to support staff in implementing care bundle interventions. This manual includes assessment forms and educational resources for care bundle tasks. To ensure easy comprehension the patient educational materials were assessed for readability to be at a fifth grade level.

This application manual includes the essential evidence-based care bundle components and resources to implement the Home Health Transitional Program for Elderly HF Patient:

- Care Bundle Categories
- Step-by-step series of actions
- Home Visit Scripts and Sequences
- Telephone Follow-up Script
- Assessment Forms, Educational Resources, and Tools

Transitional Care Bundle Interventions

Care bundles aim to improve care standards and patient health care outcome by promoting the consistent implementation evidence-based interventions (Institute for Health Improvement, 2014). The major concepts of the care bundle include transitional care planning, patient engagement and education, physician follow-up care, medication management.

Intervention Category	Description	Transitional Care Interventions
Transitional Care Planning	Formal procedures that enables the successful transitions of care among health care settings • Practitioner to coordinate transitional plan of care • Patient and caregiver transitional needs assessed and managed • Formal Assessment tool to document and develop plan of care	Advance Practice Nurse (APN) conducts transitional planning of care 24 to 48 hours post inpatient discharge. Transition care planning • Collaborate with patients and caregiver to complete an individualized assessment following sequence of visit • Initiate and update health record as needed - Medication reconciliation, - Disease specific patient education, - Arrange follow up physician appointment(s). • A scripted conversation with patient and caregiver regarding transitional care planning.
Medication Management	To safeguard the proper usage of medications by the	Assessment of Medications • Document all medications to include over the

	patient and caregiver as per the plan of care 1. Medication Assessment 2. Patient and caregiver Education 3. Medication resources/tools	counter (OTC), and herbal medications • Recognize any problems with medications • Denote polypharmacy • Follow to medication schedule Patient and Caregiver Medication Education • Use 'teach back' method to ensure patient and caregiver comprehend medications • Describe each medication to include the purpose, route, correct time, correct dosage, and side effects/interactions • Explain the purpose for any medication changes Medication Resources/Tools • Medication Profile with Side Effect completed by APN upon initial assessment and as needed during subsequent visits • Update Medications on Personal Health Record as needed
Patient Education and Engagement	Provide patient and caregiver with education to promote active engagement in self-care activities and informed decision-making 1. Knowledge and understanding	Patient and caregiver HF education and transitional care plan • Education on condition and indications that condition is worsening using "red flags" • Education appropriate for targeted population; literacy level of 5th grade or below • Patients personal health record and personal

	regarding transitional plan of care 2. Patient-centered communication 3. Self-care management skills	goals discussion • Patient caregiver HF educational handout Effective patient-center communication • Translation of information to ensure patient understands what is being communicated Self-care management skills development • Use of 'teach back' to enhance patient and family education practices • Assess degree of understanding based on 'teach back' and replication of plan of care
Physician Follow-up	To ensure safe and effective post discharge follow-up care activities. 1. Timely assess to health care providers after discharge 2. Coordination of APN visits and weekly follow-up phone calls	Patient and caregiver timely access to post discharge follow-up as per patients condition • APN schedules/confirms post discharge follow-up appointment with primary care provider or specialist • 24/7 access to home health agency staff • APN visit within 24-48 hours post inpatient discharge Documentation of APN Home visit/Follow-up phone calls • Document primary care provider and specialist follow-up visits on the Home visit/Follow-up phone call log • Document scheduled APN home visits and follow-up phone calls on the designated log

Section Two

Care Bundle Interventions Step-by-step Series of Actions

Step-by-step activities are as follow:

Initial Start of Care Visit

- APN contacts patient via telephone post inpatient discharge and schedules visits within 24 to 48 hours.
- APN visits within 24 to 48 hours post inpatient discharge; introduces transitional care program; completes comprehensive assessment (OASIS-C1 assessment).
- Medication reconciliation using Medication Profile and Side Effects form and consultation with primary care physician and pharmacist as needed.
- Personal health record and personal goals discussion; development of plan of care based on comprehensive assessment and patient and caregiver goals; introduction of "red flag" symptoms and recall using 'teach back' method. Provide home health agency's phone number and explain after-hours on-call protocol.
- Schedule/confirm follow-up appointment with primary care physician or specialist; schedule subsequent APN visits and follow-up phone calls; document on Follow-up visit/phone log.

Subsequent Home Visits

- Patient assessment using designated form for corresponding visit.
- Medication reconciliation continuation as needed.
- Review patient personal health record and personal goals with patient.
- Disease process, diet, medication education using selected education material appropriate to health literacy level and using teach back method.
- Discuss red flag symptoms and recall using the ‘teach back’ method.
- Review follow-up visit/phone log and update as needed.

Weekly APN Follow-Up Phone Calls

- Weekly phone call to patient
- Assess patient's condition and compliance with their plan of care
- Review of the patient's the symptoms and condition and determine need to schedule an as needed follow-up visit or a phone call with APN or physician (Review the “red flag” symptoms if needed)
- Assess medication regimen and compliance

- Determine if supplemental follow-up appointments made since last APN home visit

Phone Call to Initiate Home Care Script

- Contact patient upon notification that patient has been discharged from inpatient facility to schedule home visit within 24 48 hours.

- Hello Mr./Ms./Miss/Mrs._____, my name is ____. I am an Advance Practice Nurse. Your physician has written an order for home health to teaching you about Heart Failure and assist you with your medications. I will also assist in getting you prepared for your follow-up physician appointment.

- I will be visiting your home once a week visits and once a week calls to see how you're doing for the next nine weeks.

- I would like to arrange a time for to come out for my visit during a time that is fitting for you and your caregiver who assists you with your care. What is a good time and day for us to meet for the home visit?

- Could you please take a few minutes before I come for the scheduled visit and gather up all your medications, that includes any prescribed medications and any medications bought over the counter such as vitamins or eye drops, I will also need to review your discharge paperwork and any medication lists you have, from the hospital.

- Great—I look forward to meeting you and will see you on {date} at {time}.

Initial Home Visit Sequence

- Introduction of self and home care agency – establish rapport
- Clarify APN role and intent and length of HF transitional care program
- Question patient about a goals he or she can attain for the duration of the nine-week intervention.
- Begin with identifying and recognizing patient's interests and needs – begin with the completion of the OASIS-C1 assessment questions documenting findings on the OASIS-C1 assessment form.
- Ask about patient's management of medication (*In what way do you track of your medication*? *Can you tell me what medications are you taking and how often you are taking them?*). Complete Medication Profile in its entirety identifying side effects for all ordered and OTC medications patient is taking identifying discrepancies reconciling medication. Contact physician or pharmacist as needed.
- Allow patients or caregiver to list all the medications they are taking in their patient health record. Identify medications prior to and post hospital stay and provide education as appropriate.
- Utilize the patient health record and individualized patient goal as a guide to focus educational materials, the "Red Flags," and the medication regimen; use 'teach back' method to reinforce teaching.
- Review discharge documents and inquire about follow-up primary care provider and specialist visit. If discharge documentation is not available or does not list follow-up appoint information, contact the primary care provider to schedule the post discharge visit and document on the follow-up visit/phone log

- Upon completion of the visit, support the patient and summarize visit recapping key components of education; review with to the patient the content that will be the focus of the weekly follow-up phone calls.

Subsequent Home Visit Sequence

- Introduction of self – establish rapport
- Identify purpose visit
- Question patient about a personal goal he or she can attain for the duration of the nine-week intervention.
- Begin with identifying and recognizing patient's interests and needs – complete patient assessment on designated assessment form corresponding with visit week
- Inquire about patient's medication regimen (*Have their been any changes in your medication*? *Have you experienced any side effects?*). Update and reconciling medication profile list as needed. Contact physician or pharmacist as needed.
- Allow patients or caregiver to update medications list in their patient health record as needed.
- Utilize the patient health record and individualized patient goal as a guide to focus educational materials, the "Red Flags," and the medication regimen; use 'teach back' method to reinforce teaching.
- Review and complete follow-up visit/phone log as applicable
- Upon completion of the visit, support the patient and summarize visit recapping key components of education; review with to the patient the content that will be the focus of the weekly follow-up phone calls.

Visit Tips

Use the following communication methods when working with patients and caregivers:

- Active Listening
- Open-Ended Questions
- Reframing/ Paraphrasing

Weekly Follow-up Phone Script

Hello Mr./Ms./Mrs./Miss_____, my name is _____, and I'm calling from (name of home care agency). As discussed during your home visit I am checking in because it has been a few days since I was at your home and I wanted to see how you are doing. How are you feeling?

- Do you have any questions about your condition?
- Do you have any questions about your plan of care?
- Do you know which symptoms to watch for that would mean you would need to call your doctor right away? (Review the "red flag" symptoms if needed)
- Are you taking your medication(s) as your doctor ordered?
- Are you taking any other medications that are not on the list? (Explain rationale to the patient— "this information is helpful for us to know because some drugs when used together can cause different interactions and can be less effective."
- Do you have any questions about your medications?
- Did make any follow-up appointments since my last home visit? (if so "did you write the visit date and time on the log"
- Do you have any questions about any instructions that I have provided today?

Thank you for speaking with me today. If you have any additional questions, please call me at (phone number-the home health care agency's phone number).

Section Three

Assessment Forms, Educational Resources, and Tools

OASIS-C1

OMB #0938-0760

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0760. The time required to complete this information collection is estimated to average 52.8 minutes (0.9 minutes per item), including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Home Health Patient Tracking Sheet

(M0010) C M S Certification Number: __ __ __ __ __ __

(M0014) Branch State: __ __

(M0016) Branch I D Number: __ __ __ __ __ __ __ __ __ __

(M0018) National Provider Identifier (N P I) for the attending physician who has signed the plan of care:

__ __ __ __ __ __ __ __ __ __ ☐ **UK – Unknown or Not Available**

(M0020) Patient I D Number: __

(M0030) Start of Care Date: __ __/__ __/__ __ __ __
month / day / year

(M0032) Resumption of Care Date: __ __/__ __/__ __ __ __ ☐ **NA - Not Applicable**
month / day / year

(M0040) Patient Name:

__ __
(First) (M I) (Last) (Suffix)

(M0050) Patient State of Residence: __ __

(M0060) Patient Zip Code: __ __ __ __ __ __ __ __ __

(M0063) Medicare Number: __ __ __ __ __ __ __ __ __ __ __ __ ☐ **NA – No Medicare**
(including suffix)

(M0064) Social Security Number: __ __ __-__ __-__ __ __ __ ☐ **UK – Unknown or Not Available**

(M0065) Medicaid Number: __ __ __ __ __ __ __ __ __ __ __ __ __ __ ☐ **NA – No Medicaid**

(M0066) Birth Date: __ __/__ __/__ __ __ __
month / day / year

(M0069) Gender:

☐ 1 - Male
☐ 2 - Female

(M0140) Race/Ethnicity: (Mark all that apply.)

☐ 1 - American Indian or Alaska Native
☐ 2 - Asian
☐ 3 - Black or African-American
☐ 4 - Hispanic or Latino
☐ 5 - Native Hawaiian or Pacific Islander
☐ 6 - White

OMB #0938-0760

(M0150) Current Payment Sources for Home Care: (Mark all that apply.)

- ☐ 0 - None; no charge for current services
- ☐ 1 - Medicare (traditional fee-for-service)
- ☐ 2 - Medicare (HMO/managed care/Advantage plan)
- ☐ 3 - Medicaid (traditional fee-for-service)
- ☐ 4 - Medicaid (HMO/managed care)
- ☐ 5 - Workers' compensation
- ☐ 6 - Title programs (for example, Title III, V, or XX)
- ☐ 7 - Other government (for example, TriCare, VA)
- ☐ 8 - Private insurance
- ☐ 9 - Private HMO/managed care
- ☐ 10 - Self-pay
- ☐ 11 - Other (specify) _____
- ☐ UK - Unknown

OMB #0938-0760

Outcome and Assessment Information Set
Items to be Used at Specific Time Points

Time Point	Items Used
Start of Care	M0010-M0030, M0040-M0150, M1000-M1036, M1100-M1306, M1308, M1320-M1410, M1600-M2002, M2010, M2020-M2250
Start of care—further visits planned	
Resumption of Care	M0032, M0080-M0110, M1000-M1036, M1100-M1306, M1308, M1320-M1410, M1600-M2002, M2010, M2020-M2250
Resumption of care (after inpatient stay)	
Follow-Up	M0080-M0100, M0110, M1020-M1030, M1200, M1242, M1306, M1308, M1322-M1342, M1400, M1610, M1620, M1630, M1810-M1840, M1850, M1860, M2030, M2200
Recertification (follow-up) assessment	
Other follow-up assessment	
Transfer to an Inpatient Facility	M0080-M0100, M1041-M1056, M1500, M1510, M2004, M2015, M2300-M2410, M2430, M0903, M0906
Transferred to an inpatient facility—patient not discharged from an agency	
Transferred to an inpatient facility—patient discharged from agency	
Discharge from Agency — Not to an Inpatient Facility	
Death at home	M0080-M0100, M0903, M0906
Discharge from agency	M0080-M0100, M1041-M1056, M1230, M1242, M1306-M1342, M1400, M1500-M1620, M1700-M1720, M1740, M1745, M1800-M1890, M2004, M2015-M2030, M2102, M2300-M2420, M0903, M0906

CLINICAL RECORD ITEMS

(M0080) Discipline of Person Completing Assessment:

☐ 1-RN ☐ 2-PT ☐ 3-SLP/ST ☐ 4-OT

(M0090) Date Assessment Completed: __ __ / __ __ / __ __ __ __
month / day / year

(M0100) This Assessment is Currently Being Completed for the Following Reason:

Start/Resumption of Care
- ☐ 1 – Start of care—further visits planned
- ☐ 3 – Resumption of care (after inpatient stay)

Follow-Up
- ☐ 4 – Recertification (follow-up) reassessment [*Go to M0110*]
- ☐ 5 – Other follow-up [*Go to M0110*]

Transfer to an Inpatient Facility
- ☐ 6 – Transferred to an inpatient facility—patient not discharged from agency [*Go to M1041*]
- ☐ 7 – Transferred to an inpatient facility—patient discharged from agency [*Go to M1041*]

Discharge from Agency — Not to an Inpatient Facility
- ☐ 8 – Death at home [*Go to M0903*]

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☐ 9 – Discharge from agency **[*Go to M1041*]**

(M0102) Date of Physician-ordered Start of Care (Resumption of Care): If the physician indicated a specific start of care (resumption of care) date when the patient was referred for home health services, record the date specified.

__ / __ / ____ **[*Go to M0110, if date entered*]**
month / day / year

☐ NA – No specific SOC date ordered by physician

(M0104) Date of Referral: Indicate the date that the written or verbal referral for initiation or resumption of care was received by the HHA.

__ / __ / ____
month / day / year

(M0110) Episode Timing: Is the Medicare home health payment episode for which this assessment will define a case mix group an "early" episode or a "later" episode in the patient's current sequence of adjacent Medicare home health payment episodes?

☐ 1 – Early
☐ 2 – Later
☐ UK – Unknown
☐ NA – Not Applicable: No Medicare case mix group to be defined by this assessment.

PATIENT HISTORY AND DIAGNOSES

(M1000) From which of the following **Inpatient Facilities** was the patient discharged within the past 14 days? **(Mark all that apply.)**

☐ 1 – Long-term nursing facility (NF)
☐ 2 – Skilled nursing facility (SNF / TCU)
☐ 3 – Short-stay acute hospital (IPPS)
☐ 4 – Long-term care hospital (LTCH)
☐ 5 – Inpatient rehabilitation hospital or unit (IRF)
☐ 6 – Psychiatric hospital or unit
☐ 7 – Other (specify) _____
☐ NA – Patient was not discharged from an inpatient facility **[*Go to M1016*]**

(M1005) Inpatient Discharge Date (most recent)

__ / __ / ____
month / day / year

☐ UK – Unknown

(M1010) List each **Inpatient Diagnosis** and ICD-9-C M code at the level of highest specificity for only those conditions treated during an inpatient stay within the last 14 days (no E-codes, or V-codes):

	Inpatient Facility Diagnosis	ICD-9-C M Code
a.	_____	___ . __
b.	_____	___ . __
c.	_____	___ . __
d.	_____	___ . __
e.	_____	___ . __
f.	_____	___ . __

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(M1016) Diagnoses Requiring Medical or Treatment Regimen Change Within Past 14 Days: List the patient's Medical Diagnoses and ICD-9-C M codes at the level of highest specificity for those conditions requiring changed medical or treatment regimen within the past 14 days (no surgical, E-codes, or V-codes):

	Changed Medical Regimen Diagnosis	ICD-9-C M Code
a.	_____	___ ___ ___ . ___ ___
b.	_____	___ ___ ___ . ___ ___
c.	_____	___ ___ ___ . ___ ___
d.	_____	___ ___ ___ . ___ ___
e.	_____	___ ___ ___ . ___ ___
f.	_____	___ ___ ___ . ___ ___

☐ NA - Not applicable (no medical or treatment regimen changes within the past 14 days)

(M1018) Conditions Prior to Medical or Treatment Regimen Change or Inpatient Stay Within Past 14 Days: If this patient experienced an inpatient facility discharge or change in medical or treatment regimen within the past 14 days, indicate any conditions that existed prior to the inpatient stay or change in medical or treatment regimen. **(Mark all that apply.)**

☐ 1 - Urinary incontinence
☐ 2 - Indwelling/suprapubic catheter
☐ 3 - Intractable pain
☐ 4 - Impaired decision-making
☐ 5 - Disruptive or socially inappropriate behavior
☐ 6 - Memory loss to the extent that supervision required
☐ 7 - None of the above
☐ NA - No inpatient facility discharge and no change in medical or treatment regimen in past 14 days
☐ UK - Unknown

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(M1020/1022/1024) Diagnoses, Symptom Control, and Payment Diagnoses: List each diagnosis for which the patient is receiving home care (Column 1) and enter its ICD-9-CM code at the level of highest specificity (no surgical/procedure codes) (Column 2). Diagnoses are listed in the order that best reflect the seriousness of each condition and support the disciplines and services provided. Rate the degree of symptom control for each condition (Column 2). Choose one value that represents the degree of symptom control appropriate for each diagnosis. V-codes (for M1020 or M1022) or E-codes (for M1022 only) may be used. ICD-9-CM sequencing requirements must be followed if multiple coding is indicated for any diagnoses. If a V-code is reported in place of a case mix diagnosis, then optional item M1024 Payment Diagnoses (Columns 3 and 4) may be completed. A case mix diagnosis is a diagnosis that determines the Medicare PPS case mix group. Do not assign symptom control ratings for V- or E-codes.

Code each row according to the following directions for each column:

Column 1: Enter the description of the diagnosis.

Column 2: Enter the ICD-9-C M code for the diagnosis described in Column 1;

Rate the degree of symptom control for the condition listed in Column 1 using the following scale:

0 - Asymptomatic, no treatment needed at this time

1 - Symptoms well controlled with current therapy

2 - Symptoms controlled with difficulty, affecting daily functioning; patient needs ongoing monitoring

3 - Symptoms poorly controlled; patient needs frequent adjustment in treatment and dose monitoring

4 - Symptoms poorly controlled; history of re-hospitalizations

Note that in Column 2 the rating for symptom control of each diagnosis should not be used to determine the sequencing of the diagnoses listed in Column 1. These are separate items and sequencing may not coincide. Sequencing of diagnoses should reflect the seriousness of each condition and support the disciplines and services provided.

Column 3: (OPTIONAL) If a V-code is assigned to any row in Column 2, in place of a case mix diagnosis, it may be necessary to complete optional item M1024 Payment Diagnoses (Columns 3 and 4). See OASIS-C Guidance Manual.

Column 4: (OPTIONAL) If a V-code in Column 2 is reported in place of a case mix diagnosis that requires multiple diagnosis codes under ICD-9-C M coding guidelines, enter the diagnosis descriptions and the ICD-9-C M codes in the same row in Columns 3 and 4. For example, if the case mix diagnosis is a manifestation code, record the diagnosis description and ICD-9-C M code for the underlying condition in Column 3 of that row and the diagnosis description and ICD-9-C M code for the manifestation in Column 4 of that row. Otherwise, leave Column 4 blank in that row.

(Form on next page)

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(M1020) Primary Diagnosis & (M1022) Other Diagnoses		(M1024) Payment Diagnoses (OPTIONAL)	
Column 1	Column 2	Column 3	Column 4
Diagnoses (Sequencing of diagnoses should reflect the seriousness of each condition and support the disciplines and services provided.)	ICD-9-C M and symptom control rating for each condition. Note that the sequencing of these ratings may not match the sequencing of the diagnoses	Complete if a V-code is assigned under certain circumstances to Column 2 in place of a case mix diagnosis.	Complete only if the V-code in Column 2 is reported in place of a case mix diagnosis that is a multiple coding situation (e.g., a manifestation code).
Description	ICD-9-C M / Symptom Control Rating	Description/ ICD-9-C M	Description/ ICD-9-C M
(M1020) Primary Diagnosis a. _____	(V-codes are allowed) a. (_ _ _ . _ _) ☐0 ☐1 ☐2 ☐3 ☐4	(V- or E-codes NOT allowed) a._____ (_ _ _ . _ _)	(V- or E-codes NOT allowed) a._____ (_ _ _ . _ _)
(M1022) Other Diagnoses b. _____	(V- or E-codes are allowed) b. (_ _ _ . _ _) ☐0 ☐1 ☐2 ☐3 ☐4	(V- or E-codes NOT allowed) b._____ (_ _ _ . _ _)	(V- or E-codes NOT allowed) b._____ (_ _ _ . _ _)
c. _____	c. (_ _ _ . _ _) ☐0 ☐1 ☐2 ☐3 ☐4	c._____ (_ _ _ . _ _)	c._____ (_ _ _ . _ _)
d. _____	d. (_ _ _ . _ _) ☐0 ☐1 ☐2 ☐3 ☐4	d._____ (_ _ _ . _ _)	d._____ (_ _ _ . _ _)
e. _____	e. (_ _ _ . _ _) ☐0 ☐1 ☐2 ☐3 ☐4	e._____ (_ _ _ . _ _)	e._____ (_ _ _ . _ _)
f. _____	f. (_ _ _ . _ _) ☐0 ☐1 ☐2 ☐3 ☐4	f._____ (_ _ _ . _ _)	f._____ (_ _ _ . _ _)

(M1030) Therapies the patient receives at home **(Mark all that apply.)**

- ☐ 1 - Intravenous or infusion therapy (excludes TPN)
- ☐ 2 - Parenteral nutrition (TPN or lipids)
- ☐ 3 - Enteral nutrition (nasogastric, gastrostomy, jejunostomy, or any other artificial entry into the alimentary canal)
- ☐ 4 - None of the above

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(M1033) Risk for Hospitalization: Which of the following signs or symptoms characterize this patient as at risk for hospitalization? **(Mark all that apply.)**

- ☐ 1 - History of falls (2 or more falls - or any fall with an injury - in the past 12 months)
- ☐ 2 - Unintentional weight loss of a total of 10 pounds or more in the past 12 months
- ☐ 3 - Multiple hospitalizations (2 or more) in the past 6 months
- ☐ 4 - Multiple emergency department visits (2 or more) in the past 6 months
- ☐ 5 - Decline in mental, emotional, or behavioral status in the past 3 months
- ☐ 6 - Reported or observed history of difficulty complying with any medical instructions (for example, medications, diet, exercise) in the past 3 months
- ☐ 7 - Currently taking 5 or more medications
- ☐ 8 - Currently reports exhaustion
- ☐ 9 - Other risk(s) not listed in 1 - 8
- ☐ 10 - None of the above

(M1034) Overall Status: Which description best fits the patient's overall status? **(Check one)**

- ☐ 0 - The patient is stable with no heightened risk(s) for serious complications and death (beyond those typical of the patient's age).
- ☐ 1 - The patient is temporarily facing high health risk(s) but is likely to return to being stable without heightened risk(s) for serious complications and death (beyond those typical of the patient's age).
- ☐ 2 - The patient is likely to remain in fragile health and have ongoing high risk(s) of serious complications and death.
- ☐ 3 - The patient has serious progressive conditions that could lead to death within a year.
- ☐ UK - The patient's situation is unknown or unclear.

(M1036) Risk Factors, either present or past, likely to affect current health status and/or outcome: **(Mark all that apply.)**

- ☐ 1 - Smoking
- ☐ 2 - Obesity
- ☐ 3 - Alcohol dependency
- ☐ 4 - Drug dependency
- ☐ 5 - None of the above
- ☐ UK - Unknown

(M1041) Influenza Vaccine Data Collection Period: Does this episode of care (SOC/ROC to Transfer/Discharge) include any dates on or between October 1 and March 31?

- ☐ 0 - No ***[Go to M1051]***
- ☐ 1 - Yes

(M1046) Influenza Vaccine Received: Did the patient receive the influenza vaccine for this year's flu season?

- ☐ 1 - Yes; received from your agency during this episode of care (SOC/ROC to Transfer/Discharge)
- ☐ 2 - Yes; received from your agency during a prior episode of care (SOC/ROC to Transfer/Discharge)
- ☐ 3 - Yes; received from another health care provider (for example, physician, pharmacist)
- ☐ 4 - No; patient offered and declined
- ☐ 5 - No; patient assessed and determined to have medical contraindication(s)
- ☐ 6 - No; not indicated - patient does not meet age/condition guidelines for influenza vaccine
- ☐ 7 - No; inability to obtain vaccine due to declared shortage
- ☐ 8 - No; patient did not receive the vaccine due to reasons other than those listed in responses 4 – 7.

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(M1051) Pneumococcal Vaccine: Has the patient ever received the pneumococcal vaccination (for example, pneumovax)?

- ☐ 0 - No
- ☐ 1 - Yes *[Go to M1500 at TRN; Go to M1230 at DC]*

(M1056) Reason Pneumococcal Vaccine not received: If patient has never received the pneumococcal vaccination (for example, pneumovax), state reason:

- ☐ 1 - Offered and declined
- ☐ 2 - Assessed and determined to have medical contraindication(s)
- ☐ 3 - Not indicated; patient does not meet age/condition guidelines for Pneumococcal Vaccine
- ☐ 4 - None of the above

LIVING ARRANGEMENTS

(M1100) Patient Living Situation: Which of the following best describes the patient's residential circumstance and availability of assistance? **(Check one box only.)**

	Availability of Assistance				
Living Arrangement	Around the clock	Regular daytime	Regular nighttime	Occasional / short-term assistance	No assistance available
a. Patient lives alone	☐ 01	☐ 02	☐ 03	☐ 04	☐ 05
b. Patient lives with other person(s) in the home	☐ 06	☐ 07	☐ 08	☐ 09	☐ 10
c. Patient lives in congregate situation (for example, assisted living, residential care home)	☐ 11	☐ 12	☐ 13	☐ 14	☐ 15

SENSORY STATUS

(M1200) Vision (with corrective lenses if the patient usually wears them):

- ☐ 0 - Normal vision: sees adequately in most situations; can see medication labels, newsprint.
- ☐ 1 - Partially impaired: cannot see medication labels or newsprint, but can see obstacles in path, and the surrounding layout; can count fingers at arm's length.
- ☐ 2 - Severely impaired: cannot locate objects without hearing or touching them, or patient nonresponsive.

(M1210) Ability to Hear (with hearing aid or hearing appliance if normally used):

- ☐ 0 - Adequate: hears normal conversation without difficulty.
- ☐ 1 - Mildly to Moderately Impaired: difficulty hearing in some environments or speaker may need to increase volume or speak distinctly.
- ☐ 2 - Severely Impaired: absence of useful hearing.
- ☐ UK - Unable to assess hearing.

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(M1220) Understanding of Verbal Content in patient's own language (with hearing aid or device if used):

- ☐ 0 - Understands: clear comprehension without cues or repetitions.
- ☐ 1 - Usually Understands: understands most conversations, but misses some part/intent of message. Requires cues at times to understand.
- ☐ 2 - Sometimes Understands: understands only basic conversations or simple, direct phrases. Frequently requires cues to understand.
- ☐ 3 - Rarely/Never Understands.
- ☐ UK - Unable to assess understanding.

(M1230) Speech and Oral (Verbal) Expression of Language (in patient's own language):

- ☐ 0 - Expresses complex ideas, feelings, and needs clearly, completely, and easily in all situations with no observable impairment.
- ☐ 1 - Minimal difficulty in expressing ideas and needs (may take extra time; makes occasional errors in word choice, grammar or speech intelligibility; needs minimal prompting or assistance).
- ☐ 2 - Expresses simple ideas or needs with moderate difficulty (needs prompting or assistance, errors in word choice, organization or speech intelligibility). Speaks in phrases or short sentences.
- ☐ 3 - Has severe difficulty expressing basic ideas or needs and requires maximal assistance or guessing by listener. Speech limited to single words or short phrases.
- ☐ 4 - Unable to express basic needs even with maximal prompting or assistance but is not comatose or unresponsive (for example, speech is nonsensical or unintelligible).
- ☐ 5 - Patient nonresponsive or unable to speak.

(M1240) Has this patient had a formal **Pain Assessment** using a standardized, validated pain assessment tool (appropriate to the patient's ability to communicate the severity of pain)?

- ☐ 0 - No standardized, validated assessment conducted
- ☐ 1 - Yes, and it does not indicate severe pain
- ☐ 2 - Yes, and it indicates severe pain

(M1242) Frequency of Pain Interfering with patient's activity or movement:

- ☐ 0 - Patient has no pain
- ☐ 1 - Patient has pain that does not interfere with activity or movement
- ☐ 2 - Less often than daily
- ☐ 3 - Daily, but not constantly
- ☐ 4 - All of the time

INTEGUMENTARY STATUS

(M1300) Pressure Ulcer Assessment: Was this patient assessed for **Risk of Developing Pressure Ulcers?**

- ☐ 0 - No assessment conducted **[*Go to M1306*]**
- ☐ 1 - Yes, based on an evaluation of clinical factors (for example, mobility, incontinence, nutrition) without use of standardized tool
- ☐ 2 - Yes, using a standardized, validated tool (for example, Braden Scale, Norton Scale)

(M1302) Does this patient have a **Risk of Developing Pressure Ulcers?**

- ☐ 0 - No
- ☐ 1 - Yes

(M1306) Does this patient have at least one **Unhealed Pressure Ulcer at Stage II or Higher** or designated as Unstageable? (Excludes Stage I pressure ulcers and healed Stage II pressure ulcers)

- ☐ 0 - No **[*Go to M1322*]**
- ☐ 1 - Yes

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(M1307) The **Oldest Stage II Pressure Ulcer** that is present at discharge: (Excludes healed Stage II Pressure Ulcers)

- ☐ 1 - Was present at the most recent SOC/ROC assessment
- ☐ 2 - Developed since the most recent SOC/ROC assessment. Record date pressure ulcer first identified:

  __ __ / __ __ / __ __ __ __
  month / day / year
- ☐ NA - No Stage II pressure ulcers are present at discharge

(M1308) **Current Number of Unhealed Pressure Ulcers at Each Stage or Unstageable:** (Enter "0" if none; Excludes Stage I pressure ulcers and healed Stage II pressure ulcers)

Stage Descriptions—unhealed pressure ulcers	Number Currently Present
a. **Stage II:** Partial thickness loss of dermis presenting as a shallow open ulcer with red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister.	___
b. **Stage III:** Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscles are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.	___
c. **Stage IV:** Full thickness tissue loss with visible bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling.	___
d.1 Unstageable: Known or likely but Unstageable due to non-removable dressing or device	___
d.2 Unstageable: Known or likely but Unstageable due to coverage of wound bed by slough and/or eschar.	___
d.3 Unstageable: Suspected deep tissue injury in evolution.	___

(M1309) **Worsening in Pressure Ulcer Status since SOC/ROC:**

Instructions for a – c: For Stage II, III and IV pressure ulcers, report the number that are new or have increased in numerical stage since the most recent SOC/ROC.	
	Enter Number (Enter "0" if there are no current Stage II, III or IV pressure ulcers OR if all current Stage II, III or IV pressure ulcers existed at the same numerical stage at most recent SOC/ROC)
a. Stage II	___
b. Stage III	___
c. Stage IV	___
Instructions for d: For pressure ulcers that are Unstageable due to slough/eschar, report the number that are new or were a Stage I or II at the most recent SOC/ROC.	
	Enter Number (Enter "0" if there are no Unstageable pressure ulcers at discharge OR if all current Unstageable pressure ulcers were Stage III or IV or were Unstageable at most recent SOC/ROC)
d. Unstageable due to coverage of wound bed by slough or eschar	___

(M1320) **Status of Most Problematic Pressure Ulcer that is Observable:** (Excludes pressure ulcer that cannot be observed due to a non-removable dressing/device)

- ☐ 0 - Newly epithelialized
- ☐ 1 - Fully granulating
- ☐ 2 - Early/partial granulation
- ☐ 3 - Not healing
- ☐ NA - No observable pressure ulcer

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(M1322) **Current Number of Stage I Pressure Ulcers:** Intact skin with non-blanchable redness of a localized area usually over a bony prominence. The area may be painful, firm, soft, warmer, or cooler as compared to adjacent tissue.

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 or more

(M1324) **Stage of Most Problematic Unhealed Pressure Ulcer that is Stageable:** (Excludes pressure ulcer that cannot be staged due to a non-removable dressing/device, coverage of wound bed by slough and/or eschar, or suspected deep tissue injury.)

☐ 1 - Stage I
☐ 2 - Stage II
☐ 3 - Stage III
☐ 4 - Stage IV
☐ NA - Patient has no pressure ulcers or no stageable pressure ulcers

(M1330) Does this patient have a **Stasis Ulcer**?

☐ 0 - No **[*Go to M1340*]**
☐ 1 - Yes, patient has BOTH observable and unobservable stasis ulcers
☐ 2 - Yes, patient has observable stasis ulcers ONLY
☐ 3 - Yes, patient has unobservable stasis ulcers ONLY (known but not observable due to non-removable dressing/device) **[*Go to M1340*]**

(M1332) **Current Number of Stasis Ulcer(s) that are Observable:**

☐ 1 - One
☐ 2 - Two
☐ 3 - Three
☐ 4 - Four or more

(M1334) **Status of Most Problematic Stasis Ulcer that is Observable:**

☐ 1 - Fully granulating
☐ 2 - Early/partial granulation
☐ 3 - Not healing

(M1340) Does this patient have a **Surgical Wound**?

☐ 0 - No **[*At SOC/ROC, go to M1350 ; At FU/DC, go to M1400*]**
☐ 1 - Yes, patient has at least one observable surgical wound
☐ 2 - Surgical wound known but not observable due to non-removable dressing/device **[*At SOC/ROC, go to M1350 ; At FU/DC, go to M1400*]**

(M1342) **Status of Most Problematic Surgical Wound that is Observable**

☐ 0 - Newly epithelialized
☐ 1 - Fully granulating
☐ 2 - Early/partial granulation
☐ 3 - Not healing

(M1350) Does this patient have a **Skin Lesion** or **Open Wound** (excluding bowel ostomy), other than those described above, that is receiving intervention by the home health agency?

☐ 0 - No
☐ 1 - Yes

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RESPIRATORY STATUS

(M1400) When is the patient dyspneic or noticeably **Short of Breath**?

- ☐ 0 - Patient is not short of breath
- ☐ 1 - When walking more than 20 feet, climbing stairs
- ☐ 2 - With moderate exertion (for example, while dressing, using commode or bedpan, walking distances less than 20 feet)
- ☐ 3 - With minimal exertion (for example, while eating, talking, or performing other ADLs) or with agitation
- ☐ 4 - At rest (during day or night)

(M1410) **Respiratory Treatments** utilized at home: **(Mark all that apply.)**

- ☐ 1 - Oxygen (intermittent or continuous)
- ☐ 2 - Ventilator (continually or at night)
- ☐ 3 - Continuous / Bi-level positive airway pressure
- ☐ 4 - None of the above

CARDIAC STATUS

(M1500) **Symptoms in Heart Failure Patients:** If patient has been diagnosed with heart failure, did the patient exhibit symptoms indicated by clinical heart failure guidelines (including dyspnea, orthopnea, edema, or weight gain) at the time of or at any time since the previous OASIS assessment?

- ☐ 0 - No ***[Go to M2004 at TRN; Go to M1600 at DC]***
- ☐ 1 - Yes
- ☐ 2 - Not assessed ***[Go to M2004 at TRN; Go to M1600 at DC]***
- ☐ NA - Patient does not have diagnosis of heart failure ***[Go to M2004 at TRN; Go to M1600 at DC]***

(M1510) **Heart Failure Follow-up:** If patient has been diagnosed with heart failure and has exhibited symptoms indicative of heart failure at the time of or at any time since the previous OASIS assessment, what action(s) has (have) been taken to respond? **(Mark all that apply.)**

- ☐ 0 - No action taken
- ☐ 1 - Patient's physician (or other primary care practitioner) contacted the same day
- ☐ 2 - Patient advised to get emergency treatment (for example, call 911 or go to emergency room)
- ☐ 3 - Implemented physician-ordered patient-specific established parameters for treatment
- ☐ 4 - Patient education or other clinical interventions
- ☐ 5 - Obtained change in care plan orders (for example, increased monitoring by agency, change in visit frequency, telehealth)

ELIMINATION STATUS

(M1600) Has this patient been treated for a **Urinary Tract Infection** in the past 14 days?

- ☐ 0 - No
- ☐ 1 - Yes
- ☐ NA - Patient on prophylactic treatment
- ☐ UK - Unknown ***[Omit "UK" option on DC]***

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(M1610) Urinary Incontinence or Urinary Catheter Presence:

- ☐ 0 - No incontinence or catheter (includes anuria or ostomy for urinary drainage) **[*Go to M1620*]**
- ☐ 1 - Patient is incontinent
- ☐ 2 - Patient requires a urinary catheter (specifically: external, indwelling, intermittent, or suprapubic) **[*Go to M1620*]**

(M1615) When does **Urinary Incontinence** occur?

- ☐ 0 - Timed-voiding defers incontinence
- ☐ 1 - Occasional stress incontinence
- ☐ 2 - During the night only
- ☐ 3 - During the day only
- ☐ 4 - During the day and night

(M1620) Bowel Incontinence Frequency:

- ☐ 0 - Very rarely or never has bowel incontinence
- ☐ 1 - Less than once weekly
- ☐ 2 - One to three times weekly
- ☐ 3 - Four to six times weekly
- ☐ 4 - On a daily basis
- ☐ 5 - More often than once daily
- ☐ NA - Patient has ostomy for bowel elimination
- ☐ UK - Unknown **[*Omit "UK" option on FU, DC*]**

(M1630) Ostomy for Bowel Elimination: Does this patient have an ostomy for bowel elimination that (within the last 14 days): a) was related to an inpatient facility stay; or b) necessitated a change in medical or treatment regimen?

- ☐ 0 - Patient does not have an ostomy for bowel elimination.
- ☐ 1 - Patient's ostomy was not related to an inpatient stay and did not necessitate change in medical or treatment regimen.
- ☐ 2 - The ostomy was related to an inpatient stay or did necessitate change in medical or treatment regimen.

NEURO/EMOTIONAL/BEHAVIORAL STATUS

(M1700) Cognitive Functioning: Patient's current (day of assessment) level of alertness, orientation, comprehension, concentration, and immediate memory for simple commands.

- ☐ 0 - Alert/oriented, able to focus and shift attention, comprehends and recalls task directions independently.
- ☐ 1 - Requires prompting (cuing, repetition, reminders) only under stressful or unfamiliar conditions.
- ☐ 2 - Requires assistance and some direction in specific situations (for example, on all tasks involving shifting of attention) or consistently requires low stimulus environment due to distractibility.
- ☐ 3 - Requires considerable assistance in routine situations. Is not alert and oriented or is unable to shift attention and recall directions more than half the time.
- ☐ 4 - Totally dependent due to disturbances such as constant disorientation, coma, persistent vegetative state, or delirium.

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(M1710) When Confused (Reported or Observed Within the Last 14 Days):

- ☐ 0 - Never
- ☐ 1 - In new or complex situations only
- ☐ 2 - On awakening or at night only
- ☐ 3 - During the day and evening, but not constantly
- ☐ 4 - Constantly
- ☐ NA - Patient nonresponsive

(M1720) When Anxious (Reported or Observed Within the Last 14 Days):

- ☐ 0 - None of the time
- ☐ 1 - Less often than daily
- ☐ 2 - Daily, but not constantly
- ☐ 3 - All of the time
- ☐ NA - Patient nonresponsive

(M1730) Depression Screening: Has the patient been screened for depression, using a standardized, validated depression screening tool?

- ☐ 0 - No
- ☐ 1 - Yes, patient was screened using the PHQ-2®* scale.

Instructions for this two-question tool: Ask patient: "Over the last two weeks, how often have you been bothered by any of the following problems?"					
PHQ-2®*	Not at all 0 - 1 day	Several days 2 - 6 days	More than half of the days 7 – 11 days	Nearly every day 12 – 14 days	NA Unable to respond
a) Little interest or pleasure in doing things	☐0	☐1	☐2	☐3	☐NA
b) Feeling down, depressed, or hopeless?	☐0	☐1	☐2	☐3	☐NA

- ☐ 2 - Yes, patient was screened with a different standardized, validated assessment and the patient meets criteria for further evaluation for depression.
- ☐ 3 - Yes, patient was screened with a different standardized, validated assessment and the patient does not meet criteria for further evaluation for depression.

(M1740) Cognitive, behavioral, and psychiatric symptoms that are demonstrated at least once a week **(Reported or Observed): (Mark all that apply.)**

- ☐ 1 - Memory deficit: failure to recognize familiar persons/places, inability to recall events of past 24 hours, significant memory loss so that supervision is required
- ☐ 2 - Impaired decision-making: failure to perform usual ADLs or IADLs, inability to appropriately stop activities, jeopardizes safety through actions
- ☐ 3 - Verbal disruption: yelling, threatening, excessive profanity, sexual references, etc.
- ☐ 4 - Physical aggression: aggressive or combative to self and others (for example, hits self, throws objects, punches, dangerous maneuvers with wheelchair or other objects)
- ☐ 5 - Disruptive, infantile, or socially inappropriate behavior (**excludes** verbal actions)
- ☐ 6 - Delusional, hallucinatory, or paranoid behavior
- ☐ 7 - None of the above behaviors demonstrated

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(M1745) **Frequency of Disruptive Behavior Symptoms (Reported or Observed):** Any physical, verbal, or other disruptive/dangerous symptoms that are injurious to self or others or jeopardize personal safety.

- ☐ 0 - Never
- ☐ 1 - Less than once a month
- ☐ 2 - Once a month
- ☐ 3 - Several times each month
- ☐ 4 - Several times a week
- ☐ 5 - At least daily

(M1750) Is this patient receiving **Psychiatric Nursing Services** at home provided by a qualified psychiatric nurse?

- ☐ 0 - No
- ☐ 1 - Yes

ADL/IADLs

(M1800) **Grooming:** Current ability to tend safely to personal hygiene needs (specifically: washing face and hands, hair care, shaving or make up, teeth or denture care, or fingernail care).

- ☐ 0 - Able to groom self unaided, with or without the use of assistive devices or adapted methods.
- ☐ 1 - Grooming utensils must be placed within reach before able to complete grooming activities.
- ☐ 2 - Someone must assist the patient to groom self.
- ☐ 3 - Patient depends entirely upon someone else for grooming needs.

(M1810) Current **Ability to Dress Upper Body** safely (with or without dressing aids) including undergarments, pullovers, front-opening shirts and blouses, managing zippers, buttons, and snaps:

- ☐ 0 - Able to get clothes out of closets and drawers, put them on and remove them from the upper body without assistance.
- ☐ 1 - Able to dress upper body without assistance if clothing is laid out or handed to the patient.
- ☐ 2 - Someone must help the patient put on upper body clothing.
- ☐ 3 - Patient depends entirely upon another person to dress the upper body.

(M1820) Current **Ability to Dress Lower Body** safely (with or without dressing aids) including undergarments, slacks, socks or nylons, shoes:

- ☐ 0 - Able to obtain, put on, and remove clothing and shoes without assistance.
- ☐ 1 - Able to dress lower body without assistance if clothing and shoes are laid out or handed to the patient.
- ☐ 2 - Someone must help the patient put on undergarments, slacks, socks or nylons, and shoes.
- ☐ 3 - Patient depends entirely upon another person to dress lower body.

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(M1830) Bathing: Current ability to wash entire body safely. Excludes **grooming (washing face, washing hands, and shampooing hair).**

- ☐ 0 - Able to bathe self in shower or tub independently, including getting in and out of tub/shower.
- ☐ 1 - With the use of devices, is able to bathe self in shower or tub independently, including getting in and out of the tub/shower.
- ☐ 2 - Able to bathe in shower or tub with the intermittent assistance of another person:
  (a) for intermittent supervision or encouragement or reminders, OR
  (b) to get in and out of the shower or tub, OR
  (c) for washing difficult to reach areas.
- ☐ 3 - Able to participate in bathing self in shower or tub, but requires presence of another person throughout the bath for assistance or supervision.
- ☐ 4 - Unable to use the shower or tub, but able to bathe self independently with or without the use of devices at the sink, in chair, or on commode.
- ☐ 5 - Unable to use the shower or tub, but able to participate in bathing self in bed, at the sink, in bedside chair, or on commode, with the assistance or supervision of another person.
- ☐ 6 - Unable to participate effectively in bathing and is bathed totally by another person.

(M1840) Toilet Transferring: Current ability to get to and from the toilet or bedside commode safely and transfer on and off toilet/commode.

- ☐ 0 - Able to get to and from the toilet and transfer independently with or without a device.
- ☐ 1 - When reminded, assisted, or supervised by another person, able to get to and from the toilet and transfer.
- ☐ 2 - Unable to get to and from the toilet but is able to use a bedside commode (with or without assistance).
- ☐ 3 - Unable to get to and from the toilet or bedside commode but is able to use a bedpan/urinal independently.
- ☐ 4 - Is totally dependent in toileting.

(M1845) Toileting Hygiene: Current ability to maintain perineal hygiene safely, adjust clothes and/or incontinence pads before and after using toilet, commode, bedpan, urinal. If managing ostomy, includes cleaning area around stoma, but not managing equipment.

- ☐ 0 - Able to manage toileting hygiene and clothing management without assistance.
- ☐ 1 - Able to manage toileting hygiene and clothing management without assistance if supplies/implements are laid out for the patient.
- ☐ 2 - Someone must help the patient to maintain toileting hygiene and/or adjust clothing.
- ☐ 3 - Patient depends entirely upon another person to maintain toileting hygiene.

(M1850) Transferring: Current ability to move safely from bed to chair, or ability to turn and position self in bed if patient is bedfast.

- ☐ 0 - Able to independently transfer.
- ☐ 1 - Able to transfer with minimal human assistance or with use of an assistive device.
- ☐ 2 - Able to bear weight and pivot during the transfer process but unable to transfer self.
- ☐ 3 - Unable to transfer self and is unable to bear weight or pivot when transferred by another person.
- ☐ 4 - Bedfast, unable to transfer but is able to turn and position self in bed.
- ☐ 5 - Bedfast, unable to transfer and is unable to turn and position self.

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(M1860) Ambulation/Locomotion: Current ability to walk safely, once in a standing position, or use a wheelchair, once in a seated position, on a variety of surfaces.

- ☐ 0 - Able to independently walk on even and uneven surfaces and negotiate stairs with or without railings (specifically: needs no human assistance or assistive device).
- ☐ 1 - With the use of a one-handed device (for example, cane, single crutch, hemi-walker), able to independently walk on even and uneven surfaces and negotiate stairs with or without railings.
- ☐ 2 - Requires use of a two-handed device (for example, walker or crutches) to walk alone on a level surface and/or requires human supervision or assistance to negotiate stairs or steps or uneven surfaces.
- ☐ 3 - Able to walk only with the supervision or assistance of another person at all times.
- ☐ 4 - Chairfast, unable to ambulate but is able to wheel self independently.
- ☐ 5 - Chairfast, unable to ambulate and is unable to wheel self.
- ☐ 6 - Bedfast, unable to ambulate or be up in a chair.

(M1870) Feeding or Eating: Current ability to feed self meals and snacks safely. Note: This refers only to the process of eating, chewing, and swallowing, not preparing the food to be eaten.

- ☐ 0 - Able to independently feed self.
- ☐ 1 - Able to feed self independently but requires:
  (a) meal set-up; OR
  (b) intermittent assistance or supervision from another person; OR
  (c) a liquid, pureed or ground meat diet.
- ☐ 2 - Unable to feed self and must be assisted or supervised throughout the meal/snack.
- ☐ 3 - Able to take in nutrients orally and receives supplemental nutrients through a nasogastric tube or gastrostomy.
- ☐ 4 - Unable to take in nutrients orally and is fed nutrients through a nasogastric tube or gastrostomy.
- ☐ 5 - Unable to take in nutrients orally or by tube feeding.

(M1880) Current **Ability to Plan and Prepare Light Meals** (for example, cereal, sandwich) or reheat delivered meals safely:

- ☐ 0 - (a) Able to independently plan and prepare all light meals for self or reheat delivered meals; OR
  (b) Is physically, cognitively, and mentally able to prepare light meals on a regular basis but has not routinely performed light meal preparation in the past (specifically: prior to this home care admission).
- ☐ 1 - Unable to prepare light meals on a regular basis due to physical, cognitive, or mental limitations.
- ☐ 2 - Unable to prepare any light meals or reheat any delivered meals.

(M1890) Ability to Use Telephone: Current ability to answer the phone safely, including dialing numbers, and effectively using the telephone to communicate.

- ☐ 0 - Able to dial numbers and answer calls appropriately and as desired.
- ☐ 1 - Able to use a specially adapted telephone (for example, large numbers on the dial, teletype phone for the deaf) and call essential numbers.
- ☐ 2 - Able to answer the telephone and carry on a normal conversation but has difficulty with placing calls.
- ☐ 3 - Able to answer the telephone only some of the time or is able to carry on only a limited conversation.
- ☐ 4 - Unable to answer the telephone at all but can listen if assisted with equipment.
- ☐ 5 - Totally unable to use the telephone.
- ☐ NA - Patient does not have a telephone.

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(M1900) Prior Functioning ADL/IADL: Indicate the patient's usual ability with everyday activities prior to his/her most recent illness, exacerbation, or injury. Check only **one** box in each row.

Functional Area	Independent	Needed Some Help	Dependent
a. Self-Care (specifically: grooming, dressing, bathing, and toileting hygiene)	☐0	☐1	☐2
b. Ambulation	☐0	☐1	☐2
c. Transfer	☐0	☐1	☐2
d. Household tasks (specifically: light meal preparation, laundry, shopping, and phone use)	☐0	☐1	☐2

(M1910) Has this patient had a multi-factor **Falls Risk Assessment** using a standardized, validated assessment tool?

- ☐ 0 - No
- ☐ 1 - Yes, and it does not indicate a risk for falls.
- ☐ 2 - Yes, and it does indicate a risk for falls.

MEDICATIONS

(M2000) Drug Regimen Review: Does a complete drug regimen review indicate potential clinically significant medication issues (for example, adverse drug reactions, ineffective drug therapy, significant side effects, drug interactions, duplicate therapy, omissions, dosage errors, or noncompliance [non-adherence])?

- ☐ 0 - Not assessed/reviewed **[*Go to M2010*]**
- ☐ 1 - No problems found during review **[*Go to M2010*]**
- ☐ 2 - Problems found during review
- ☐ NA - Patient is not taking any medications **[*Go to M2040*]**

(M2002) Medication Follow-up: Was a physician or the physician-designee contacted within one calendar day to resolve clinically significant medication issues, including reconciliation?

- ☐ 0 - No
- ☐ 1 - Yes

(M2004) Medication Intervention: If there were any clinically significant medication issues at the time of, or at any time since the previous OASIS assessment, was a physician or the physician-designee contacted within one calendar day to resolve any identified clinically significant medication issues, including reconciliation?

- ☐ 0 - No
- ☐ 1 - Yes
- ☐ NA - No clinically significant medication issues identified at the time of or at any time since the previous OASIS assessment

(M2010) Patient/Caregiver High-Risk Drug Education: Has the patient/caregiver received instruction on special precautions for all high-risk medications (such as hypoglycemics, anticoagulants, etc.) and how and when to report problems that may occur?

- ☐ 0 - No
- ☐ 1 - Yes
- ☐ NA - Patient not taking any high-risk drugs OR patient/caregiver fully knowledgeable about special precautions associated with all high-risk medications

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(M2015) Patient/Caregiver Drug Education Intervention: At the time of, or at any time since the previous OASIS assessment, was the patient/caregiver instructed by agency staff or other health care provider to monitor the effectiveness of drug therapy, adverse drug reactions, and significant side effects, and how and when to report problems that may occur?

- ☐ 0 - No
- ☐ 1 - Yes
- ☐ NA - Patient not taking any drugs

(M2020) Management of Oral Medications: Patient's current ability to prepare and take all oral medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals. **Excludes injectable and IV medications. (NOTE: This refers to ability, not compliance or willingness.)**

- ☐ 0 - Able to independently take the correct oral medication(s) and proper dosage(s) at the correct times.
- ☐ 1 - Able to take medication(s) at the correct times if:
  (a) individual dosages are prepared in advance by another person; OR
  (b) another person develops a drug diary or chart.
- ☐ 2 - Able to take medication(s) at the correct times if given reminders by another person at the appropriate times
- ☐ 3 - Unable to take medication unless administered by another person.
- ☐ NA - No oral medications prescribed.

(M2030) Management of Injectable Medications: Patient's current ability to prepare and take all prescribed injectable medications reliably and safely, including administration of correct dosage at the appropriate times/intervals. **Excludes IV medications.**

- ☐ 0 - Able to independently take the correct medication(s) and proper dosage(s) at the correct times.
- ☐ 1 - Able to take injectable medication(s) at the correct times if:
  (a) individual syringes are prepared in advance by another person; OR
  (b) another person develops a drug diary or chart.
- ☐ 2 - Able to take medication(s) at the correct times if given reminders by another person based on the frequency of the injection
- ☐ 3 - Unable to take injectable medication unless administered by another person.
- ☐ NA - No injectable medications prescribed.

(M2040) Prior Medication Management: Indicate the patient's usual ability with managing oral and injectable medications prior to his/her most recent illness, exacerbation or injury. Check only **one** box in each row.

Functional Area	Independent	Needed Some Help	Dependent	Not Applicable
a. Oral medications	☐0	☐1	☐2	☐NA
b. Injectable medications	☐0	☐1	☐2	☐NA

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CARE MANAGEMENT

(M2102) Types and Sources of Assistance: Determine the ability and willingness of non-agency caregivers (such as family members, friends, or privately paid caregivers) to provide assistance for the following activities, if assistance is needed. Excludes all care by your agency staff. (Check only **one** box in each row.)

Type of Assistance	No assistance needed – patient is independent or does not have needs in this area	Non-agency caregiver(s) currently provide assistance	Non-agency caregiver(s) need training/ supportive services to provide assistance	Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance	Assistance needed, but no non-agency caregiver(s) available
a. **ADL assistance** (for example, transfer/ ambulation, bathing, dressing, toileting, eating/feeding)	☐0	☐1	☐2	☐3	☐4
b. **IADL assistance** (for example, meals, housekeeping, laundry, telephone, shopping, finances)	☐0	☐1	☐2	☐3	☐4
c. **Medication administration** (for example, oral, inhaled or injectable)	☐0	☐1	☐2	☐3	☐4
d. **Medical procedures/ treatments** (for example, changing wound dressing, home exercise program)	☐0	☐1	☐2	☐3	☐4
e. **Management of Equipment** (for example, oxygen, IV/infusion equipment, enteral/ parenteral nutrition, ventilator therapy equipment or supplies)	☐0	☐1	☐2	☐3	☐4
f. **Supervision and safety** (for example, due to cognitive impairment)	☐0	☐1	☐2	☐3	☐4
g. **Advocacy or facilitation** of patient's participation in appropriate medical care (for example, transportation to or from appointments)	☐0	☐1	☐2	☐3	☐4

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(M2110) How Often does the patient receive **ADL or IADL assistance** from any caregiver(s) (other than home health agency staff)?

- ☐ 1 - At least daily
- ☐ 2 - Three or more times per week
- ☐ 3 - One to two times per week
- ☐ 4 - Received, but less often than weekly
- ☐ 5 - No assistance received
- ☐ UK - Unknown

THERAPY NEED AND PLAN OF CARE

(M2200) Therapy Need: In the home health plan of care for the Medicare payment episode for which this assessment will define a case mix group, what is the indicated need for therapy visits (total of reasonable and necessary physical, occupational, and speech-language pathology visits combined)? **(Enter zero ["000"] if no therapy visits indicated.)**

- (_ _ _) Number of therapy visits indicated (total of physical, occupational and speech-language pathology combined).
- ☐ NA - Not Applicable: No case mix group defined by this assessment.

(M2250) Plan of Care Synopsis: (Check only one box in each row.) Does the physician-ordered plan of care include the following:

Plan / Intervention	No	Yes	Not Applicable	
a. Patient-specific parameters for notifying physician of changes in vital signs or other clinical findings	☐0	☐1	☐NA	Physician has chosen not to establish patient-specific parameters for this patient. Agency will use standardized clinical guidelines accessible for all care providers to reference.
b. Diabetic foot care including monitoring for the presence of skin lesions on the lower extremities and patient/caregiver education on proper foot care	☐0	☐1	☐NA	Patient is not diabetic or is missing lower legs due to congenital or acquired condition (bilateral amputee)
c. Falls prevention interventions	☐0	☐1	☐NA	Falls risk assessment indicates patient has no risk for falls.
d. Depression intervention(s) such as medication, referral for other treatment, or a monitoring plan for current treatment and/or physician notified that patient screened positive for depression	☐0	☐1	☐NA	Patient has no diagnosis of depression AND depression screening indicates patient has: 1) no symptoms of depression, or 2) has some symptoms of depression but does not meet criteria for further evaluation of depression based on screening tool used.
e. Intervention(s) to monitor and mitigate pain	☐0	☐1	☐NA	Pain assessment indicates patient has no pain.
f. Intervention(s) to prevent pressure ulcers	☐0	☐1	☐NA	Pressure ulcer risk assessment (clinical or formal) indicates patient is not at risk of developing pressure ulcers.
g. Pressure ulcer treatment based on principles of moist wound healing OR order for treatment based on moist wound healing has been requested from physician	☐0	☐1	☐NA	Patient has no pressure ulcers OR has no pressure ulcers for which moist wound healing is indicated.

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EMERGENT CARE

(M2300) Emergent Care: At the time of or at any time since the previous OASIS assessment has the patient utilized a hospital emergency department (includes holding/observation status)?

- ☐ 0 - No [*Go to M2400*]
- ☐ 1 - Yes, used hospital emergency department WITHOUT hospital admission
- ☐ 2 - Yes, used hospital emergency department WITH hospital admission
- ☐ UK - Unknown [*Go to M2400*]

(M2310) Reason for Emergent Care: For what reason(s) did the patient seek and/or receive emergent care (with or without hospitalization)? **(Mark all that apply.)**

- ☐ 1 - Improper medication administration, adverse drug reactions, medication side effects, toxicity, anaphylaxis
- ☐ 2 - Injury caused by fall
- ☐ 3 - Respiratory infection (for example, pneumonia, bronchitis)
- ☐ 4 - Other respiratory problem
- ☐ 5 - Heart failure (for example, fluid overload)
- ☐ 6 - Cardiac dysrhythmia (irregular heartbeat)
- ☐ 7 - Myocardial infarction or chest pain
- ☐ 8 - Other heart disease
- ☐ 9 - Stroke (CVA) or TIA
- ☐ 10 - Hypo/Hyperglycemia, diabetes out of control
- ☐ 11 - GI bleeding, obstruction, constipation, impaction
- ☐ 12 - Dehydration, malnutrition
- ☐ 13 - Urinary tract infection
- ☐ 14 - IV catheter-related infection or complication
- ☐ 15 - Wound infection or deterioration
- ☐ 16 - Uncontrolled pain
- ☐ 17 - Acute mental/behavioral health problem
- ☐ 18 - Deep vein thrombosis, pulmonary embolus
- ☐ 19 - Other than above reasons
- ☐ UK - Reason unknown

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DATA ITEMS COLLECTED AT INPATIENT FACILITY ADMISSION OR AGENCY DISCHARGE ONLY

(M2400) Intervention Synopsis: (Check only one box in each row.) At the time of or at any time since the previous OASIS assessment, were the following interventions BOTH included in the physician-ordered plan of care AND implemented?

Plan / Intervention	No	Yes	Not Applicable	
a. Diabetic foot care including monitoring for the presence of skin lesions on the lower extremities and patient/caregiver education on proper foot care	☐0	☐1	☐NA	Patient is not diabetic or is missing lower legs due to congenital or acquired condition (bilateral amputee)
b. Falls prevention interventions	☐0	☐1	☐NA	Every standardized, validated multi-factor fall risk assessment conducted at or since the last OASIS assessment indicates the patient has no risk for falls.
c. Depression intervention(s) such as medication, referral for other treatment, or a monitoring plan for current treatment	☐0	☐1	☐NA	Patient has no diagnosis of depression AND every standardized, validated depression screening conducted at or since the last OASIS assessment indicates the patient has: 1) no symptoms of depression; or 2) has some symptoms of depression but does not meet criteria for further evaluation of depression based on screening tool used.
d. Intervention(s) to monitor and mitigate pain	☐0	☐1	☐NA	Every standardized, validated pain assessment conducted at or since the last OASIS assessment indicates the patient has no pain.
e. Intervention(s) to prevent pressure ulcers	☐0	☐1	☐NA	Every standardized, validated pressure ulcer risk assessment conducted at or since the last OASIS assessment indicates the patient is not at risk of developing pressure ulcers.
f. Pressure ulcer treatment based on principles of moist wound healing	☐0	☐1	☐NA	Patient has no pressure ulcers OR has no pressure ulcers for which moist wound healing is indicated.

(M2410) To which **Inpatient Facility** has the patient been admitted?

- ☐ 1 - Hospital [*Go to M2430*]
- ☐ 2 - Rehabilitation facility [*Go to M0903*]
- ☐ 3 - Nursing home [*Go to M0903*]
- ☐ 4 - Hospice [*Go to M0903*]
- ☐ NA - No inpatient facility admission [*Omit "NA" option on TRN*]

(M2420) Discharge Disposition: Where is the patient after discharge from your agency? **(Choose only one answer.)**

- ☐ 1 - Patient remained in the community (without formal assistive services)
- ☐ 2 - Patient remained in the community (with formal assistive services)
- ☐ 3 - Patient transferred to a non-institutional hospice
- ☐ 4 - Unknown because patient moved to a geographic location not served by this agency
- ☐ UK - Other unknown [*Go to M0903*]

Page _____ of _____

(Addendum to Comprehensive Assessment) MEDICATION PROFILE

Patient Name	Record #	Physician	Phone #
Allergies	Weight	Height	
Pharmacy	Phone	Fax	

Medications Administered by: ☐ Patient ☐ Nurse ☐ Family _____ ☐ Caregiver

* In the **Potential Side Effects** column write either appropriate Medication Class Reference #, OTC or ALT. *(See canary pages for Medication Classes and associated Side Effects.)*

Date Started	Date Disc.	Medication	Code	Dose/Route	Freq.	Purpose	Potential Side Effects*

Code: N = New C = Changed L/S = Long standing H = Hospice Provided

DRUG REGIMEN REVIEW — Date ▶	1	2	3	4
A. The patient reports experiencing 1 or more significant side effects to current drug regimen.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
B. Does the patient and/or caregiver demonstrate a knowledge deficit related to current medication use?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
C. Does the patient demonstrate noncompliance with medication use, as prescribed by physician?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
D. Does patient and/or caregiver have any questions related to current medications, including purpose, dosage, or administration?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
E. Have potential adverse effects, significant drug interactions, duplicate/ineffective drug therapy and potential contraindications been identified?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

F. **Describe Problem and Action for any "YES" responses:**

Date:

Date:

Date:

Date:

G. ☐ **Medications Reconciled (per agency policy)**

1 Signature/Date	3 Signature/Date
2 Signature/Date	4 Signature/Date

WHITE – Clinical Record CANARY – In-home Copy

Heart Failure Start of Care Orders and Goals

Start of Care Discipline Orders:

APN VISIT FREQUENCY

Recommended: **1WK9 and 3 PRN visits for HF management complications**

Other Discipline Orders

___ PT Evaluate and Treat Orders & Goals to follow ___OT Evaluate and Treat Orders & Goals to follow
___ ST Evaluate and Treat Orders & Goals to follow ___ MSW Evaluate Orders & Goals to follow
___ HHA Orders & Goals to follow ___ Other:_____

Start of Care Goals (Mark X for appropriate goals)

DISEASE PROCESS

_____ 1. Patient/Caregiver will verbalize understanding of disease process within three visits
_____ 2. Patient/Caregiver will verbalize signs & symptoms to report to skilled nurse or doctor within three visits
_____ 3. Patient will demonstrate ability to manage pain through appropriate use of medication and/or other therapies during certification period
_____ 4. Patient will demonstrate ability to maintain disease process in home without unplanned doctor's visit, Emergency Room visit, or re-hospitalization during certification period
_____ 5. Patient will demonstrate knowledge of disease process, treatment goals and self-care management by the end of the certification period

MEDICATION

_____ 6. Patient/Caregiver will demonstrate compliance with medication schedule and administration by the end of the certification period

SAFETY

_____ 7. Patient will verbalize and demonstrate injury and fall risk in the home environment throughout the certification period

PSYCHOSOCIAL

_____ 8. Patient/Caregiver will demonstrate positive health behaviors by the end of the certification period
_____ 9. Patient/Caregiver will verbalize coping strategies to deal with lifestyle changes as a result of disease process by the end of the certification period

COMMUNITY

_____10. Patient/Caregiver will verbalize available community resources available within five weeks
_____11. Patient/Caregiver will verbalize dates and times of follow-up physician appointments throughout certification period

Other:_____
_____

Signature/Title	Date:

Heart Failure Pain Management

GOAL: Patient will demonstrate effective level of pain control

Initiate upon admission and document each visit

INTERVENTIONS: (Use "X" for completed) **Dates:**					
1. Assess pain level and quality on pain scale					
2. Evaluate the effectiveness if pain management measures					
3. Instruct on pain management methods					
4. Instruct on alternative pain treatment measures/non-pharmacological to increase comfort; describe_____					
5. Instruct on action of prescribed medication					
6. Instruct on adverse effects of prescribed medications and methods to prevent/control					
7. Evaluate knowledge of pain management and symptom control					
8. Evaluate compliance with prescribed medication regimen					
9. Verbalize/demonstrate effective pain level					
10. Verbalize level of pain per pain scale					
11. Verbalize knowledge of non-pharmacological methods of pain control: guided imagery, relaxation techniques, etc.					

Comments_____
_____
_____

Initials:	Signature:	Initials:	Signature:
Initials:	Signature:	Initials:	Signature:

Heart Failure Oxygen Use and Safety

GOALS: Patient/Caregiver will verbalize and demonstrate correct use of oxygen therapy and oxygen safety precautions. Home environment will remain free of hazardous conditions that could interfere with oxygen therapy.

Initiate upon admission and document each visit

INTERVENTIONS: (Use "X" for completed) **Dates:**					
1. Instruct on sign & symptoms of hypoxemia					
2. Instruct on use of oxygen for disease process					
3. Instruct on oxygen flow use and not to change unless instructed by physician					
4. Instruct on use of oxygen tank/concentrator & to have backup tank					
5. Assess home environment for oxygen safety hazards					
6. Assess home environment for fire extinguisher and use					
7. Instruct to place NO SMOKING SIGNS on door					
8. Instruct no to smoke and to stay away from open flames					
9. Evaluate understanding of actions to take for malfunctioning oxygen equipment					
10. Evaluate compliance with safe oxygen use					
11. Verbalize knowledge of correct oxygen flow rate					
12. Demonstrate safe usage of oxygen					
13. Verbalizes causes and actions to take in the event of a fire					
14. Verbalizes evacuation plan					
15. Demonstrate compliance with oxygen safety precautions					

Comments:_____
_____
_____

Initials:	Signature:	Initials:	Signature:
Initials:	Signature:	Initials:	Signature:

Heart Failure Assessment Form

Patient Name: _____
MR#_____ Visit # _____

Care Elements	Interventions: Use "X" for completed	Assessment Findings/Comments
Disease Process	___Assess cardiac/circulatory status ___Assess level of dyspnea at rest and with activity ___Instruct on the signs and symptoms of exacerbation of HF and treatment option ___Instruct to report signs and symptoms of skin breakdown ___Instruct on causes of edema; measures to control and need to monitor ___Instruct to record weight daily and to report weight gain of 2lbs in one day or 5lbs in one week or per doctor's orders ___Instruct to avoid stressors that may precipitate HF exacerbation ___Instruct on long-term effects of disease process and preventative measures for disease management ___Instruct on effects of diet, medication and physical activity ___Instruct on reason to avoid alcohol and smoking ___Instruct on potential effects of noncompliance with plan of care ___Evaluate knowledge of disease process, causes, s/s of complications ___Evaluate ability to take pulse ___Evaluate compliance with skin care to areas with noted edema ___Evaluate knowledge of how to decrease risk of HF exacerbation ___Evaluate compliance with self-monitoring activities	Vital Signs: ___BP ___T ___P ___R Pain: location/frequency/duration: Patient denies pain ___ Pain rate: start of visit__ end of visit__ Acceptable pain level __yes __no Methods of pain relief: Chest Pain_____ Lung Sounds:_____ Dyspnea:_____ O2@____L/____; Pulse Ox_____ Edema:_____ Skin Integrity /Color:_____ Abdomen: _____ Bladder/Bowel:_____
Medication	___Instruct on medications: action, adverse effects, OTC meds, supplements	___New medications (complete medication profile sheet)
Nutrition/ Elimination	___Assess nutrition and hydration status ___Instruct on diet/fluid restriction ___Assess GU and GI function	Appetite: ___good ___fair ___poor Dietary Intake: NAS diet___ 24 hr. Fluid Intake ____
Safety	___Instruct on oxygen safety precautions	Environment: ___safe ___unsafe/risk factors:
Psychosocial	___Assess family/caregiver/social support system ___Assess access to community resources (food, transportation etc.)	Orientation: __Person __Place __Time Confused, frequency:_____ Sleep pattern: # pillows___; semi___; full Fowlers___
Interdisciplinary Team/Community Referrals	___Assess need for interdisciplinary conference with_____ ___Assess for next doctor's appt.	Reason for conference/outcome of conference:

	Date:_____	

Heart Failure Assessment Form

Patient Name: _____

MR#_____ Visit # _____

Patient/Caregiver Outcomes (Use "X" for completed)	**Met**	**Not Met Variance**	**Additional Comments**
1. Demonstrate no deterioration in condition			Condition __improved __unchanged __worsening
2. Demonstrate ability to sustain medical condition in home without hospitalization, ER visit, unplanned doctor visit since last nursing visit			__Emergency Room visit __hospital __# days in hospital __unplanned doctor's visit __prn nursing visit
3. Demonstrate optimum GI/GU function			
4. Demonstrate decreased edema, if applicable			
5. Demonstrate compliance with meds/supplement			
6. Demonstrate compliance with prescribed nutrition/hydration			
7. Demonstrate compliance with standard precautions			
8. Demonstrate safe use of equipment (oxygen, fire extinguishers, supplemental oxygen tanks)			
9. Demonstrate ability to remain safe in home environment without falls/injury			
10. Demonstrate inclusion of prescribed treatment into lifestyle			
11. Verbalize purpose, action, adverse effects of meds/supplements instructed this visit			
12. Verbalize dietary & fluid restrictions (appropriate food and fluid choices)			
13. Verbalize three oxygen safety precautions			
14. Verbalize cause of disease process			
15. Verbalize three exacerbation measures			
16. Verbalize the signs and symptoms of electrolyte imbalance			
17. Verbalize effects of dehydration & electrolyte imbalance on disease process and appropriate actions to take			
18. Verbalize the importance of monitoring daily weights			
19. Verbalize importance of exercise and physical activity			
20. Verbalize effective coping skills			
21. Verbalize importance of follow-up doctor's appt., meds, Diagnostic lab test after discharge			
22. Verbalize ability to access community resources			
23. Verbalize satisfactory adaptation to disease process			
21. Verbalize agreement with discharge plans			

Comments:_____
_____
_____

Clinician Signature/Title	**Date**

My Follow-up Visit/Phone Call Log

Patient Name _____

Date	Doctor or APN	Reason

My Vital Sign Log

Patient Name_____

Date	Weight	Blood Pressure	Heart Rate	Blood Sugar	Misc.

Contact
(_____)
Phone (____) ____ - _____

with concerns or question, if you have difficulty contacting your primary care provider, heart specialist, or home health nurse.

My Personal Health Record

Name_____

If you have concerns or questions
Call _____
Phone (____) ____-_____

Take your record with you to all visits with your doctors.

Home Address:	
Home Phone:	
Cell Phone:	
Birthday:	
Primary Care Provider:	
Medical Directive Advance:	YES NO

Caregiver Information

Name:	
Relation to me:	
Home Phone:	
Cell Phone:	

Latest Hospital Visits

Hospital	Admission/ Discharge	Purpose for Admission
	__/__/__ to __/__/__	

Symptoms …

Notes and Questions for my Doctor:

Symptoms …

Questions for Home Nurse:

Important Phone Numbers

911	Emergency	Police, Fire, Paramedics
1.800.222.1222	Poison	Poison Control
What	**Who/Name**	**Number**
Doctor #1		
Dentist		
Pharmacy		
Relative/Friend		
Relative/Friend		
Home Care Agency		

My Specialty Doctors

Name	Specialist	Phone Number

History – Medical

Check any health problems that you have had:

- ❑ Drug or Food Allergies
- ❑ Abnormal Heart Rhythm (Slow, Fast or Irregular Heart Beat)
- ❑ Back Surgery/Pain
- ❑ Diabetes
- ❑ Cancer
- ❑ Heart Failure
- ❑ Heart Disease
- ❑ Fractures
- ❑ Disease of Lung
- ❑ Stroke
- ❑ Other: _____

The individual who may make decisions about my health, if I cannot speak:

Name_____

Phone _____

My Advance Directive is located:

_____

_____

_____

My Advance Directives

Advance Directive is a document that is signed and states either:

(1) Desires for medical treatment if unable to make known for yourself or;

(2) The identification of an individual who knows desires and can make desires know if you are unable to make known for yourself.

Pledge for My Personal Health

To better manage my health and medications, I will

- ✓ Take this Personal Health Record with me to wherever I go, including ALL doctor visits and future trips to the hospital
- ✓ Call my doctor if I have questions about my medications or if I want to change how I take my medications
- ✓ Tell my doctors about ALL medications I am taking, including over-the-counter drugs, vitamins and herbal formulas
- ✓ Update my Medication Record with any changes to my medications
- ✓ Know why I am taking each of my medications
- ✓ Know how much, when and for how long I am to take each medication
- ✓ Know possible medication side effects to watch out for and what to do if I notice any.

My Responsibilities Checklist

Participating in self-care management, I will be able to say …

- ❑ I have been involved in decision-making and planning my care
- ❑ I have someone to call if I have problems.
- ❑ I understand what my medications are, how to get them and how to take them.
- ❑ I understand the potential side effects of my medications and whom I should call if I experience them.
- ❑ I understand what symptoms I need to watch out for and whom to call should I notice them.
- ❑ I understand how to keep my health problems from becoming worse.
- ❑ My doctor or nurse has answered my most important questions.

“Red Flags” and Warning Signs

When to Get Help Right Away

Here is a list of things that mean you need to get medical help right away:

- You have trouble breathing.
- You have a bad pain in the chest or stomach and find it hard to breath, with sweating.
- You have a bad pain in the neck, shoulders, and arms.
- All of a sudden you can’t talk.
- All of a sudden you can’t move one side of your body.
- One side of your body feels numb.
- All of a sudden you have pain in one eye.
- All of a sudden you can’t see with one eye.
- You have bleeding that can’t be stopped.
- You have pain from a fall.

When you need help right away, call 911 or local emergency services.

Medication Record

Questions about my medications for my Doctor or Nurse:

Date_____ List of Medications

Medicine the Doctor Prescribed

Name	Dose	When	Color	Why Taken?	New?
(example) Cipro	*250mg,1 capsule, four times a day – Until gone*	*9am, 1pm, 5pm, 9pm*	*red*	*To treat my infection*	❑
					❑
					❑
					❑
					❑
					❑
					❑

Medicine I buy and take for myself ("over-the-counter"). Check any you use.

❑ Laxatives	❑ Aspirin/other pain	❑ Antacids	❑ Vitamins	❑ Herbal Remedy
❑ Cold medicine	❑ Cough medicine	❑ Allergy	❑ Sleeping Pills	
Others	❑	❑	❑	❑

(names) _____ _____ _____ _____

Reactions and Allergies: (*example: Penicillin Rash*)

_____

Follow-Up Weekly Phone Call Intervention Checklist

Medication Management

Interventions	Dates:					
Review and reconciliation of medications						
Document current medications list						
Discuss medication management						
Identify medication discrepancies						
Answer questions about medications						
Identify medications needing refills or barriers to refills						

Personal Health Record (PHR)

Explain PHR to patient and caregiver (initial visit and as needed)						
Update PHR as needed						
Reinforce the importance of bringing PHR to all future health care encounters and show it to health professionals						

Medical Care Follow-Up

Schedule patient f/u appointment with PCP or Specialist						
Identify problems that require immediate PCP or Specialist visit						
Develop questions with patient for PCP or Specialist						

Education - Red Flags

Discuss self management of condition(s)						
Discuss and teach self-management of condition(s)						
Discuss target symptoms/side effects to monitor and what to do should they arise						
Discuss when PCP should be called						

Discuss pain management						
Discuss oxygen management as applicable						

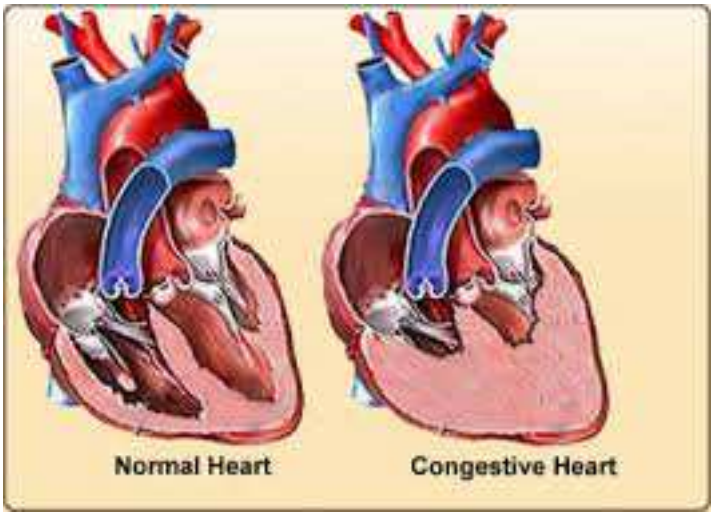
Information About Heart Failure

What Is Heart Failure?

Heart failure is not a "failure." It is a weakness that makes the heart unable to pump enough blood throughout the body.

Heart failure can also occur when the heart becomes so thick or stiff that it cannot let enough blood go through to meet the body's needs.

The heart can get weak by other diseases, such as high blood pressure, or block in the arteries.



Can Heart Failure Be Treated?

Heart failure can shorten your life. However, new treatments, drugs, and exercise can give you the chance to live a longer and healthier life.

To treat your heart failure, your doctor will:

- Ask you about your signs/symptoms, other diseases, and other medical tests that you have had.
- Look how your heart failure affecting the rest of your body. You may need special tests, such as exercise testing.
- Decide the best treatment for you. This may include other medicines, exercise, and a change the way you eat.

What Can You Do?

Heart failure is not managed only by your doctor. **You** are the key to the success of managing your heart failure.

You can earn about the disease how to monitor your condition and adjust your medicines. You will work with your doctor and home health care providers and to be an important part of your own care.